- 1	BlueCross BlueShield of Oklahoma	2024 Recommended Clinical Review (Predetermination), Post- Service Review and Non-Covered Procedure Code List Effective 1/1/2024 (Updated June 2024)				
codes related t otherwise indica	rrent Procedural Terminology (CPT®) and/or Heal o services/categories for which prior authorization ated through Blue Cross and Blue Shield of Oklaho - Blue Choice Preferred I - Blue Choice PPO ^S - Blue Traditional ^{SI} For Medical Policy information, please access the	oma managed for one or more of our networks: PPO SM M	This file is a sear Press "CTRL" an	rchable PDF. d "F" keys at the sa	me time to bring up the or description of the	
	Procedure Code Groups	Procedure	Code Group Descr	ription		
Medical Policy Criter	ia (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 co	ontract agreement.	
Non Covered		Procedures/services not covered by the Plan. Not subject to pre-service review.				
Experimental, Invest	igational, 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 Undefine	ed	Procedures/services not specifically defined or cla	ssified, may be sul	bject to contract/cli	nical review.	
	Note: Some codes will appear t	twice if Ending Date and Effective Date are within th	e same quarter pe	eriod.		
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 servic meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predeterminatior 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 servic meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predeterminatior request if it is unclear if the service meets BCBSOK Medical Policy criteria.	_	-	-	

11055	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg Corn	MP Criteria: Procedure/service reviewed to ensure each service			
11055	Or Callus); Single Lesion	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	or callus, single Lesion	submitting a Recommended Clinical Review (Predetermination)			
		с , , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
11056	Paring Or Cutting Of Benign Hyperkeratotic Lesion (Eg Corn	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
11050			-	-	-
	Or Callus); 2 To 4 Lesions	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Or Callus); More Than 4 Lesions	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	_	_
	Area; Up To And Including 15 Lesions	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Area; Each Additional 10 Lesions Or Part Thereof (List	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Separately In Addition To Code For Primary Procedure)	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Pigments To Correct Color Defects Of Skin Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Micropigmentation; 6.0 Sq Cm Or Less	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	MP Criteria: Procedure/service reviewed to ensure each service		5/31/2024	Retire effective
-	Pigments To Correct Color Defects Of Skin Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-		5/31/2024
	Micropigmentation; 6.1 To 20.0 Sq Cm	submitting a Recommended Clinical Review (Predetermination)			-,,
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
11922	Tattooing Intradermal Introduction Of Insoluble Opaque	MP Criteria: Procedure/service reviewed to ensure each service			
	Pigments To Correct Color Defects Of Skin Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Micropigmentation; Each Additional 20.0 Sq Cm Or Part	submitting a Recommended Clinical Review (Predetermination)			
	Thereof (List Separately In Addition To Code For Primary	request if it is unclear if the service meets BCBSOK Medical			
	Procedure)	Policy criteria.			

11950		MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Cc Or Less	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	То 5.0 Сс	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	To 10.0 Cc	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
1		request if it is unclear if the service meets BCBSOK Medical		
l		Policy criteria.		
11954		MP Criteria: Procedure/service reviewed to ensure each service _	-	_
	Over 10.0 Cc	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Including Subsequent Expansion	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
11000		Policy criteria.		
11980	Subcutaneous Hormone Pellet Implantation (Implantation	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Of Estradiol And/Or Testosterone Pellets Beneath The Skin)	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
11981	Insertion Drug-Delivery Implant (le Bioresorbable	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
11901	Biodegradable Non-Biodegradable)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	blouegradable Non-blouegradable)	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		
11902	Removal Hon Diodegradable Drug Denvery implant	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _		1
	Implant	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
	Ļ	runcy criteria.	I	ļ

15271	Application Of Skin Substitute Graft To Trunk Arms Legs	MP Criteria: Procedure/service reviewed to ensure each service			
19211	Total Wound Surface Area Up To 100 Sq Cm; First 25 Sq Cm	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Or Less Wound Surface Area	submitting a Recommended Clinical Review (Predetermination)			
	Of Less Would Surface Alea	request if it is unclear if the service meets BCBSOK Medical			
15272	Application Of Skin Substitute Graft To Trunk Arms Legs	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
15272		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· · · · · · · · · · · · · · · · · · ·			
	25 Sq Cm Wound Surface Area Or Part Thereof (List	submitting a Recommended Clinical Review (Predetermination)			
	Separately In Addition To Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
15273	Application Of Skin Substitute Graft To Trunk Arms Legs	MP Criteria: Procedure/service reviewed to ensure each service			
15275		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Cm; First 100 Sq Cm Wound Surface Area Or 1% Of Body	submitting a Recommended Clinical Review (Predetermination)			
	Area Of Infants And Children	request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
15274	Application Of Skin Substitute Graft To Trunk Arms Legs	MP Criteria: Procedure/service reviewed to ensure each service			
15274	Total Wound Surface Area Greater Than Or Equal To 100 Sq	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Cm; Each Additional 100 Sq Cm Wound Surface Area Or	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
	And Children Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	Policy criteria.			
15275	Application Of Skin Substitute Graft To Face Scalp Eyelids	MP Criteria: Procedure/service reviewed to ensure each service			
15275	Mouth Neck Ears Orbits Genitalia Hands Feet And/Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	First 25 Sq Cm Or Less Wound Surface Area	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
15276	Application Of Skin Substitute Graft To Face Scalp Eyelids	MP Criteria: Procedure/service reviewed to ensure each service			
	Mouth Neck Ears Orbits Genitalia Hands Feet And/Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Multiple Digits Total Wound Surface Area Up To 100 Sq Cm;	submitting a Recommended Clinical Review (Predetermination)			
	Each Additional 25 Sq Cm Wound Surface Area Or Part	request if it is unclear if the service meets BCBSOK Medical			
	Thereof (List Separately In Addition To Code For Primary	Policy criteria.			
	Procedure)	roncy enterta.			
15277	Application Of Skin Substitute Graft To Face Scalp Eyelids	MP Criteria: Procedure/service reviewed to ensure each service			
	Mouth Neck Ears Orbits Genitalia Hands Feet And/Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Multiple Digits Total Wound Surface Area Greater Than Or	submitting a Recommended Clinical Review (Predetermination)			
	Equal To 100 Sq Cm; First 100 Sq Cm Wound Surface Area	request if it is unclear if the service meets BCBSOK Medical			
	Or 1% Of Body Area Of Infants And Children	Policy criteria.			
15278	Application Of Skin Substitute Graft To Face Scalp Eyelids	MP Criteria: Procedure/service reviewed to ensure each service			
	Mouth Neck Ears Orbits Genitalia Hands Feet And/Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Multiple Digits Total Wound Surface Area Greater Than Or	submitting a Recommended Clinical Review (Predetermination)			
	Equal To 100 Sq Cm; Each Additional 100 Sq Cm Wound	request if it is unclear if the service meets BCBSOK Medical			
	Surface Area Or Part Thereof Or Each Additional 1% Of	Policy criteria.			
	Body Area Of Infants And Children Or Part Thereof (List				
	Separately In Addition To Code For Primary Procedure)				

15758	Eroo Escrial Elan With Microvescular Anastamasis	MB Critoria: Procedure/convice reviewed to ensure each earlier	1		1
86161	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			
45774		Policy criteria.			
15771	Grafting Of Autologous Fat Harvested By Liposuction	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Technique To Trunk Breasts Scalp Arms And/Or Legs; 50	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Cc Or Less Injectate	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
	Addition To Code For Primary Procedure)	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Wrinkling Rhytids General Keratosis)	meets BCBSOK 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			
13780	Abrasion, single Lesion (Eg. Keratosis Scar)		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical			
15787	Abrasion; Each Additional 4 Lesions Or Less (List Separately	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13787	In Addition To Code For Primary Procedure)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	In Addition to code for Phinary Procedure)	,			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
15788	Chemical Peel Facial; Epidermal	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13788		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
15789	Chemical Peel Facial; Dermal	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
10705		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		. . ,			
		request if it is unclear if the service meets BCBSOK Medical			
15792	Chemical Peel Nonfacial; Epidermal	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13792		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		1 ·			
15793	Chemical Peel Nonfacial; Dermal	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13733		meets BCBSOK 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			
15015	cervicopidsty	subject to utilization review.	-	-	-
15820	Blepharoplasty Lower Eyelid;	MP Criteria: Procedure/service reviewed to ensure each service			
15020	Diepharopiasty Lower Lycia,	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
15021	Pad	meets BCBSOK 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: MP Criteria: Procedure/service reviewed to ensure each service			
13022		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.	<u>I</u>		ļ

15823	Blepharoplasty Upper Evelid: With Excessive Skin Weighting	MP Criteria: Procedure/service reviewed to ensure each service			
	Down Lid	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Flap P-Flap)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	(Smas) Flap	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	() - P	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Lipectomy); Abdomen Infraumbilical Panniculectomy	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Lipectomy); Thigh	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Lipectomy); Leg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Lipectomy); Hip	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Lipectomy); Buttock	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

45020				
15836	Excision Excessive Skin And Subcutaneous Tissue (Includes	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Lipectomy); Arm	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Lipectomy); Forearm Or Hand	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Lipectomy); Submental Fat Pad	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Lipectomy); Other Area	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Lipectomy) Abdomen (Eg Abdominoplasty) (Includes	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Umbilical Transposition And Fascial Plication) (List	submitting a Recommended Clinical Review (Predetermination)		
	Separately In Addition To Code For Primary Procedure)	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			
20000		defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
17106	Destruction Of Cutaneous Vascular Proliferative Lesions (Eg	MP Criteria: Procedure/service reviewed to ensure each service			
	Laser Technique); Less Than 10 Sq Cm	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Laser Technique); 10.0 To 50.0 Sq Cm	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			_
	Laser Technique); Over 50.0 Sq Cm	meets BCBSOK 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	Unlisted or Undefined: Procedure/service not otherwise	-	_	-
	Subcutaneous Tissue	defined or classified, and may be subject to benefit and/or			
		clinical review.			
19105	Ablation Cryosurgical Of Fibroadenoma Including	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Ultrasound Guidance Each Fibroadenoma	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	
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.			

10202	Mastastany, Cincela Convolute	MD Cuttoria. Decodure / and in an investigation of the same state in the			1
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Contents (Eg Saline Silicone Gel)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Immediate)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Day From Mastectomy	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Including Subsequent Expansion(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
1		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

19370	Revision Of Peri-Implant Capsule Breast Including	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Removal Of All Intracapsular Contents	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
2002/	Dupuytren'S Contracture)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Supultions contractarcy	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Noninvasive (Nonoperative)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	When Involved By Tumor Extension Percutaneous Including	submitting a Recommended Clinical Review (Predetermination)			
	Imaging Guidance When Performed; Radiofrequency	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
20983	Ablation Therapy For Reduction Or Eradication Of 1 Or More	MP Criteria: Procedure/service reviewed against Medical Policy	_	_	_
	Bone Tumors (Eg Metastasis) Including Adjacent Soft Tissue	Criteria. Submit for Recommended Clinical Review			
	When Involved By Tumor Extension Percutaneous Including				
	Imaging Guidance When Performed; Cryoablation				

20985	Computer-Assisted Surgical Navigational Procedure For	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
20505	Musculoskeletal Procedures Image-Less (List Separately In	to utilization review. Please see the Clinical Payment and	-	-	-
	Addition To Code For Primary Procedure)	Coding Policy titled: Non-Reimbursable Experimental,			
	Addition to code for Finnary Frocedure)	Investigational and/or Unproven Services (EIU).			
20999	Unlisted Procedure Musculoskeletal System General	Unlisted or Undefined: Procedure/services (EIO).			
20555	Unisted Procedure Musculoskeletal System General	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
21073	Manipulation Of Temporomandibular Joint(S) (Tmj)	MP Criteria: Procedure/service reviewed to ensure each service			
21073		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	Monitored Anesthesia Care)	, , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
21083	Impression And Custom Preparation; Palatal Lift Prosthesis	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
21083	Impression And Custom Preparation; Palatal Lift Prostnesis		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
21080	Unlisted Maxillafe siel Dreath stie Duagedung	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			
24420	Control of a second disc (A second Allowed Developments	clinical review.			
21120		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Material)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
24424		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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	(Eg Wedge Excision Or Bone Wedge Reversal For	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Asymmetrical Chin)	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Bone Grafts (Includes Obtaining Autografts)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Bone Plate (Eg Mandibular Staple Bone Plate)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
21240	Implant; Partial	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Implant; Complete	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Cartilage Autografts (Includes Obtaining Grafts) (Eg For	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Hemifacial Microsomia)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Eg Blade Cylinder); Partial	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Eg Blade Cylinder); Complete	meets BCBSOK 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			
24.625		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			
21740	Reconstructive Repair Of Pectus Excavatum Or Carinatum;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
21740			-	-	-
	Open	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
21742	Reconstructive Repair Of Pectus Excavatum Or Carinatum;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
LT/7L	Minimally Invasive Approach (Nuss Procedure) Without	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
1	Thoracoscopy	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.	I		

21743	Reconstructive Repair Of Pectus Excavatum Or Carinatum;	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Minimally Invasive Approach (Nuss Procedure) With	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Thoracoscopy	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Unilateral Or Bilateral Including Fluoroscopic Guidance;	to utilization review. Please see the Clinical Payment and			
	Single Level	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
22527	Percutaneous Intradiscal Electrothermal Annuloplasty	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Unilateral Or Bilateral Including Fluoroscopic Guidance; 1 Or	to utilization review. Please see the Clinical Payment and			
	More Additional Levels (List Separately In Addition To Code	Coding Policy titled: Non-Reimbursable Experimental,			
	For Primary Procedure)	Investigational and/or Unproven Services (EIU).			
22586	Arthrodesis Pre-Sacral Interbody Technique Including Disc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Space Preparation Discectomy With Posterior	to utilization review. Please see the Clinical Payment and			
	Instrumentation With Image Guidance Includes Bone Graft	Coding Policy titled: Non-Reimbursable Experimental,			
	When Performed L5-S1 Interspace	Investigational and/or Unproven Services (EIU).			
22836	Anterior Thoracic Vertebral Body Tethering Including	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Thoracoscopy When Performed; Up To 7 Vertebral	Criteria. Submit for Recommended Clinical Review			05/14/2024
	Segments	(Predetermination) to avoid post-service review.			
22836	Anterior Thoracic Vertebral Body Tethering Including	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Thoracoscopy When Performed; Up To 7 Vertebral	to pre-service review. Check EIU policy, which is one of our			05/15/2024
	Segments	Clinical Payment and Coding Policy (CPCP).			
22837	Anterior Thoracic Vertebral Body Tethering Including	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Thoracoscopy When Performed; 8 Or More Vertebral	Criteria. Submit for Recommended Clinical Review			05/14/2024
	Segments	(Predetermination) to avoid post-service review.			
22837	Anterior Thoracic Vertebral Body Tethering Including	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Thoracoscopy When Performed; 8 Or More Vertebral	to pre-service review. Check EIU policy, which is one of our			05/15/2024
	Segments	Clinical Payment and Coding Policy (CPCP).		- / /	
22838	Revision (Eg Augmentation Division Of Tether)	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Replacement Or Removal Of Thoracic Vertebral Body	Criteria. Submit for Recommended Clinical Review			05/14/2024
22020	Tethering Including Thoracoscopy When Performed	(Predetermination) to avoid post-service review.	F /4 F /2024		
22838	Revision (Eg Augmentation Division Of Tether)	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Replacement Or Removal Of Thoracic Vertebral Body	to pre-service review. Check EIU policy, which is one of our			05/15/2024
22067	Tethering Including Thoracoscopy When Performed	Clinical Payment and Coding Policy (CPCP).			
22867	Insertion Of Interlaminar/Interspinous Process	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Stabilization/Distraction Device Without Fusion Including	to utilization review. Please see the Clinical Payment and			
	Image Guidance When Performed With Open	Coding Policy titled: Non-Reimbursable Experimental,			
	Decompression Lumbar; Single Level	Investigational and/or Unproven Services (EIU).			

22050		FUL Deceder for the set with wedle DCDCOK Note birth			
22868	Insertion Of Interlaminar/Interspinous Process	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Stabilization/Distraction Device Without Fusion Including	to utilization review. Please see the Clinical Payment and			
	Image Guidance When Performed With Open	Coding Policy titled: Non-Reimbursable Experimental,			
	Decompression Lumbar; Second Level (List Separately In	Investigational and/or Unproven Services (EIU).			
22222	Addition To Code For Primary Procedure)				
22869	Insertion Of Interlaminar/Interspinous Process	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Stabilization/Distraction Device Without Open	to utilization review. Please see the Clinical Payment and			
	Decompression Or Fusion Including Image Guidance When	Coding Policy titled: Non-Reimbursable Experimental,			
	Performed Lumbar; Single Level	Investigational and/or Unproven Services (EIU).			
22870	Insertion Of Interlaminar/Interspinous Process	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Stabilization/Distraction Device Without Open	to utilization review. Please see the Clinical Payment and			
	Decompression Or Fusion Including Image Guidance When	Coding Policy titled: Non-Reimbursable Experimental,			
	Performed Lumbar; Second Level (List Separately In	Investigational and/or Unproven Services (EIU).			
	Addition To Code For Primary Procedure)				
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 (le Dupuytren'S Cord)	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Post Enzyme Injection (Eg Collagenase) Single Cord	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Including Congenital Or Pathological) By Abduction Splint	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Or Traction; With Manipulation Requiring Anesthesia	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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Guidance Including Placement Of Intra-Articular Implant(S)	Criteria. Submit for Recommended Clinical Review			05/14/2024
	(Eg Bone Allograft[S] Synthetic Device[S]) Without	(Predetermination) to avoid post-service review.			
	Placement Of Transfixation Device				
27278	Arthrodesis Sacroiliac Joint Percutaneous With Image	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Guidance Including Placement Of Intra-Articular Implant(S)	to pre-service review. Check EIU policy, which is one of our			05/15/2024
	(Eg Bone Allograft[S] Synthetic Device[S]) Without	Clinical Payment and Coding Policy (CPCP).			
27200	Placement Of Transfixation Device				
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			
27599	Unlisted Procedure Femur Or Knee	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
27599	offinisted Procedure Femul Of Knee		-	-	-
		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			
27702	Arthopiasty Ankle, with implant (Total Ankle)		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
27703	Arthroplasty Ankle; Revision Total Ankle	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
27703	Arthropiasty Ankle, Revision Total Ankle		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
27704	Removal Of Ankle Implant	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
27704	Removal Of Ankle Implant		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
27000		Policy criteria.			
27860	Manipulation Of Ankle Under General Anesthesia (Includes	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Application Of Traction Or Other Fixation Apparatus)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
27000		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			
20000	Entransministral Charle Marine High Engrand Der A	clinical review.			
28890	Extracorporeal Shock Wave High Energy Performed By A	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Physician Or Other Qualified Health Care Professional	to utilization review. Please see the Clinical Payment and			
	Requiring Anesthesia Other Than Local Including Ultrasound				
20000	Guidance Involving The Plantar Fascia	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			
20700		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			
20062		clinical review.			
29862	Arthroscopy Hip Surgical; With Debridement/Shaving Of	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Articular Cartilage (Chondroplasty) Abrasion Arthroplasty	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And/Or Resection Of Labrum	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
20055		Policy criteria.			
29866	Arthroscopy Knee Surgical; Osteochondral Autograft(S) (Eg	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Mosaicplasty) (Includes Harvesting Of The Autograft[S])	meets BCBSOK 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	

29867	Arthroscopy Knee Surgical; Osteochondral Allograft (Eg	MP Criteria: Procedure/service reviewed to ensure each service	2		
	Mosaicplasty)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	2 _		_
	(Includes Arthrotomy For Meniscal Insertion) Medial Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Lateral	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 (le	MP Criteria: Procedure/service reviewed to ensure each service	e	_	_
	Treatment Of Cam Lesion)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	2_	_	_
	Treatment Of Pincer Lesion)	meets BCBSOK 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	e_	_	_
		meets BCBSOK 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	e	_	_
		meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Subcutaneous/Submucosal Lateral Wall Implant(S)	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Temperature-Controlled (Ie Radiofrequency)	to utilization review. Please see the Clinical Payment and			
	Subcutaneous/Submucosal Remodeling	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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Radiofrequency Ablation Posterior Nasal Nerve	Criteria. Submit for Recommended Clinical Review	1		05/14/2024
		(Predetermination) to avoid post-service review.			

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

31647	Bronchoscopy Rigid Or Flexible Including Fluoroscopic	MP Criteria: Procedure/service reviewed to ensure each service			
51047	Guidance When Performed; With Balloon Occlusion When	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· ·			
	Performed Assessment Of Air Leak Airway Sizing And	submitting a Recommended Clinical Review (Predetermination)			
	Insertion Of Bronchial Valve(S) Initial Lobe	request if it is unclear if the service meets BCBSOK Medical			
31648	Bronchoscopy Rigid Or Flexible Including Fluoroscopic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
51048	Guidance When Performed; With Removal Of Bronchial	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Valve(S) Initial Lobe	· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
31649	Bronchoscopy Rigid Or Flexible Including Fluoroscopic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
51045	Guidance When Performed; With Removal Of Bronchial	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
	Code For Primary Procedure)	1 ·			
31651	Bronchoscopy Rigid Or Flexible Including Fluoroscopic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
51051	Guidance When Performed; With Balloon Occlusion When	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Performed Assessment Of Air Leak Airway Sizing And	submitting a Recommended Clinical Review (Predetermination)			
	Insertion Of Bronchial Valve(S) Each Additional Lobe (List	request if it is unclear if the service meets BCBSOK Medical			
	Separately In Addition To Code For Primary Procedure[S]	Policy criteria.			
	separately in Addition to code for Primary Procedure[5])	Policy criteria.			
31660	Bronchoscopy Rigid Or Flexible Including Fluoroscopic	MP Criteria: Procedure/service reviewed to ensure each service			
	Guidance When Performed; With Bronchial Thermoplasty 1	· · · · · · · · · · · · · · · · · · ·	-	-	-
	Lobe	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Guidance When Performed; With Bronchial Thermoplasty 2	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Or More Lobes	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Guidance (Eg Fiducial Markers Dosimeter) Percutaneous	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intra-Thoracic Single Or Multiple	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 Fradication Of 1 Or More	MP Criteria: Procedure/service reviewed to ensure each service			
52554	Pulmonary Tumor(S) Including Pleura Or Chest Wall When	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Involved By Tumor Extension Percutaneous Including	submitting a Recommended Clinical Review (Predetermination)			
	Imaging Guidance When Performed Unilateral; Cryoablation	, , , , , , , , , , , , , , , , , , ,			
		Policy criteria.			
32998	Ablation Therapy For Reduction Or Eradication Of 1 Or More	MP Criteria: Procedure/service reviewed to ensure each service			
	Pulmonary Tumor(S) Including Pleura Or Chest Wall When	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	Involved By Tumor Extension Percutaneous Including	submitting a Recommended Clinical Review (Predetermination)			
	Imaging Guidance When Performed Unilateral;	request if it is unclear if the service meets BCBSOK Medical			
	Radiofrequency	Policy criteria.			
32999	Unlisted Procedure Lungs And Pleura	Unlisted or Undefined: Procedure/service not otherwise			
	, i i i i i i i i i i i i i i i i i i i	defined or classified, and may be subject to benefit and/or	_	_	_
		clinical review.			
33211	Insertion Or Replacement Of Temporary Transvenous Dual	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Chamber Pacing Electrodes (Separate Procedure)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Dual Leads	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Left Ventricular Pacing At Time Of Insertion Of Implantable	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Defibrillator Or Pacemaker Pulse Generator (Eg For Upgrade	submitting a Recommended Clinical Review (Predetermination)			
	To Dual Chamber System) (List Separately In Addition To	request if it is unclear if the service meets BCBSOK Medical			
	Code For Primary Procedure)	Policy criteria.			
33267	Exclusion Of Left Atrial Appendage Open Any Method (Eg	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Excision Isolation Via Stapling Oversewing Ligation	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Plication Clip)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
33268		MP Criteria: Procedure/service reviewed to ensure each service	—	-	-
	Time Of Other Sternotomy Or Thoracotomy Procedure(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Any Method (Eg Excision Isolation Via Stapling Oversewing	submitting a Recommended Clinical Review (Predetermination)			
	Ligation Plication Clip) (List Separately In Addition To Code	request if it is unclear if the service meets BCBSOK Medical			
22252	For Primary Procedure)	Policy criteria.			
33269	Exclusion Of Left Atrial Appendage Thoracoscopic Any	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Method (Eg Excision Isolation Via Stapling Oversewing	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Ligation Plication Clip)	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Implantable Defibrillator System With Subcutaneous	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Electrode Including Defibrillation Threshold Evaluation	submitting a Recommended Clinical Review (Predetermination)			
	Induction Of Arrhythmia Evaluation Of Sensing For	request if it is unclear if the service meets BCBSOK Medical			
	Arrhythmia Termination And Programming Or	Policy criteria.			
		Folicy criteria.			
	Reprogramming Of Sensing Or Therapeutic Parameters				
33271	When Performed Insertion Of Subcutaneous Implantable Defibrillator	MP Criteria: Procedure/service reviewed to ensure each service			
33271	Electrode	-	_	-	-
	Electrode	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
22274		Policy criteria.			
33274	Transcatheter Insertion Or Replacement Of Permanent	MP Criteria: Procedure/service reviewed to ensure each service	² –	-	-
	Leadless Pacemaker Right Ventricular Including Imaging	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Guidance (Eg Fluoroscopy Venous Ultrasound	submitting a Recommended Clinical Review (Predetermination)			
	Ventriculography Femoral Venography) And Device	request if it is unclear if the service meets BCBSOK Medical			
	Evaluation (Eg Interrogation Or Programming) When	Policy criteria.			
	Performed				
33275	Transcatheter Removal Of Permanent Leadless Pacemaker	MP Criteria: Procedure/service reviewed to ensure each service	e	_	_
	Right Ventricular Including Imaging Guidance (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fluoroscopy Venous Ultrasound Ventriculography Femoral	submitting a Recommended Clinical Review (Predetermination)			
	Venography) When Performed	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Generator And Stimulating Lead[S]) Including Vessel	Criteria. Submit for Recommended Clinical Review			05/14/2024
	Catheterization All Imaging Guidance And Pulse Generator	(Predetermination) to avoid post-service review.			
	Initial Analysis With Diagnostic Mode Activation When				
	Performed				
33276	Insertion Of Phrenic Nerve Stimulator System (Pulse	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
	Generator And Stimulating Lead[S]) Including Vessel	to pre-service review. Check EIU policy, which is one of our		-	05/15/2024
	Catheterization All Imaging Guidance And Pulse Generator	Clinical Payment and Coding Policy (CPCP).			, -, -
	Initial Analysis With Diagnostic Mode Activation When				
	Performed				
33277	Insertion Of Phrenic Nerve Stimulator Transvenous Sensing	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Lead (List Separately In Addition To Code For Primary	Criteria. Submit for Recommended Clinical Review	, _,	-,,	05/14/2024
	Procedure)	(Predetermination) to avoid post-service review.			03/11/2021
33277		EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
55277	Lead (List Separately In Addition To Code For Primary	to pre-service review. Check EIU policy, which is one of our	. 5, 15, 2021	-	05/15/2024
	Procedure)	Clinical Payment and Coding Policy (CPCP).			03/13/2024
33278	Removal Of Phrenic Nerve Stimulator Including Vessel	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
33270	6	Criteria. Submit for Recommended Clinical Review	1/ 1/ 2024	5/ 14/ 2024	
	Catheterization All Imaging Guidance And Interrogation				05/14/2024
	And Programming When Performed; System Including	(Predetermination) to avoid post-service review.			
22270	Pulse Generator And Lead(S)		F /4 F /2 C2 4		
33278	Removal Of Phrenic Nerve Stimulator Including Vessel	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Catheterization All Imaging Guidance And Interrogation	to pre-service review. Check EIU policy, which is one of our			05/15/2024
	And Programming When Performed; System Including	Clinical Payment and Coding Policy (CPCP).			
	Pulse Generator And Lead(S)				

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

22200	The second standard station of Milesters D. J. A. S.				
33289	Transcatheter Implantation Of Wireless Pulmonary Artery	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Pressure Sensor For Long-Term Hemodynamic Monitoring	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including Deployment And Calibration Of The Sensor Right	submitting a Recommended Clinical Review (Predetermination)			
	Heart Catheterization Selective Pulmonary Catheterization	request if it is unclear if the service meets BCBSOK Medical			
	Radiological Supervision And Interpretation And Pulmonary	Policy criteria.			
	Artery Angiography When Performed				
33340	Percutaneous Transcatheter Closure Of The Left Atrial	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Appendage With Endocardial Implant Including Fluoroscopy	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Transseptal Puncture Catheter Placement(S) Left Atrial	submitting a Recommended Clinical Review (Predetermination)			
	Angiography Left Atrial Appendage Angiography When	request if it is unclear if the service meets BCBSOK Medical			
	Performed And Radiological Supervision And Interpretation	Policy criteria.			
33361	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Prosthetic Valve; Percutaneous Femoral Artery Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Prosthetic Valve; Open Femoral Artery Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Prosthetic Valve; Open Axillary Artery Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Prosthetic Valve; Open Iliac Artery Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Prosthetic Valve; Transaortic Approach (Eg Median	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Sternotomy Mediastinotomy)	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Prosthetic Valve; Transapical Exposure (Eg Left	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Thoracotomy)	submitting a Recommended Clinical Review (Predetermination)			
1		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

33367	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With	MP Criteria: Procedure/service reviewed to ensure each service			
55507	,		-	-	-
	Prosthetic Valve; Cardiopulmonary Bypass Support With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Percutaneous Peripheral Arterial And Venous Cannulation	submitting a Recommended Clinical Review (Predetermination)			
	(Eg Femoral Vessels) (List Separately In Addition To Code	request if it is unclear if the service meets BCBSOK Medical			
22200	For Primary Procedure)	Policy criteria.			
33368	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Prosthetic Valve; Cardiopulmonary Bypass Support With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Open Peripheral Arterial And Venous Cannulation (Eg	submitting a Recommended Clinical Review (Predetermination)			
	Femoral Iliac Axillary Vessels) (List Separately In Addition To	•			
22252	Code For Primary Procedure)	Policy criteria.			
33369	Transcatheter Aortic Valve Replacement (Tavr/Tavi) With	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Prosthetic Valve; Cardiopulmonary Bypass Support With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Central Arterial And Venous Cannulation (Eg Aorta Right	submitting a Recommended Clinical Review (Predetermination)			
	Atrium Pulmonary Artery) (List Separately In Addition To	request if it is unclear if the service meets BCBSOK Medical			
	Code For Primary Procedure)	Policy criteria.			
33418	Transcatheter Mitral Valve Repair Percutaneous Approach	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Including Transseptal Puncture When Performed; Initial	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Prosthesis	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Prosthesis(Es) During Same Session (List Separately In	submitting a Recommended Clinical Review (Predetermination)			
	Addition To Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
33477	· · ·	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	When Performed	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			
22222		Policy criteria.			
33880	Endovascular Repair Of Descending Thoracic Aorta (Eg	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intramural Hematoma Or Traumatic Disruption); Involving	submitting a Recommended Clinical Review (Predetermination)			
	Coverage Of Left Subclavian Artery Origin Initial	request if it is unclear if the service meets BCBSOK Medical			
	Endoprosthesis Plus Descending Thoracic Aortic Extension(S)	Policy criteria.			
22004	If Required To Level Of Celiac Artery Origin				
33881	Endovascular Repair Of Descending Thoracic Aorta (Eg	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intramural Hematoma Or Traumatic Disruption); Not	submitting a Recommended Clinical Review (Predetermination)			
	Involving Coverage Of Left Subclavian Artery Origin Initial	request if it is unclear if the service meets BCBSOK Medical			
	Endoprosthesis Plus Descending Thoracic Aortic Extension(S)	Policy criteria.			
	If Required To Level Of Celiac Artery Origin				

Placement Of Proximal Extension Prosthesis For	MP Criteria: Procedure/service reviewed to ensure each convice			
		—	-	_
	-			
	Ū , , , , , , , , , , , , , , , , , , ,			
	-	-	-	-
	-			
	Ū , , , , , , , , , , , , , , , , , , ,			
	Policy criteria.			
	-	-	—	-
Endovascular Repair Of Descending Thoracic Aorta	-			
	Ū , , , , , , , , , , , , , , , , , , ,			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
	-	-	-	_
In Conjunction With Endovascular Repair Of Descending	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Thoracic Aorta By Neck Incision Unilateral	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Implantation Of A Total Replacement Heart System (Artificial	MP Criteria: Procedure/service reviewed to ensure each service	_	-	_
Heart) With Recipient Cardiectomy	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Removal And Replacement Of Total Replacement Heart	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
System (Artificial Heart)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Removal Of A Total Replacement Heart System (Artificial	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
Heart) For Heart Transplantation (List Separately In Addition	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
To Code For Primary Procedure)	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Insertion Of Ventricular Assist Device; Extracorporeal Single	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
Ventricle	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
Insertion Of Ventricular Assist Device; Extracorporeal		_		_
Biventricular	-	-	_	-
	-			
	request if it is unclear if the service meets BCBSOK Medical			
	Code For Primary Procedure) Placement Of Distal Extension Prosthesis(S) Delayed After Endovascular Repair Of Descending Thoracic Aorta Open Subclavian To Carotid Artery Transposition Performed In Conjunction With Endovascular Repair Of Descending Thoracic Aorta By Neck Incision Unilateral Implantation Of A Total Replacement Heart System (Artificial Heart) With Recipient Cardiectomy Removal And Replacement Of Total Replacement Heart System (Artificial Heart) Removal Of A Total Replacement Heart System (Artificial Heart) For Heart Transplantation (List Separately In Addition To Code For Primary Procedure) Insertion Of Ventricular Assist Device; Extracorporeal Single Ventricle	Endovascular Repair Of Descending Thoracic Aorta (Eg meets BCBSOK Medical Policy criteria. BCBSOK recommends Aneurysm Pseudoaneurysm Dissection Penetrating Uleer submitting a Recommended Clinical Review (Predetermination) Placement Of Proximal Extension Prosthesis For MP Criteria: Procedure/service reviewed to ensure each service Endovascular Repair Of Descending Thoracic Aorta (Eg MP Criteria: Procedure/service reviewed to ensure each service Aneurysm Pseudoaneurysm Dissection Penetrating Uleer Intramury Procedure) Intramury Hematoma Or Traumatic Disruption); East Submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Code For Primary Procedure) Placement Of Distal Extension Prosthesis(5) Delayed After Endovascular Repair Of Descending Thoracic Aorta MP Criteria: Procedure/service reviewed to ensure each service In Conjunction With Endovascular Repair Of Descending MP Criteria: Procedure/service reviewed to ensure each service Implantation Of A Total Replacement Heart System (Artificial MP Criteria: Procedure/service revies BCBSOK recommends Submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK recommends Implantation Of A Total Replacement Heart System (Artificial MP Criteria: Procedure/service reviewed to ensure each service <tr< td=""><td>Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Uter Intramural Hematoma Or Traumatic Disruption); Initial Policy criteria. Procedure/service reviewed to ensure each service Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Dissection Penetrating Uter Intramural Hematoma Or Traumatic Disruption); Each Aneurysm Dissection Penetrating Uter Intramural Hematoma Or Traumatic Disruption); Each Additional Prokimal Extension (List Separately in Addition To Policy criteria. More Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Redical Additional Prokimal Extension (List Separately in Addition To Policy criteria. Code Ear Primary Procedure/ Placement Of Distal Extension Prosthesis(5) Delayed After Endovascular Repair Of Descending Thoracic Aorta Uniting a Recommended Clinical Review (Predetermination) request if its unclear if the service meets BCBSOK Medical Policy criteria. Open Subclavian To Carotid Artery Transposition Performed In Conjunction With Endovascular Repair Of Descending Thoracic Aorta By Neck Incision Unilateral request if it is unclear if the service meets BCBSOK Medical Policy criteria. MMC Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. 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 Medical Policy criteria. Removal Of A Total Replacement Heart System (Artificial Heart) MP Criteria: Procedure/service reviewe</td><td>Endowscular Repair Of Descending Thoracic Aorta (Eg. neets 0CBSOK Medical Policy Criteria. BCBSOK Medical - Aneurym Preudoaneurym Disscition Peerformed Linking a Recommended Clinical Review (Predetermination) - Placement Of Proximal Extension Prosthesis For MP (Criteria: Prededure/service reviewed to ensure each service _ - Endowacular Repair Of Descending Thoracic Aorta (Eg. meets 0CBSOK Medical Policy Criteria. - - Aneurym Preudoaneurym Olitics Service Tranumatic Disruption); Each MP Criteria: Procedure/service reviewed to ensure each service _ - International Technolon Prosthesis(S) Delayed After MP Criteria: Procedure/service reviewed to ensure each service _ - Placement Of Distal Extension Prosthesis(S) Delayed After MP Criteria: Procedure/service reviewed to ensure each service _ - Placement Of Distal Extension Prosthesis(S) Delayed After MP Criteria: Procedure/service reviewed to ensure each service _ - Open Subclavian to Carotid Artery Transposition Performed MP Criteria: Procedure/service reviewed to ensure each service _ - In conjunction With Endowscular Repair Of Descending MP Criteria: Procedure/service reviewed to ensure each service _ - In conjunction With Endowscular Repair Of Descending Bits Criteria MP Criteria: Procedure/service reviewed to ensure each service _ -</td></tr<>	Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Pseudoaneurysm Dissection Penetrating Uter Intramural Hematoma Or Traumatic Disruption); Initial Policy criteria. Procedure/service reviewed to ensure each service Endovascular Repair Of Descending Thoracic Aorta (Eg Aneurysm Dissection Penetrating Uter Intramural Hematoma Or Traumatic Disruption); Each Aneurysm Dissection Penetrating Uter Intramural Hematoma Or Traumatic Disruption); Each Additional Prokimal Extension (List Separately in Addition To Policy criteria. More Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Redical Additional Prokimal Extension (List Separately in Addition To Policy criteria. Code Ear Primary Procedure/ Placement Of Distal Extension Prosthesis(5) Delayed After Endovascular Repair Of Descending Thoracic Aorta Uniting a Recommended Clinical Review (Predetermination) request if its unclear if the service meets BCBSOK Medical Policy criteria. Open Subclavian To Carotid Artery Transposition Performed In Conjunction With Endovascular Repair Of Descending Thoracic Aorta By Neck Incision Unilateral request if it is unclear if the service meets BCBSOK Medical Policy criteria. MMC Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. 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 Medical Policy criteria. Removal Of A Total Replacement Heart System (Artificial Heart) MP Criteria: Procedure/service reviewe	Endowscular Repair Of Descending Thoracic Aorta (Eg. neets 0CBSOK Medical Policy Criteria. BCBSOK Medical - Aneurym Preudoaneurym Disscition Peerformed Linking a Recommended Clinical Review (Predetermination) - Placement Of Proximal Extension Prosthesis For MP (Criteria: Prededure/service reviewed to ensure each service _ - Endowacular Repair Of Descending Thoracic Aorta (Eg. meets 0CBSOK Medical Policy Criteria. - - Aneurym Preudoaneurym Olitics Service Tranumatic Disruption); Each MP Criteria: Procedure/service reviewed to ensure each service _ - International Technolon Prosthesis(S) Delayed After MP Criteria: Procedure/service reviewed to ensure each service _ - Placement Of Distal Extension Prosthesis(S) Delayed After MP Criteria: Procedure/service reviewed to ensure each service _ - Placement Of Distal Extension Prosthesis(S) Delayed After MP Criteria: Procedure/service reviewed to ensure each service _ - Open Subclavian to Carotid Artery Transposition Performed MP Criteria: Procedure/service reviewed to ensure each service _ - In conjunction With Endowscular Repair Of Descending MP Criteria: Procedure/service reviewed to ensure each service _ - In conjunction With Endowscular Repair Of Descending Bits Criteria MP Criteria: Procedure/service reviewed to ensure each service _ -

33979	Insertion Of Ventricular Assist Device Implantable	MP Criteria: Procedure/service reviewed to ensure each service	_	_
	Intracorporeal Single Ventricle	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Single Or Biventricular Pump(S) Single Or Each Pump	meets BCBSOK 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);	MP Criteria: Procedure/service reviewed to ensure each service _	-	_
	Implantable Intracorporeal Single Ventricle Without	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Cardiopulmonary Bypass	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);	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Implantable Intracorporeal Single Ventricle With	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Cardiopulmonary Bypass	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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Including Radiological Supervision And Interpretation; Left	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Heart Arterial Access Only	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Including Radiological Supervision And Interpretation; Left	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Heart Both Arterial And Venous Access With Transseptal	submitting a Recommended Clinical Review (Predetermination)		
	Puncture	request if it is unclear if the service meets BCBSOK Medical		
22002		Policy criteria.		
33992	Removal Of Percutaneous Left Heart Ventricular Assist	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Device Arterial Or Arterial And Venous Cannula(S) At	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Separate And Distinct Session From Insertion	submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
33993	Repositioning Of Percutaneous Right Or Left Heart	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	And Distinct Session From Insertion	submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		

Unlisted Procedure Cardiac Surgery	MP Criteria: Procedure/service reviewed to ensure each service			
		-	-	-
Insertion Of Implantable Intra-Arterial Infusion Pump (Eg				
		-	_	-
	· · ·			
Unlisted Procedure Vascular Injection				
		-	-	-
Injection Of Non-Compounded Foam Sclerosant With				
		-	-	-
		-	-	-
,				
Saphenous vent Accessory Saphenous vent) Same Leg	Policy citteria.			
Injection(S) Of Sclerosant For Spider Veins (Telangiectasia)	MP Criteria: Procedure/service reviewed to ensure each service	_		_
Limb Or Trunk	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Injection Of Sclerosant; Single Incompetent Vein (Other				
Than Telangiectasia)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		
	submitting a Recommended Clinical Review (Predetermination)			
Injection Of Sclerosant; Multiple Incompetent Veins (Other		_		
Than Telangiectasia) Same Leg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	· · ·			
	•			
Endovenous Ablation Therapy Of Incompetent Vein		_		_
	Coding Policy titled: Non-Reimbursable Experimental,			
Percutaneous Mechanochemical; First Vein Treated	COULING FOLICY LILIED, NOT-REITIOUISADIE EXDELITIETICAL			
	Injection Of Sclerosant; Single Incompetent Vein (Other Than Telangiectasia) Injection Of Sclerosant; Multiple Incompetent Veins (Other Than Telangiectasia) Injection Of Sclerosant; Multiple Incompetent Veins (Other Than Telangiectasia) Same Leg Endovenous Ablation Therapy Of Incompetent Vein Extremity Inclusive Of All Imaging Guidance And Monitoring	meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. 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. Unlisted Procedure Vascular Injection Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. 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 Sabhenous 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) meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Injection Of Sclerosant For Spider Veins (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. Injection Of Sclerosant; Single Incompetent Vein (Other Tha	meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request fit is unclear fit he service meets BCBSOK Medical Policy criteria. Insertion Of Implantable Intra-Arterial Infusion Pump (Eg For Chemotherapy Of Liver) MP Criteria: Frocedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request fit is unclear fit he service meets BCBSOK Medical Policy criteria. Unlisted Procedure Vascular Injection Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. 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 Externity Truncal Viei (Eg Granta Stahenous Vein Accessory Stahenous Vein) MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request fit is unclear fit he service meets BCBSOK Medical Policy criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request fit is unclear fit he service meets BCBSOK Medical Policy criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request fit is unclear fit he service meets BCBSOK Medical Policy criteria. Injection Of Sclerosant For Spider Veins (Telangiettasia) MP Criteria: Procedure/service reviewed to ensure	meets RCBSOK Medical Policy criteria. BCBSOK recommends

26474	Endourse Ablation Thereas Of Incompation (1975)	FULL Decord and from the next as included by DCDCOV, Market birth			
36474	Endovenous Ablation Therapy Of Incompetent Vein	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Extremity Inclusive Of All Imaging Guidance And Monitoring				
	Percutaneous Mechanochemical; Subsequent Vein(S)	Coding Policy titled: Non-Reimbursable Experimental,			
	Treated In A Single Extremity Each Through Separate Access	Investigational and/or Unproven Services (EIU).			
	Sites (List Separately In Addition To Code For Primary				
	Procedure)				
36475	Endovenous Ablation Therapy Of Incompetent Vein	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Extremity Inclusive Of All Imaging Guidance And Monitoring	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Percutaneous Radiofrequency; First Vein Treated	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Extremity Inclusive Of All Imaging Guidance And Monitoring	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Percutaneous Radiofrequency; Subsequent Vein(S) Treated	submitting a Recommended Clinical Review (Predetermination)			
	In A Single Extremity Each Through Separate Access Sites	request if it is unclear if the service meets BCBSOK Medical			
	(List Separately In Addition To Code For Primary Procedure)	Policy criteria.			
		,			
36478	Endovenous Ablation Therapy Of Incompetent Vein	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Extremity Inclusive Of All Imaging Guidance And Monitoring	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Percutaneous Laser; First Vein Treated	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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Extremity Inclusive Of All Imaging Guidance And Monitoring	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Percutaneous Laser; Subsequent Vein(S) Treated In A Single	submitting a Recommended Clinical Review (Predetermination)			
	Extremity Each Through Separate Access Sites (List	request if it is unclear if the service meets BCBSOK Medical			
	Separately In Addition To Code For Primary Procedure)	Policy criteria.			
36482	Endovenous Ablation Therapy Of Incompetent Vein	MP Criteria: Procedure/service reviewed to ensure each service			
	Extremity By Transcatheter Delivery Of A Chemical Adhesive	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	–	_
	(Eg Cyanoacrylate) Remote From The Access Site Inclusive	submitting a Recommended Clinical Review (Predetermination)			
	Of All Imaging Guidance And Monitoring Percutaneous;	request if it is unclear if the service meets BCBSOK Medical			
	First Vein Treated	Policy criteria.			
36483	Endovenous Ablation Therapy Of Incompetent Vein	MP Criteria: Procedure/service reviewed to ensure each service		1	
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	 -	_
	(Eg Cyanoacrylate) Remote From The Access Site Inclusive	submitting a Recommended Clinical Review (Predetermination)			
	Of All Imaging Guidance And Monitoring Percutaneous;	request if it is unclear if the service meets BCBSOK Medical			
	Subsequent Vein(S) Treated In A Single Extremity Each	Policy criteria.			
	,				
	Through Separate Access Sites (List Separately In Addition To Code For Primary Procedure)				
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	Photophorocia Extragornage-1	MD Critoria. Drocoduro (convico reviewed to prove as the		1	1
30522	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			
265.62	Incention Of Turnelled Controlly, Incented Control Meneuro	Policy criteria.			
36563	Insertion Of Tunneled Centrally Inserted Central Venous	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Access Device With Subcutaneous Pump	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
20020	Densite a cour Artenia una cua Fistula Creation I lanca	Policy criteria.			
36836	Percutaneous Arteriovenous Fistula Creation Upper	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Extremity Single Access Of Both The Peripheral Artery And	to utilization review. Please see the Clinical Payment and			
	Peripheral Vein Including Fistula Maturation Procedures (Eg	Coding Policy titled: Non-Reimbursable Experimental,			
	Transluminal Balloon Angioplasty Coil Embolization) When	Investigational and/or Unproven Services (EIU).			
	Performed Including All Vascular Access Imaging Guidance				
	And Radiologic Supervision And Interpretation				
36837	Percutaneous Arteriovenous Fistula Creation Upper	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Extremity Separate Access Sites Of The Peripheral Artery	to utilization review. Please see the Clinical Payment and			
	And Peripheral Vein Including Fistula Maturation	Coding Policy titled: Non-Reimbursable Experimental,			
	Procedures (Eg Transluminal Balloon Angioplasty Coil	Investigational and/or Unproven Services (EIU).			
	Embolization) When Performed Including All Vascular				
	Access Imaging Guidance And Radiologic Supervision And				
	Interpretation				
37215	Transcatheter Placement Of Intravascular Stent(S) Cervical	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Carotid Artery Open Or Percutaneous Including Angioplasty	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	When Performed And Radiological Supervision And	submitting a Recommended Clinical Review (Predetermination)			
	Interpretation; With Distal Embolic Protection	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
37216	Transcatheter Placement Of Intravascular Stent(S) Cervical	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Carotid Artery Open Or Percutaneous Including Angioplasty	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	When Performed And Radiological Supervision And	submitting a Recommended Clinical Review (Predetermination)			
	Interpretation; Without Distal Embolic Protection	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
37217	Transcatheter Placement Of Intravascular Stent(S)	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Intrathoracic Common Carotid Artery Or Innominate Artery	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	By Retrograde Treatment Open Ipsilateral Cervical Carotid	submitting a Recommended Clinical Review (Predetermination)			
	Artery Exposure Including Angioplasty When Performed	request if it is unclear if the service meets BCBSOK Medical			
	And Radiological Supervision And Interpretation	Policy criteria.			
37218	Transcatheter Placement Of Intravascular Stent(S)	MP Criteria: Procedure/service reviewed to ensure each service			
	Intrathoracic Common Carotid Artery Or Innominate Artery	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	–	-
		<i>i</i>		1	
	Open Or Percutaneous Antegrade Approach Including	submitting a Recommended (Jinical Review (Predetermination)			
	Open Or Percutaneous Antegrade Approach Including Angioplasty When Performed And Radiological Supervision	submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical			

37241	Vacaular Embolization Or Occlusion Indusive Of All	MD Criteria: Presedure (convice reviewed to ensure each convice		1	
37241	Vascular Embolization Or Occlusion Inclusive Of All	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Radiological Supervision And Interpretation Intraprocedural	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Roadmapping And Imaging Guidance Necessary To	submitting a Recommended Clinical Review (Predetermination)			
	Complete The Intervention; Venous Other Than	request if it is unclear if the service meets BCBSOK Medical			
	Hemorrhage (Eg Congenital Or Acquired Venous	Policy criteria.			
	Malformations Venous And Capillary Hemangiomas Varices				
	Varicoceles)				
37242	Vascular Embolization Or Occlusion Inclusive Of All	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Radiological Supervision And Interpretation Intraprocedural	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Roadmapping And Imaging Guidance Necessary To	submitting a Recommended Clinical Review (Predetermination)			
	Complete The Intervention; Arterial Other Than	request if it is unclear if the service meets BCBSOK Medical			
	Hemorrhage Or Tumor (Eg Congenital Or Acquired Arterial	Policy criteria.			
	Malformations Arteriovenous Malformations				
	Arteriovenous Fistulas Aneurvsms Pseudoaneurvsms)				
37243	Vascular Embolization Or Occlusion Inclusive Of All	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Radiological Supervision And Interpretation Intraprocedural	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Roadmapping And Imaging Guidance Necessary To	submitting a Recommended Clinical Review (Predetermination)			
	Complete The Intervention; For Tumors Organ Ischemia Or	request if it is unclear if the service meets BCBSOK Medical			
	Infarction	Policy criteria.			
37244	Vascular Embolization Or Occlusion Inclusive Of All	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Radiological Supervision And Interpretation Intraprocedural	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Roadmapping And Imaging Guidance Necessary To	submitting a Recommended Clinical Review (Predetermination)			
	Complete The Intervention; For Arterial Or Venous	request if it is unclear if the service meets BCBSOK Medical			
	Hemorrhage Or Lymphatic Extravasation	Policy criteria.			
37500	Vascular Endoscopy Surgical With Ligation Of Perforator	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Veins Subfascial (Seps)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Saphenofemoral Junction Or Distal Interruptions	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Veins From Saphenofemoral Junction To Knee Or Below	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
57755	Short Saphenous Veins With Radical Excision Of Ulcer And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
	Skin Graft And/Or Interruption Of Communicating Veins Of	submitting a Recommended Clinical Review (Predetermination)			
	Lower Leg With Excision Of Deep Fascia	request if it is unclear if the service meets BCBSOK Medical			
2770	Lipstics Of Daufaustau Vising Cubfassial Dadies! (Liptau Tura)	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
37760			-	-	-
	Including Skin Graft When Performed Open 1 Leg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	_
	Ultrasound Guidance When Performed 1 Leg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Incisions	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Than 20 Incisions	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Saphenopopliteal Junction (Separate Procedure)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		1	
57765	Cluster(S) 1 Leg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	cluster(s) I Leg	-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
27700	Death Dears Indeath Adam Mith Ochthler (Mith Carf	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.		1	

37799	Unlisted Procedure Vascular Surgery	Unlisted or Undefined: Procedure/service not otherwise			
57755	offisted frocedure vascular surgery	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			
50125		defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
38204	Management Of Recipient Hematopoietic Progenitor Cell	MP Criteria: Procedure/service reviewed to ensure each service			
00201	Donor Search And Cell Acquisition	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Transplantation Per Collection; Allogeneic	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Transplantation Per Collection; Autologous	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Cryopreservation And Storage	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Thawing Of Previously Frozen Harvest Without Washing	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Per Donor	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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Thawing Of Previously Frozen Harvest With Washing Per	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Donor	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;	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Specific Cell Depletion Within Harvest T-Cell Depletion	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Tumor Cell Depletion	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service			
30212	Red Blood Cell Removal	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
38213	Transplant Preparation Of Hematopoietic Progenitor Cells;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
38213			-	-	-
	Platelet Depletion	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
38214	Transplant Preparation Of Hematopoietic Progenitor Cells;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
30214	Plasma (Volume) Depletion	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Plasma (Volume) Depletion				
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
38215	Transplant Preparation Of Hematopoietic Progenitor Cells;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
50215	Cell Concentration In Plasma Mononuclear Or Buffy Coat	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	Layer	Ū , , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
38230	Bone Marrow Harvesting For Transplantation; Allogeneic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
30230	bolie Martow Harvesting for Harsplantation, Allogeneic	meets BCBSOK 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			
00101		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Transplantation Per Donor	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Transplantation	meets BCBSOK 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		1	

38243	Hematopoietic Progenitor Cell (Hpc); Hpc Boost	MP Criteria: Procedure/service reviewed to ensure each service			
30243	nematopoletic Progenitor Cell (npc); npc Boost		-	-	-
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	_
	Channels	meets BCBSOK 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			
11512	rongue base suspension remainent sutare reaminque	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
41530	Submucosal Ablation Of The Tongue Base, Padiofroguopou	Policy criteria. 1 EIU: Procedure/service not reimbursed by BCBSOK. Not subject		3/31/2024	Retire effective
41000	Or More Sites Per Session		-	5/31/2024	
	OF WORE SILES PER SESSION	to utilization review. Please see the Clinical Payment and			03/31/2024
		Coding Policy titled: Non-Reimbursable Experimental,			
41520	Culture of the Trans of Dealth f	Investigational and/or Unproven Services (EIU).	4/1/2024		
41530		1 MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	-	Add effectuce
	Or More Sites Per Session	Criteria. Submit for Recommended Clinical Review			04/01/2024
		(Predetermination) to avoid post-service review.			

41599	Unlisted Procedure Tongue Floor Of Mouth	Unlisted or Undefined: Procedure/service not otherwise			
	C C	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	2/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review		_	02/01/2024
		(Predetermination) to avoid post-service review.			
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	MP Criteria: Procedure/service reviewed to ensure each service			_
	Uvulopharyngoplasty)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	3/15/2024	_	Add effectuce
	Pharynx)	Criteria. Submit for Recommended Clinical Review			03/15/2024
		(Predetermination) to avoid post-service review.			
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Injection(S) Any Substance	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Submucosal Injection(S) Any Substance	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Endomicroscopy	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Esophagogastric Fundoplasty Partial Or Complete Includes	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Duodenoscopy When Performed	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
43236	Esophagogastroduodenoscopy Flexible Transoral; With	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Directed Submucosal Injection(S) Any Substance	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Optical Endomicroscopy	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Transendoscopic Ultrasound-Guided Transmural Injection Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Diagnostic Or Therapeutic Substance(S) (Eg Anesthetic	submitting a Recommended Clinical Review (Predetermination)			
	Neurolytic Agent) Or Fiducial Marker(S) (Includes Endoscopic	request if it is unclear if the service meets BCBSOK Medical			
	Ultrasound Examination Of The Esophagus Stomach And	Policy criteria.			
	Either The Duodenum Or A Surgically Altered Stomach				
	Where The Jejunum Is Examined Distal To The Anastomosis)				
43257	Esophagogastroduodenoscopy Flexible Transoral; With	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Delivery Of Thermal Energy To The Muscle Of Lower	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Esophageal Sphincter And/Or Gastric Cardia For Treatment	submitting a Recommended Clinical Review (Predetermination)			
	Of Gastroesophageal Reflux Disease	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
43284	Laparoscopy Surgical Esophageal Sphincter Augmentation	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Procedure Placement Of Sphincter Augmentation Device (le	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Magnetic Band) Including Cruroplasty When Performed	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
45250	Deployment Of Intragastric Bariatric Balloon	to utilization review. Please see the Clinical Payment and	-	-	-
	Deployment of intragastile banatile balloon	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
43291	Esophagogastroduodenoscopy Flexible Transoral; With	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
45251	Removal Of Intragastric Bariatric Balloon(S)	to utilization review. Please see the Clinical Payment and	-	-	-
	Kentoval Of Intragastile Barlatile Balloon(5)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
43312	Esonhagonlasty (Plastic Renair Or Reconstruction) Thoracic	MP Criteria: Procedure/service reviewed to ensure each service			
45512	Approach; With Repair Of Tracheoesophageal Fistula	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Approach, with Repair of Hacheocsophagear Istala	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			
10 100		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				
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Gastric Bypass And Roux-En-Y Gastroenterostomy (Roux	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Limb 150 Cm Or Less)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Gastric Bypass And Small Intestine Reconstruction To Limit	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Absorption	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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Placement Of Adjustable Gastric Restrictive Device (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Gastric Band And Subcutaneous Port Components)	submitting a Recommended Clinical Review (Predetermination)			
1		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

43771	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed to ensure each service			
45771			_	-	-
	Revision Of Adjustable Gastric Restrictive Device Component	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Only	submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical			
43772	Laparoscopy Surgical Gastric Restrictive Procedure;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
43772	Removal Of Adjustable Gastric Restrictive Device	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Component Only	submitting a Recommended Clinical Review (Predetermination)			
	component only				
		request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
43773	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed to ensure each service			
43773	Removal And Replacement Of Adjustable Gastric Restrictive	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Device Component Only	submitting a Recommended Clinical Review (Predetermination)			
	Device component only	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
43774	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed to ensure each service			
13771	Removal Of Adjustable Gastric Restrictive Device And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Subcutaneous Port Components	submitting a Recommended Clinical Review (Predetermination)			
	Subcutaneous Fort components	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
43775	Laparoscopy Surgical Gastric Restrictive Procedure;	MP Criteria: Procedure/service reviewed to ensure each service			
10770	Longitudinal Gastrectomy (le Sleeve Gastrectomy)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Morbid Obesity; Vertical-Banded Gastroplasty	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Morbid Obesity; Other Than Vertical-Banded Gastroplasty	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Pylorus-Preserving Duodenoileostomy And Ileoileostomy (50	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	To 100 Cm Common Channel) To Limit Absorption	submitting a Recommended Clinical Review (Predetermination)			
	(Biliopancreatic Diversion With Duodenal Switch)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
43846	Gastric Restrictive Procedure With Gastric Bypass For	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Morbid Obesity; With Short Limb (150 Cm Or Less) Roux-En-	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Y Gastroenterostomy	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	MP Criteria: Procedure/service reviewed to ensure each service		1	
43047	· · · · · · · · · · · · · · · · · · ·	-	-	-	-
	Morbid Obesity; With Small Intestine Reconstruction To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Limit Absorption	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
420.40	Devision Onen Of Contrin Destrictive Dependence For Markid	Policy criteria.			
43848	Revision Open Of Gastric Restrictive Procedure For Morbid	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Obesity Other Than Adjustable Gastric Restrictive Device	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	(Separate Procedure)	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)	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	With Reconstruction With Or Without Partial Gastrectomy	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Or Intestine Resection; Without Vagotomy	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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Subcutaneous Port Component Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Subcutaneous Port Component Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Replacement Of Subcutaneous Port Component Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		1	
	Assessment Of Donor Specimen	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Assessment of Donor Specimen	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		1 ·			
		Policy criteria.			

44799	Unlisted Procedure Small Intestine	Unlisted or Undefined: Procedure/service not otherwise			
44739	omisted Procedure Small miestine		-	-	-
		defined or classified, and may be subject to benefit and/or			
44899	Unlisted Procedure Meckel'S Diverticulum And The	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
44899		· ·	-	-	-
	Mesentery	defined or classified, and may be subject to benefit and/or			
44070		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			
45200	United December Color	clinical review.			
45399	Unlisted Procedure Colon	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
		defined or classified, and may be subject to benefit and/or			
45.400		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			
45000		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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Intestine Submucosa [Sis])	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		MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Radiofrequency	meets BCBSOK 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);	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Radiofrequency	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		1	
-, 502	Radiofrequency	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Radionequency	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			
47333		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			
47575	offisted Laparoscopy frocedure binary fract	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			
47555	offisted frocedure binary fract	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
48999	Unlisted Procedure Pancreas	Unlisted or Undefined: Procedure/service not otherwise			
40000	offisted i focedure i ancreas	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
49329	Unlisted Laparoscopy Procedure Abdomen Peritoneum And				
49329	Omentum	defined or classified, and may be subject to benefit and/or	-	-	-
	omentum	clinical review.			
49411	Placement Of Interstitial Device(S) For Radiation Therapy	MP Criteria: Procedure/service reviewed to ensure each service			
49411	Guidance (Eg Fiducial Markers Dosimeter) Percutaneous	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Intra-Abdominal Intra-Pelvic (Except Prostate) And/Or	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
	Retroperitoneum Single Or Multiple				
49412	Placement Of Interstitial Device(S) For Radiation Therapy	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
-3-12	Guidance (Eg Fiducial Markers Dosimeter) Open Intra-	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Abdominal Intrapelvic And/Or Retroperitoneum Including	submitting a Recommended Clinical Review (Predetermination)			
	Image Guidance If Performed Single Or Multiple (List	request if it is unclear if the service meets BCBSOK Medical			
	Separately In Addition To Code For Primary Procedure)	Policy criteria.			
	Separately in Addition to Code For Primary Procedure)	Policy criteria.			
49659	Unlisted Laparoscopy Procedure Hernioplasty	Unlisted or Undefined: Procedure/service not otherwise			
	Herniorrhaphy Herniotomy	defined or classified, and may be subject to benefit and/or	-	-	-
	nemiornaphy nemioromy	clinical review.			
49999	Unlisted Procedure Abdomen Peritoneum And Omentum	Unlisted or Undefined: Procedure/service not otherwise			
	enisted i roccure Abdomen i entoneun And omentum	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
50250	Ablation Open 1 Or More Renal Mass Lesion(S)	MP Criteria: Procedure/service reviewed to ensure each service			
	Cryosurgical Including Intraoperative Ultrasound Guidance	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	And Monitoring If Performed	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Recipient Nephrectomy	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		ר טוונץ נוונכוומ.			

50541	Laparoscopy Surgical; Ablation Of Renal Cysts	MP Criteria: Procedure/service reviewed to ensure each service			
00012		meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service			
	Including Intraoperative Ultrasound Guidance And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Monitoring When Performed	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Unilateral Radiofrequency	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Cryotherapy	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Submucosal Tissues Of The Urethra And/Or Bladder Neck	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Urethral Therapeutic Drug Delivery By Drug-Coated Balloon	Criteria. Submit for Recommended Clinical Review			05/14/2024
	Catheter For Urethral Stricture Or Stenosis Male Including	(Predetermination) to avoid post-service review.			
	Fluoroscopy When Performed				
52284	Cystourethroscopy With Mechanical Urethral Dilation And	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Urethral Therapeutic Drug Delivery By Drug-Coated Balloon	to pre-service review. Check EIU policy, which is one of our			05/15/2024
	Catheter For Urethral Stricture Or Stenosis Male Including	Clinical Payment and Coding Policy (CPCP).			
53307	Fluoroscopy When Performed				
52287		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Of The Bladder	meets BCBSOK 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);	MP Criteria: Procedure/service reviewed to ensure each service			
	With Subureteric Injection Of Implant Material	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Transprostatic Implant; Single Implant	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Transprostatic Implant; Each Additional Permanent	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Adjustable Transprostatic Implant (List Separately In	submitting a Recommended Clinical Review (Predetermination)			
	Addition To Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
53	451 Periurethral Transperineal Adjustable Balloon Continence	MP Criteria: Procedure/service reviewed against Medical Policy	5/1/2024	_	Add effective
	Device; Bilateral Insertion Including Cystourethroscopy And	Criteria. Submit for Recommended Clinical Review			5/1/2024
	Imaging Guidance	(Predetermination) to avoid post-service review.			
53	452 Periurethral Transperineal Adjustable Balloon Continence	MP Criteria: Procedure/service reviewed against Medical Policy	5/1/2024	_	Add effective
	Device; Unilateral Insertion Including Cystourethroscopy	Criteria. Submit for Recommended Clinical Review			5/1/2024
	And Imaging Guidance	(Predetermination) to avoid post-service review.			
53	453 Periurethral Transperineal Adjustable Balloon Continence	MP Criteria: Procedure/service reviewed against Medical Policy	5/1/2024	_	Add effective
	Device; Removal Each Balloon	Criteria. Submit for Recommended Clinical Review			5/1/2024
		(Predetermination) to avoid post-service review.			
53	454 Periurethral Transperineal Adjustable Balloon Continence	MP Criteria: Procedure/service reviewed against Medical Policy	5/1/2024	_	Add effective
	Device; Percutaneous Adjustment Of Balloon(S) Fluid	Criteria. Submit for Recommended Clinical Review			5/1/2024
	Volume	(Predetermination) to avoid post-service review.			
53855		MP Criteria: Procedure/service reviewed to ensure each service	-	5/14/2024	retire effective
	Urethral Measurement	meets BCBSOK Medical Policy criteria. BCBSOK recommends			05/14/2024
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
52055		Policy criteria.	F /4 F /2024		
53855		EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Urethral Measurement	to pre-service review. Check EIU policy, which is one of our			05/15/2024
53860	Transurethral Radiofrequency Micro-Remodeling Of The	Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
53800	Female Bladder Neck And Proximal Urethra For Stress		-	-	-
		to utilization review. Please see the Clinical Payment and			
	Urinary Incontinence	Coding Policy titled: Non-Reimbursable Experimental,			
53899	Unlisted Procedure Urinary System	Investigational and/or Unproven Services (EIU). Unlisted or Undefined: Procedure/service not otherwise			
55055	Shisted Frotedure Ornary System	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			
51110		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		רטוונץ נוונכוומ.			

54111	Excision Of Penile Plague (Peyronie Disease); With Graft To S	MP Criteria: Procedure/service reviewed to ensure each service			
-	Cm In Length	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Greater Than 5 Cm In Length	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Exposure Of Plaque	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Agent(S) (Eg Papaverine Phentolamine)	meets BCBSOK 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	-
submitting a neconimentate annear never (i reacter initiation)	
request if it is unclear if the service meets BCBSOK Medical	
Policy criteria.	
54405 Insertion Of Multi-Component Inflatable Penile Prosthesis MP Criteria: Procedure/service reviewed to ensure each service	
Including Placement Of Pump Cylinders And Reservoir meets BCBSOK 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 MP Criteria: Procedure/service reviewed to ensure each service	
Inflatable Penile Prosthesis Without Replacement Of meets BCBSOK Medical Policy criteria. BCBSOK recommends	
Prosthesis 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 MP Criteria: Procedure/service reviewed to ensure each service	_
Penile Prosthesis meets BCBSOK 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- MP Criteria: Procedure/service reviewed to ensure each service	_
Component Inflatable Penile Prosthesis At The Same meets BCBSOK Medical Policy criteria. BCBSOK recommends	
Operative Session 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- MP Criteria: Procedure/service reviewed to ensure each service	_
Component Inflatable Penile Prosthesis Through An Infected meets BCBSOK Medical Policy criteria. BCBSOK recommends	
Field At The Same Operative Session Including Irrigation submitting a Recommended Clinical Review (Predetermination)	
And Debridement Of Infected Tissue request if it is unclear if the service meets BCBSOK Medical	
Policy criteria.	
54415 Removal Of Non-Inflatable (Semi-Rigid) Or Inflatable (Self- Contained) Death Removal Of A Partice Proceedings of the American Section of the Section	-
Contained) Penile Prosthesis Without Replacement Of meets BCBSOK Medical Policy criteria. BCBSOK recommends	
Prosthesis 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 MP Criteria: Procedure/service reviewed to ensure each service	
Inflatable (Self-Contained) Penile Prosthesis At The Same meets BCBSOK Medical Policy criteria. BCBSOK recommends	-
Operative Session 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 MP Criteria: Procedure/service reviewed to ensure each service	
Inflatable (Self-Contained) Penile Prosthesis Through An meets BCBSOK Medical Policy criteria. BCBSOK recommends	-
Infected Field At The Same Operative Session Including submitting a Recommended Clinical Review (Predetermination)	
Irrigation And Debridement Of Infected Tissue 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	-

54660	In continue Of Testion Ing Dreath sais (Concerts Dreas dure)	MAD Criteria: Dresedure / service reviewed to service sech service			1
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			
54600		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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Template Guided Saturation Sampling Including Imaging	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Guidance	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Guidance And Monitoring)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	High Intensity-Focused Ultrasound (Hifu) Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Ultrasound Guidance	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.			
		Policy criteria.		<u> </u>	

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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Procedure)	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	_	-	_
	Vaginal Approach	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Open Abdominal Approach	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
57007		Policy criteria.			
57307		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Concomitant Colostomy	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
57335	Vaginanlacty For Intercov State	Policy criteria.			
5/335	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			
57426	Revision (Including Removal) Of Prosthetic Vaginal Graft	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
57420	Laparoscopic Approach	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		•			
58321	Artificial Insemination; Intra-Cervical	Policy criteria. Non Covered: Procedure/service not covered by BCBSOK. Not			
50521		subject to utilization review.	-	-	-
		שטובכר נס טרוויצמרוטור ובעובש.			

58322	Artificial Insemination; Intra-Uterine	Non Covered: Procedure/service not covered by BCBSOK. Not			
56522	Altificial insemination, intra-oterine	· · ·	-	-	-
58323	Charm Washing For Artificial Incomination	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
58525	Sperm Washing For Artificial Insemination	· · ·	-	-	-
58578	Unlisted Laparoscopy Procedure Uterus	subject to utilization review. Unlisted or Undefined: Procedure/service not otherwise			
50570	Offisied Laparoscopy Procedure Oterus	· ·	-	-	-
		defined or classified, and may be subject to benefit and/or			
58579	Unlisted Hysteroscopy Procedure Uterus	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
56579	offisted Hysteroscopy Procedure Oterus		-	-	-
		defined or classified, and may be subject to benefit and/or			
58580	Transcervical Ablation Of Uterine Fibroid(S) Including	clinical review. MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
56560	Intraoperative Ultrasound Guidance And Monitoring	Criteria. Submit for Recommended Clinical Review	1/1/2024	-	01/01/2024
					01/01/2024
58674	Radiofrequency Laparoscopy Surgical Ablation Of Uterine Fibroid(S)	(Predetermination) to avoid post-service review.			
58074		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Including Intraoperative Ultrasound Guidance And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Monitoring Radiofrequency	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50670		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			
50750	The ball Assessments	clinical review.			
58750	Tubotubal Anastomosis	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
50753	Tubeuterine Incelestation	subject to utilization review.			
58752	Tubouterine Implantation	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
58970	Fallisla Dunatura Fan Oan ta Datriaval Any Mathed	subject to utilization review.			
58970	Follicle Puncture For Oocyte Retrieval Any Method	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
F9074	Embrue Transfor Intrautoring	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
58974	Embryo Transfer Intrauterine	· · · ·	-	-	-
58976	Comoto Zuzoto Or Embruo Introfollonian Transfor Anu	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
58970	Gamete Zygote Or Embryo Intrafallopian Transfer Any Method		-	-	-
58999		subject to utilization review. Unlisted or Undefined: Procedure/service not otherwise			
26999	Omisted Procedure Female Genital System (Nonobstetrical)	· ·	-	-	-
		defined or classified, and may be subject to benefit and/or			
59072	Fetal Umbilical Cord Occlusion Including Ultrasound	clinical review. MP Criteria: Procedure/service reviewed against Medical Policy			
59072	Guidance	Criteria. Submit for Recommended Clinical Review	-	-	-
	Guidance				
59074	Fetal Fluid Drainage (Eg Vesicocentesis Thoracocentesis	(Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed to ensure each service			
59074			-	-	-
	Paracentesis) Including Ultrasound Guidance	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50076	Fotol Shunt Discoment Industries Ultrassund Cuide	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	MP Criteria: Procedure/service reviewed to ensure each service			
29897	Guidance When Performed	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Guidance when Performed	· ·			
		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			
50000	Helisted Lesserer Describer Markers's Core And	clinical review.			
59898	Unlisted Laparoscopy Procedure Maternity Care And	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Delivery	defined or classified, and may be subject to benefit and/or			
50000		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			
69659		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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Infusion System For Connection To Ventricular Catheter	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	-
	Stenosis) Percutaneous	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)	MP Criteria: Procedure/service reviewed against Medical Policy	2/1/2024	_	Add effective
	Intracranial (Eg Atherosclerotic Stenosis) Including Balloon	Criteria. Submit for Recommended Clinical Review			02/01/2024
	Angioplasty If Performed	(Predetermination) to avoid post-service review.			
61645	Percutaneous Arterial Transluminal Mechanical	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Thrombectomy And/Or Infusion For Thrombolysis	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intracranial Any Method Including Diagnostic Angiography	submitting a Recommended Clinical Review (Predetermination)			
	Fluoroscopic Guidance Catheter Placement And	request if it is unclear if the service meets BCBSOK Medical			
	Intraprocedural Pharmacological Thrombolytic Injection(S)	Policy criteria.			

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

62264	Percutanoous Lycis Of Enidural Adhesions Lising Solution	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
02204	Percutaneous Lysis Of Epidural Adhesions Using Solution		-	-	-
	Injection (Eg Hypertonic Saline Enzyme) Or Mechanical	to utilization review. Please see the Clinical Payment and			
	Means (Eg Catheter) Including Radiologic Localization	Coding Policy titled: Non-Reimbursable Experimental,			
	(Includes Contrast When Administered) Multiple	Investigational and/or Unproven Services (EIU).			
62287	Adhesiolysis Sessions; 1 Day Decompression Procedure Percutaneous Of Nucleus	Ell I: Procedure (convice not reimburged by PCPSOK, Net subject			
02287		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Pulposus Of Intervertebral Disc. Any Method Utilizing Needle				
	Based Technique To Remove Disc Material Under	Coding Policy titled: Non-Reimbursable Experimental,			
	Fluoroscopic Imaging Or Other Form Of Indirect Visualization	Investigational and/or Unproven Services (EIU).			
	With Discography And/Or Epidural Injection(S) At The				
	Treated Level(S) When Performed Single Or Multiple Levels				
64505	Lumbar Injection Anesthetic Agent; Sphenopalatine Ganglion	MP Criteria: Procedure/service reviewed to ensure each service			
04303	injection Alesticite Agent, spiteropalatile ourgion	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
0.000	Array; Peripheral Nerve (Excludes Sacral Nerve)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Electrode Single Treatment Includes Programming	meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service			
	Neurostimulator Electrode Array And Pulse Generator	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Peripheral Nerve (Excludes Sacral Nerve)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Array Pulse Generator And Distal Respiratory Sensor	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Electrode Or Electrode Array	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Neurostimulator Array And Distal Respiratory Sensor	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Electrode Or Electrode Array Including Connection To	submitting a Recommended Clinical Review (Predetermination)			
	Existing Pulse Generator	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

64584	Removal Of Hypoglossal Nerve Neurostimulator Array Pulse	MP Criteria: Procedure/service reviewed to ensure each service			
	Generator And Distal Respiratory Sensor Electrode Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Electrode Array	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Neurostimulator Pulse Generator Or Receiver Requiring	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pocket Creation And Connection Between Electrode Array	submitting a Recommended Clinical Review (Predetermination)			
	And Pulse Generator Or Receiver	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
64596	Insertion Or Replacement Of Percutaneous Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Peripheral Nerve With Integrated Neurostimulator	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Including Imaging Guidance When Performed; Initial	(Predetermination) to avoid post-service review.			
	Electrode Array				
64597	Insertion Or Replacement Of Percutaneous Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Peripheral Nerve With Integrated Neurostimulator	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Including Imaging Guidance When Performed; Each	(Predetermination) to avoid post-service review.			
	Additional Electrode Array (List Separately In Addition To				
	Code For Primary Procedure)				
64598	Revision Or Removal Of Neurostimulator Electrode Array	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Peripheral Nerve With Integrated Neurostimulator	Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
64615	Chemodenervation Of Muscle(S); Muscle(S) Innervated By	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Facial Trigeminal Cervical Spinal And Accessory Nerves	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Bilateral (Eg For Chronic Migraine)	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Including Imaging Guidance When Performed	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	-
	Including All Imaging Guidance; First 2 Vertebral Bodies	to utilization review. Please see the Clinical Payment and			
	Lumbar Or Sacral	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
64629	Thermal Destruction Of Intraosseous Basivertebral Nerve	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Including All Imaging Guidance; Each Additional Vertebral	to utilization review. Please see the Clinical Payment and			
	Body Lumbar Or Sacral (List Separately In Addition To Code	Coding Policy titled: Non-Reimbursable Experimental,			
	For Primary Procedure)	Investigational and/or Unproven Services (EIU).			
64640	Destruction By Neurolytic Agent; Other Peripheral Nerve Or	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Branch	meets BCBSOK 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			
0-00	Chemodenervation of Lectine Gianus, both Axiilde	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
64653	Chemodenervation Of Eccrine Glands; Other Area(S) (Eg	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
04055	Scalp Face Neck) Per Day	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Scalp Face Necky Fel Day	submitting a Recommended Clinical Review (Predetermination)			
		5			
		request if it is unclear if the service meets BCBSOK Medical			
64802	Sympathectomy Cervical	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
04802	Sympathectomy Cervical	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
64804	Sympathectomy Cervicothoracic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
04804	Sympathectomy Cervicothoracic	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
64809	Sympathectomy Thoracolumbar	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
04809	Sympathectomy moracolumbar		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
C 40 10	Constant and a start and a start	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
64818	Sympathectomy Lumbar		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
64020	Construction District Advances Freeh District	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			
C 4000		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			1
05710	Keratoplasty (Comear Transplant); Anterior Lamenar		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
65720	Konstanlastic (Consol Transmissic), Departmenting (Consol In	Policy criteria.			
65730	Keratoplasty (Corneal Transplant); Penetrating (Except In	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Aphakia Or Pseudophakia)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Pseudophakia)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	To Transplantation (List Separately In Addition To Code For	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Primary Procedure)	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			
65771	Radial Keratotomy	Policy criteria. Non Covered: Procedure/service not covered by BCBSOK. Not			
03771			-	-	-
		subject to utilization review.			

65772	Corneal Relaxing Incision For Correction Of Surgically	MP Criteria: Procedure/service reviewed to ensure each service			
03/72	Induced Astigmatism	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		· ·			
65775	Corneal Wedge Resection For Correction Of Surgically	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
03773		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Induced Astigmatism	· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
65778	Placement Of Amniotic Membrane On The Ocular Surface;	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
05778	Without Sutures	· · ·	_	-	-
	without sutures	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
65785	Implantation Of Intrastromal Corneal Ring Segments	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service	L	ł	
65785	Implantation Of Intrastromal Corneal Ring Segments	· ·	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
CC174	Transluminal Dilation Of Assessed Outflaw Canal (Ea	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
66174	Transluminal Dilation Of Aqueous Outflow Canal (Eg		-	-	-
	Canaloplasty); Without Retention Of Device Or Stent	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
66175	Transluminal Dilation Of Aqueous Outflow Canal (Eg	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
00175			-	-	-
	Canaloplasty); With Retention Of Device Or Stent	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
CC170	Anusaus Churt Ta Futur en Jan Enustarial Dista Deservair	Policy criteria.			
66179	Aqueous Shunt To Extraocular Equatorial Plate Reservoir	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	External Approach; Without Graft	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
664.00		Policy criteria.			
66180	Aqueous Shunt To Extraocular Equatorial Plate Reservoir	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	External Approach; With Graft	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		<u> </u>	
66183	Insertion Of Anterior Segment Aqueous Drainage Device	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Without Extraocular Reservoir External Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
00184	Reservoir; Without Graft	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Reservoir, without Gran				
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
66185	Revision Of Aqueous Shunt To Extraocular Equatorial Plate	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20100			-	-	-
	Reservoir; With Graft	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
66989	Extracapsular Cataract Removal With Insertion Of	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
00585	Intraocular Lens Prosthesis (1-Stage Procedure) Manual Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Mechanical Technique (Eg. Irrigation And Aspiration Or	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
	Phacoemulsification) Complex Requiring Devices Or				
		Policy criteria.			
	(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				
66991	Extracapsular Cataract Removal With Insertion Of	MP Criteria: Procedure/service reviewed to ensure each service			
	Intraocular Lens Prosthesis (1 Stage Procedure) Manual Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Mechanical Technique (Eg Irrigation And Aspiration Or	submitting a Recommended Clinical Review (Predetermination)			
	Phacoemulsification); With Insertion Of Intraocular (Eg	request if it is unclear if the service meets BCBSOK Medical			
	Trabecular Meshwork Supraciliary Suprachoroidal) Anterior				
	Segment Aqueous Drainage Device Without Extraocular				
	Reservoir Internal Approach One Or More				
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Ganciclovir Implant) Includes Concomitant Removal Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Vitreous	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Procedure)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Neovascularization); Photodynamic Therapy (Includes	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intravenous Infusion)	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Neovascularization); Photodynamic Therapy Second Eye At	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Single Session (List Separately In Addition To Code For	submitting a Recommended Clinical Review (Predetermination)			
	Primary Eye Treatment)	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	MP Criteria: Procedure/service reviewed against Medical Policy	2/15/2024	_	Add effectuce
	(Separate Procedure)	Criteria. Submit for Recommended Clinical Review			02/15/2024
		(Predetermination) to avoid post-service review.			
67599	Unlisted Procedure Orbit	Unlisted or Undefined: Procedure/service not otherwise			
		defined or classified, and may be subject to benefit and/or			
		clinical review.			
67901	Repair Of Blepharoptosis; Frontalis Muscle Technique With	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Suture Or Other Material (Eg Banked Fascia)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Autologous Fascial Sling (Includes Obtaining Fascia)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Advancement Internal Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Advancement External Approach	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Fascial Sling (Includes Obtaining Fascia)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Muscle-Levator Resection (Eg Fasanella-Servat Type)	meets BCBSOK 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			
07999	Unisted Procedure Eyends		-	-	-
		defined or classified, and may be subject to benefit and/or			
68399	Unlisted Procedure Conjunctiva	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
00599	Offisied Procedure Conjunctiva	· ·	-	-	-
		defined or classified, and may be subject to benefit and/or			
69900	Unlisted Procedure Lacrimal System	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
68899	Unisted Procedure Lacrimar System		-	-	-
		defined or classified, and may be subject to benefit and/or			
69090	For Discours	clinical review. MP Criteria: Procedure/service reviewed to ensure each service			
69090	Ear Piercing	· ·	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
60200	Otoplastic Drotanding For With Or Without Circ Deduction	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			
60200		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			
60676	The second state of the second second	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			
60705		Policy criteria.			
69705	Nasopharyngoscopy Surgical With Dilation Of Eustachian	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Tube (le Balloon Dilation); Unilateral	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
60706		Policy criteria.			
69706	Nasopharyngoscopy Surgical With Dilation Of Eustachian	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Tube (le Balloon Dilation); Bilateral	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	
69716		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Transcutaneous Attachment To External Speech Processor	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Within The Mastoid And/Or Resulting In Removal Of Less	submitting a Recommended Clinical Review (Predetermination)			
	Than 100 Sq Mm Surface Area Of Bone Deep To The Outer	request if it is unclear if the service meets BCBSOK Medical			
	Cranial Cortex	Policy criteria.			

69719	Replacement (Including Removal Of Existing Device)	MP Criteria: Procedure/service reviewed to ensure each service			
05715	Osseointegrated Implant Skull; With Magnetic	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Transcutaneous Attachment To External Speech Processor	submitting a Recommended Clinical Review (Predetermination)			
	•				
	Within The Mastoid And/Or Involving A Bony Defect Less	request if it is unclear if the service meets BCBSOK Medical			
	Than 100 Sq Mm Surface Area Of Bone Deep To The Outer	Policy criteria.			
69728	Cranial Cortex Removal Entire Osseointegrated Implant Skull; With	MP Criteria: Procedure/service reviewed to ensure each service		1	
09728			-	-	-
	Magnetic Transcutaneous Attachment To External Speech	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	. .	submitting a Recommended Clinical Review (Predetermination)			
	Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone	request if it is unclear if the service meets BCBSOK Medical			
	Deep To The Outer Cranial Cortex	Policy criteria.			
69729		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Transcutaneous Attachment To External Speech Processor	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Outside Of The Mastoid And Resulting In Removal Of	submitting a Recommended Clinical Review (Predetermination)			
	Greater Than Or Equal To 100 Sq Mm Surface Area Of Bone	request if it is unclear if the service meets BCBSOK Medical			
	Deep To The Outer Cranial Cortex	Policy criteria.			
69730	Replacement (Including Removal Of Existing Device)	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Osseointegrated Implant Skull; With Magnetic	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Transcutaneous Attachment To External Speech Processor	submitting a Recommended Clinical Review (Predetermination)			
	Outside The Mastoid And Involving A Bony Defect Greater	request if it is unclear if the service meets BCBSOK Medical			
	Than Or Equal To 100 Sq Mm Surface Area Of Bone Deep To	Policy criteria.			
	The Outer Cranial Cortex				
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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	(Ffr) Derived From Augmentative Software Analysis Of The	Criteria. Submit for Recommended Clinical Review		Γ	01/01/2024
	Data Set From A Coronary Computed Tomography	(Predetermination) to avoid post-service review.			
	Angiography With Interpretation And Report By A Physician	···· · · · · · · · · · · · · · · · · ·			
	Or Other Qualified Health Care Professional				
	of other Qualified Health eare Professional				
75894	Transcatheter Therapy Embolization Any Method	MP Criteria: Procedure/service reviewed to ensure each service			
	Radiological Supervision And Interpretation	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
/ 5550	Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Intramural Hematoma Or Traumatic Disruption); Involving	submitting a Recommended Clinical Review (Predetermination)			
	Coverage Of Left Subclavian Artery Origin Initial	request if it is unclear if the service meets BCBSOK Medical			
	Endoprosthesis Plus Descending Thoracic Aortic Extension(S)				
	If Required To Level Of Celiac Artery Origin Radiological	roncy citteria.			
	Supervision And Interpretation				
75957	Endovascular Repair Of Descending Thoracic Aorta (Eg	MP Criteria: Procedure/service reviewed to ensure each service			
	Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Intramural Hematoma Or Traumatic Disruption); Not	submitting a Recommended Clinical Review (Predetermination)			
	Involving Coverage Of Left Subclavian Artery Origin Initial	request if it is unclear if the service meets BCBSOK Medical			
	Endoprosthesis Plus Descending Thoracic Aortic Extension(S)				
	If Required To Level Of Celiac Artery Origin Radiological	roncy enterta.			
	Supervision And Interpretation				
75958	Placement Of Proximal Extension Prosthesis For	MP Criteria: Procedure/service reviewed to ensure each service			
	Endovascular Repair Of Descending Thoracic Aorta (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Aneurysm Pseudoaneurysm Dissection Penetrating Ulcer	submitting a Recommended Clinical Review (Predetermination)			
	Intramural Hematoma Or Traumatic Disruption)	request if it is unclear if the service meets BCBSOK Medical			
	Radiological Supervision And Interpretation	Policy criteria.			
75959	Placement Of Distal Extension Prosthesis(S) (Delayed) After	MP Criteria: Procedure/service reviewed to ensure each service			
	Endovascular Repair Of Descending Thoracic Aorta As	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Needed To Level Of Celiac Origin Radiological Supervision	submitting a Recommended Clinical Review (Predetermination)			
	And Interpretation	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
76120	Cineradiography/Videoradiography Except Where	MP Criteria: Procedure/service reviewed to ensure each service			
	Specifically Included	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Examination (List Separately In Addition To Code For	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Primary Procedure)	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	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Interventional)	defined or classified, and may be subject to benefit and/or			
		clinical review.			
76497	Unlisted Computed Tomography Procedure (Eg Diagnostic	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Interventional)	meets BCBSOK 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.			

Unlisted Magnetic Resonance Procedure (Eg. Diagnostic	MP Criteria: Procedure/service reviewed to ensure each service			
		-	-	-
	· ·			
	1 ·			
Haltstad Discountin Deditors and in Descendence				
Unlisted Diagnostic Radiographic Procedure		-	-	-
. .		-	-	-
Tissue Ablation	· ·			
	, , , , , , , , , , , , , , , , , , ,			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
		-	_	_
Supervision And Interpretation	subject to utilization review.			
Unlisted Ultrasound Procedure (Eg Diagnostic		_	-	-
Interventional)	defined or classified, and may be subject to benefit and/or			
	clinical review.			
Computed Tomography Guidance For And Monitoring Of	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
Parenchymal Tissue Ablation	meets BCBSOK 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 Procedure Therapeutic Radiology Clinical	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
Treatment Planning	meets BCBSOK 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			
	· ·			
Unlisted Procedure Medical Radiation Physics Dosimetry		_	_	
And Treatment Devices And Special Services	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	· ·			
	request if it is unclear if the service meets BCBSOK Medical			
	1 ·			
	1 '			
	defined of classified, and may be subject to benefit and/or			
	Unlisted Ultrasound Procedure (Eg Diagnostic Interventional) Computed Tomography Guidance For And Monitoring Of Parenchymal Tissue Ablation Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning Unlisted Procedure Medical Radiation Physics Dosimetry	Interventional) meets BCBSOK 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 Diagnostic Radiographic Procedure Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. Ultrasound Guidance For And Monitoring Of Parenchymal MP Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. Ultrasound Guidance For And Monitoring Of Parenchymal MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Medical Policy criteria. Ultrasonic Guidance For Aspiration Of Ova Imaging Non Covered: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. Unlisted Utrasound Procedure (Eg Diagnostic Interventional) Unlisted or Undefined: Procedure/service not otherwise dified or classified, and may be subject to benefit and/or clinical review. Computed Tomography Guidance For And Monitoring Of Parenchymal Tissue Ablation MP Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning MP Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning MP Criteria: Procedure/service revie	Interventional) meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Vullisted Diagnostic Radiographic Procedure Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or	Interventional) meets BCSDV. Medical Policy criteria. BCSDV Medical Submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCSDV Medical Policy criteria. Unlisted Diagnostic Radiographic Procedure Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. - Ultrasound Guidance For And Monitoring OF Parenchymal Tissue Ablation MP Criteria: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or clinical review. - Ultrasound Guidance For And Monitoring OF Parenchymal Tissue Ablation MP Criteria: Procedure/service reviewed to ensure each service procedure/service net SoCBSOK Medical Policy criteria. - Ultrasound For Aspiration Of Ova Imaging Supervision And Interpretation Unlisted Ultrasound Procedure [Eg. Diagnostic Interventional) MID Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. - 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. - Unlisted Procedure Therapeutic Radiology Clinical Treatment Planning MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Medical Policy criteria. BCBSOK Medical Pol

77499	Unlisted Procedure Therapeutic Radiology Treatment	MP Criteria: Procedure/service reviewed to ensure each service			
77455	Management		-	-	-
	Management	meets BCBSOK 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			
	Ŭ	defined or classified, and may be subject to benefit and/or	-	_	-
		clinical review.			
78199	Unlisted Hematopoietic Reticuloendothelial And Lymphatic	Unlisted or Undefined: Procedure/service not otherwise			
	Procedure Diagnostic Nuclear Medicine	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
78299	Unlisted Gastrointestinal Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise			
/ 0200	Medicine	defined or classified, and may be subject to benefit and/or	-	-	-
	Weddine	clinical review.			
78399	Unlisted Musculoskeletal Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise			
/0555	Medicine	defined or classified, and may be subject to benefit and/or	-	-	-
	Weucine	clinical review.			
78434	Absolute Quantitation Of Myocardial Blood Flow (Agmbf)	MP Criteria: Procedure/service reviewed to ensure each service			
70434			-	-	-
	Positron Emission Tomography (Pet) Rest And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pharmacologic Stress (List Separately In Addition To Code	submitting a Recommended Clinical Review (Predetermination)			
	For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
70.400		Policy criteria.			
78499	Unlisted Cardiovascular Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Medicine	defined or classified, and may be subject to benefit and/or			
		clinical review.			
78599	Unlisted Respiratory Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Medicine	defined or classified, and may be subject to benefit and/or			
		clinical review.			
78699	Unlisted Nervous System Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Medicine	defined or classified, and may be subject to benefit and/or			
		clinical review.			
78799	Unlisted Genitourinary Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise	_	-	_
	Medicine	defined or classified, and may be subject to benefit and/or			
		clinical review.			

78999	Unlisted Miscellaneous Procedure Diagnostic Nuclear	Unlisted or Undefined: Procedure/service not otherwise			
	Medicine	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
79445	Radiopharmaceutical Therapy By Intra-Arterial Particulate	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Administration	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Dystrophy) Deletion Analysis And Duplication Analysis If	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Performed	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)	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Translocation Analysis; Major Breakpoint Qualitative Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Quantitative	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)	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Translocation Analysis; Minor Breakpoint Qualitative Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Quantitative	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
01211		Policy criteria.			
81241		MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Gene Analysis Leiden Variant	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
81243	Emri (Erocile V Macconger Dihenvaleenretein 1) (Eg. Erocile	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
81243			-	-	-
	X Syndrome X-Linked Intellectual Disability [Xlid]) Gene	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Analysis; Evaluation To Detect Abnormal (Eg Expanded)	submitting a Recommended Clinical Review (Predetermination)			
	Alleles	request if it is unclear if the service meets BCBSOK Medical			
81420	Fetal Chromosomal Aneuploidy (Eg Trisomy 21 Monosomy	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
01420	X) Genomic Sequence Analysis Panel Circulating Cell-Free		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fetal Dna In Maternal Blood Must Include Analysis Of	submitting a Recommended Clinical Review (Predetermination)			
	Chromosomes 13 18 And 21	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		1	

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

04506			1		
81536	Oncology (Gynecologic) Live Tumor Cell Culture And	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Chemotherapeutic Response By Dapi Stain And Morphology	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Predictive Algorithm Reported As A Drug Response Score;	submitting a Recommended Clinical Review (Predetermination)			
	Each Additional Single Drug Or Drug Combination (List	request if it is unclear if the service meets BCBSOK Medical			
	Separately In Addition To Code For Primary Procedure)	Policy criteria.			
81538	On solary (lung) Mass Creation ratio (Dustain Circuit, us	MAD Criteria: Dread un (con incorrection de constante contente con incorrection)			
81538	Oncology (Lung) Mass Spectrometric 8-Protein Signature	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Including Amyloid A Utilizing Serum Prognostic And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Predictive Algorithm Reported As Good Versus Poor Overall	submitting a Recommended Clinical Review (Predetermination)			
	Survival	request if it is unclear if the service meets BCBSOK Medical			
04520	O contra d'Utata Conde Decetata Concertà Disete estada Acce	Policy criteria.			
81539	Oncology (High-Grade Prostate Cancer) Biochemical Assay	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Kallikrein-2 [Hk2]) Utilizing Plasma Or Serum Prognostic	submitting a Recommended Clinical Review (Predetermination)			
	Algorithm Reported As A Probability Score	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Receptor Like-1)	meets BCBSOK 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).			
		האינטוקמנוטוומו מווערטר טווטוטעפון שבו עונבט (בוט).			

83701	Lipoprotein Blood; High Resolution Fractionation And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
05701	Quantitation Of Lipoproteins Including Lipoprotein	to utilization review. Please see the Clinical Payment and	-	-	-
		,			
	Subclasses When Performed (Eg Electrophoresis	Coding Policy titled: Non-Reimbursable Experimental,			
83704	Ultracentrifugation) Lipoprotein Blood; Quantitation Of Lipoprotein Particle	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
83704			-	-	-
	Number(S) (Eg By Nuclear Magnetic Resonance	to utilization review. Please see the Clinical Payment and			
	Spectroscopy) Includes Lipoprotein Particle Subclass(Es)	Coding Policy titled: Non-Reimbursable Experimental,			
01711	When Performed	Investigational and/or Unproven Services (EIU).			
83722	Lipoprotein Direct Measurement; Small Dense Ldl	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Cholesterol	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
00007		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		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Protein(S) (Eg Placental Alpha Microglobulin-1 [Pamg-1]	to utilization review. Please see the Clinical Payment and			
	Placental Protein 12 [Pp12] Alpha-Fetoprotein) Qualitative	Coding Policy titled: Non-Reimbursable Experimental,			
	Each Specimen	Investigational and/or Unproven Services (EIU).			
84431	Thromboxane Metabolite(S) Including Thromboxane If	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Performed Urine	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	
	Allergen	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 Antihody/Ios) Qualitative	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
80328	Or Semiquantitative Single-Step Method (Eg Reagent Strip);		-	-	-
	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-				
	2) (Coronavirus Disease [Covid-19])	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Or Antigen) And Detection Of Biomarker (Eg Atp)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Antigen Induced Blastogenesis	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]);	to utilization review. Please see the Clinical Payment and			
	Screen	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
86409	Neutralizing Antibody Severe Acute Respiratory Syndrome	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Coronavirus 2 (Sars-Cov-2) (Coronavirus Disease [Covid-19]);	to utilization review. Please see the Clinical Payment and			
	Titer	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
86413	Severe Acute Respiratory Syndrome Coronavirus 2 (Sars-Cov-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	2) (Coronavirus Disease [Covid-19]) Antibody Quantitative	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	(Sars-Cov-2) (Coronavirus Disease [Covid-19])	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	And Mn	subject to utilization review.			

86950	Leukocyte Transfusion	MP Criteria: Procedure/service reviewed to ensure each service		1	
00000		meets BCBSOK 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);	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Salmonella Shigella Norovirus Giardia) Includes Multiplex	submitting a Recommended Clinical Review (Predetermination)			
	Reverse Transcription When Performed And Multiplex	request if it is unclear if the service meets BCBSOK Medical			
	Amplified Probe Technique Multiple Types Or Subtypes 3-5	Policy criteria.			
	Targets				
87506	Infectious Agent Detection By Nucleic Acid (Dna Or Rna);	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Salmonella Shigella Norovirus Giardia) Includes Multiplex	submitting a Recommended Clinical Review (Predetermination)			
	Reverse Transcription When Performed And Multiplex	request if it is unclear if the service meets BCBSOK Medical			
	Amplified Probe Technique Multiple Types Or Subtypes 6-	Policy criteria.			
	11 Targets				
87507	Infectious Agent Detection By Nucleic Acid (Dna Or Rna);	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Gastrointestinal Pathogen (Eg Clostridium Difficile E. Coli	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Salmonella Shigella Norovirus Giardia) Includes Multiplex	submitting a Recommended Clinical Review (Predetermination)			
	Reverse Transcription When Performed And Multiplex	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
87797	25 Targets Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not	Inlisted or Indefined: Procedure/service not otherwise			
0// 5/	Otherwise Specified; Direct Probe Technique Each Organism		-	-	-
	otherwise specified, birect robe rechnique Each organism	clinical review.			
87798	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not				
01100	Otherwise Specified; Amplified Probe Technique Each	defined or classified, and may be subject to benefit and/or	-	-	-
	Organism	clinical review.			
87799	Infectious Agent Detection By Nucleic Acid (Dna Or Rna) Not				
	Otherwise Specified; Quantification Each Organism	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
87899	Infectious Agent Antigen Detection By Immunoassay With	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Direct Optical (le Visual) Observation; Not Otherwise	defined or classified, and may be subject to benefit and/or			
	Specified	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 Outogenetic Study	Unlisted or Undefined, Dresedure (convice not athematics			
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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Report Real-Time Or Referred Each Endoscopic Session	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-				
05251	Culture Of Oocyte(S)/Embryos	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· · ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
00252	Assisted Fusience Ustabling Misusteals simular (Am. Mathed)	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Fluid)	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-	Non Covered: Procedure/service not covered by BCBSOK. Not			
			—	1-	-

89261	Sperm Isolation; Complex Prep (Eg Percoll Gradient	Non Covered: Procedure/service not covered by BCBSOK. Not			
09201	Albumin Gradient) For Insemination Or Diagnosis With	subject to utilization review.	-	-	-
	,	subject to utilization review.			
89264	Semen Analysis Sperm Identification From Testis Tissue Fresh Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
89204		subject to utilization review.	-	-	-
89268	Cryopreserved Insemination Of Oocytes	Non Covered: Procedure/service not covered by BCBSOK. Not			
09200	Insemination of Oocytes		-	-	-
89272	Extended Culture Of Oocyte(S)/Embryo(S) 4-7 Days	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
05272		· · · ·	-	-	-
		subject to utilization review.			
89280	Assisted Oocyte Fertilization Microtechnique; Less Than Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Equal To 10 Oocytes	subject to utilization review.	-	-	-
		····,····			
89281	Assisted Oocyte Fertilization Microtechnique; Greater Than	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	10 Oocytes	subject to utilization review.			
89290	Biopsy Oocyte Polar Body Or Embryo Blastomere	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Microtechnique (For Pre-Implantation Genetic Diagnosis);	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Less Than Or Equal To 5 Embryos	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Microtechnique (For Pre-Implantation Genetic Diagnosis);	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Greater Than 5 Embryos	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Without Spinnbarkeit Test	subject to utilization review.			
89331	Sperm Evaluation For Retrograde Ejaculation Urine (Sperm	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Concentration Motility And Morphology As Indicated)	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			
89332	mawing of cryopreserved, Embryo(s)	subject to utilization review.	-	-	-
		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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Testicular/Ovarian	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	MP Criteria: Procedure/service reviewed to ensure each service	-	—	-
	Infusions 100 Mg Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
00270	Providence Constitution Management Antibact	Prior Authorization may be required per contract agreement.			
90378	Respiratory Syncytial Virus Monoclonal Antibody	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Recombinant For Intramuscular Use 50 Mg Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
90399	Unlisted Immune Globulin	Prior Authorization may be required per contract agreement. Unlisted or Undefined: Procedure/service not otherwise			
90399	offisted infinute Globalin	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
90584	Dengue Vaccine Quadrivalent Live 2 Dose Schedule For	Non Covered: Procedure/service not covered by BCBSOK. Not			
50504	Subcutaneous Use	subject to utilization review.	-	-	-
90626	Tick-Borne Encephalitis Virus Vaccine Inactivated; 0.25 MI	Non Covered: Procedure/service not covered by BCBSOK. Not			
50020	Dosage For Intramuscular Use	subject to utilization review.	-	-	-
90627	Tick-Borne Encephalitis Virus Vaccine Inactivated; 0.5 Ml	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Dosage For Intramuscular Use	subject to utilization review.	_		-
90664	Influenza Virus Vaccine Live (Laiv) Pandemic Formulation	MP Criteria: Procedure/service reviewed to ensure each service			
-	For Intranasal Use	meets BCBSOK 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 (liv) Pandemic Formulation Split	MP Criteria: Procedure/service reviewed to ensure each service			
	Virus Preservative Free For Intramuscular Use	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		_	
	Virus Adjuvanted For Intramuscular Use	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Nanoparticles For Intramuscular Use	subject to utilization review.			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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Mcg Dosage 3 Dose Schedule For Intramuscular Use	subject to utilization review.			
90867	Therapeutic Repetitive Transcranial Magnetic Stimulation	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Tms) Treatment; Initial Including Cortical Mapping Motor	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Threshold Determination Delivery And Management	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Tms) Treatment; Subsequent Delivery And Management	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Per Session	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Tms) Treatment; Subsequent Motor Threshold Re-	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Determination With Delivery And Management	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
90875	Individual Psychophysiological Therapy Incorporating	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Biofeedback Training By Any Modality (Face-To-Face With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	The Patient) With Psychotherapy (Eg Insight Oriented	submitting a Recommended Clinical Review (Predetermination)			
	Behavior Modifying Or Supportive Psychotherapy); 30	request if it is unclear if the service meets BCBSOK Medical			
	Minutes	Policy criteria.			
90876	Individual Psychophysiological Therapy Incorporating	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Biofeedback Training By Any Modality (Face-To-Face With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	The Patient) With Psychotherapy (Eg Insight Oriented	submitting a Recommended Clinical Review (Predetermination)			
	Behavior Modifying Or Supportive Psychotherapy); 45	request if it is unclear if the service meets BCBSOK Medical			1
	Minutes	Policy criteria.		- / /	
90880x	Hypnotherapy	MP Criteria: Procedure/service reviewed to ensure each service	-	5/31/2024	Retire effective
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			5/31/2024
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

90885	Psychiatric Evaluation Of Hospital Pacards, Other Psychiatric	Non Covered: Procedure/service not covered by BCBSOK. Not			
50885	Reports Psychometric And/Or Projective Tests And Other	subject to utilization review.	-	-	-
		subject to utilization review.			
	Accumulated Data For Medical Diagnostic Purposes				
90889	Preparation Of Report Of Patient'S Psychiatric Status History	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Treatment Or Progress (Other Than For Legal Or	subject to utilization review.			
	Consultative Purposes) For Other Individuals Agencies Or				
	Insurance Carriers				
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Urethral Sphincter Including Emg And/Or Manometry	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	When Performed; Initial 15 Minutes Of One-On-One	submitting a Recommended Clinical Review (Predetermination)			
	Physician Or Other Qualified Health Care Professional	request if it is unclear if the service meets BCBSOK Medical			
	Contact With The Patient	Policy criteria.			
90913	Biofeedback Training Perineal Muscles Anorectal Or	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Urethral Sphincter Including Emg And/Or Manometry	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	When Performed; Each Additional 15 Minutes Of One-On-	submitting a Recommended Clinical Review (Predetermination)			
	One Physician Or Other Qualified Health Care Professional	request if it is unclear if the service meets BCBSOK Medical			
	Contact With The Patient (List Separately In Addition To	Policy criteria.			
	Code For Primary Procedure)				
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		MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Catheter Ph Electrode(S) Placement Recording Analysis And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Interpretation	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
91035		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Attached Telemetry Ph Electrode Placement Recording	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Analysis And Interpretation	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
91037		MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	With Nasal Catheter Intraluminal Impedance Electrode(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Placement Recording Analysis And Interpretation;	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	MP Criteria: Procedure/service reviewed to ensure each service			
51050	With Nasal Catheter Intraluminal Impedance Electrode(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Placement Recording Analysis And Interpretation;	submitting a Recommended Clinical Review (Predetermination)			
	Prolonged (Greater Than 1 Hour Up To 24 Hours)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
91065	Breath Hydrogen Or Methane Test (Eg For Detection Of	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Lactase Deficiency Fructose Intolerance Bacterial	to utilization review. Please see the Clinical Payment and			
	Overgrowth Or Oro-Cecal Gastrointestinal Transit)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
91110	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Endoscopy) Esophagus Through Ileum With Interpretation	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Report	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Endoscopy) Esophagus With Interpretation And Report	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
91112		Investigational and/or Unproven Services (EIU).			
91112	Gastrointestinal Transit And Pressure Measurement	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Stomach Through Colon Wireless Capsule With	to utilization review. Please see the Clinical Payment and			
	Interpretation And Report	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).			
91113	Gastrointestinal Tract Imaging Intraluminal (Eg Capsule	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
51115	Endoscopy) Colon With Interpretation And Report	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Continuous Recording (Including Provocation Tests Eg Meal	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intracolonic Balloon Distension Pharmacologic Agents If	submitting a Recommended Clinical Review (Predetermination)			
	Performed) With Interpretation And Report	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Provocative Testing	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
91299	Unlisted Diagnostic Gastroenterology Procedure	Investigational and/or Unproven Services (EIU). Unlisted or Undefined: Procedure/service not otherwise			
91299	offisted Diagnostic Gastroenterology Procedure	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
92065	Orthoptic Training; Performed By A Physician Or Other	MP Criteria: Procedure/service reviewed to ensure each service			
	Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	F	-
		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	MP Criteria: Procedure/service reviewed to ensure each service			
	Other Qualified Health Care Professional	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
52102	Anterior Segment With Interpretation And Report	to utilization review. Please see the Clinical Payment and	-	-	-
	Unilateral Or Bilateral	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
92145	Corneal Hysteresis Determination By Air Impulse	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
52115	Stimulation Unilateral Or Bilateral With Interpretation And	to utilization review. Please see the Clinical Payment and	-	-	-
	Report	Coding Policy titled: Non-Reimbursable Experimental,			
	Report				
92273	Electroretinography (Erg) With Interpretation And Report;	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
92275	Full Field (le Fferg Flash Erg Ganzfeld Erg)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Full Field (le Fielg Flash Elg Galizield Elg)	-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
02274		Policy criteria.			
92274	Electroretinography (Erg) With Interpretation And Report;	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Multifocal (Mferg)	meets BCBSOK 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			
00510		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		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Interpretation And Report; Cervical (Cvemp)	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
92518		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	Interpretation And Report; Ocular (Ovemp)	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
92519		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Interpretation And Report; Cervical (Cvemp) And Ocular	to utilization review. Please see the Clinical Payment and			
	(Ovemp)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
92520	Laryngeal Function Studies (Ie Aerodynamic Testing And	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Acoustic Testing)	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
52540	Test (Cdp-Sot) 6 Conditions (le Eyes Open Eyes Closed	to utilization review. Please see the Clinical Payment and	-	-	-
	Visual Sway Platform Sway Eyes Closed Platform Sway	Coding Policy titled: Non-Reimbursable Experimental,			
	Platform And Visual Sway) Including Interpretation And	Investigational and/or Unproven Services (EIU).			
02540	Report;	FUL Dread we familie and wind wood by DCDCOK Nation biost			
92549	Computerized Dynamic Posturography Sensory Organization	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Test (Cdp-Sot) 6 Conditions (Ie Eyes Open Eyes Closed	to utilization review. Please see the Clinical Payment and			
	Visual Sway Platform Sway Eyes Closed Platform Sway	Coding Policy titled: Non-Reimbursable Experimental,			
	Platform And Visual Sway) Including Interpretation And	Investigational and/or Unproven Services (EIU).			
	Report; With Motor Control Test (Mct) And Adaptation Test				
	(Adt)				
92601	Diagnostic Analysis Of Cochlear Implant Patient Younger	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Than 7 Years Of Age; With Programming	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Than 7 Years Of Age; Subsequent Reprogramming	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Older; With Programming	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
52022	Auditory Osseointegrated Sound Processor Any Type; First	Criteria. Submit for Recommended Clinical Review	-, -,	-	01/01/2024
	60 Minutes	(Predetermination) to avoid post-service review.			01/01/2021
92623	Diagnostic Analysis Programming And Verification Of An	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
52025	Auditory Osseointegrated Sound Processor Any Type; Each	Criteria. Submit for Recommended Clinical Review	1, 1, 202 1	-	01/01/2024
	Additional 15 Minutes (List Separately In Addition To Code	(Predetermination) to avoid post-service review.			01/01/2024
		(Fredetermination) to avoid post-service review.			
92640	For Primary Procedure) Diagnostic Analysis With Programming Of Auditory	MP Criteria: Procedure/service reviewed to ensure each service			
52040	Brainstem Implant Per Hour	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Brainstein impiant Per Hour	· · · · · · · · · · · · · · · · · · ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
00700		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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Separately In Addition To Code For Primary Procedure)	Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
92974	Transcatheter Placement Of Radiation Delivery Device For	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Subsequent Coronary Intravascular Brachytherapy (List	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Separately In Addition To Code For Primary Procedure)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Intravascular Ultrasound (Ivus) Or Optical Coherence	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Tomography (Oct) During Diagnostic Evaluation And/Or	submitting a Recommended Clinical Review (Predetermination)			
	Therapeutic Intervention Including Imaging Supervision	request if it is unclear if the service meets BCBSOK Medical			
	Interpretation And Report; Initial Vessel (List Separately In	Policy criteria.			
	Addition To Code For Primary Procedure)				
92979	Endoluminal Imaging Of Coronary Vessel Or Graft Using	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
l	Intravascular Ultrasound (Ivus) Or Optical Coherence	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Tomography (Oct) During Diagnostic Evaluation And/Or	submitting a Recommended Clinical Review (Predetermination)			
	Therapeutic Intervention Including Imaging Supervision	request if it is unclear if the service meets BCBSOK Medical			
	Interpretation And Report; Each Additional Vessel (List	Policy criteria.			
	Separately In Addition To Code For Primary Procedure)				
93025	Microvolt T-Wave Alternans For Assessment Of Ventricular	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Arrhythmias	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Central Arterial Pressures Includes Obtaining Waveform(S)	to utilization review. Please see the Clinical Payment and			
	Digitization And Application Of Nonlinear Mathematical	Coding Policy titled: Non-Reimbursable Experimental,			
	Transformations To Determine Central Arterial Pressures	Investigational and/or Unproven Services (EIU).			
	And Augmentation Index With Interpretation And Report				
	Upper Extremity Artery Non-Invasive				
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	System Including All Interrogation And Programming	Criteria. Submit for Recommended Clinical Review			05/14/2024
		(Predetermination) to avoid post-service review.			
93150	Therapy Activation Of Implanted Phrenic Nerve Stimulator	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	System Including All Interrogation And Programming	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
93151	Interrogation And Programming (Minimum One Parameter)	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Of Implanted Phrenic Nerve Stimulator System	Criteria. Submit for Recommended Clinical Review			05/14/2024
		(Predetermination) to avoid post-service review.			
93151	Interrogation And Programming (Minimum One Parameter)	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	Of Implanted Phrenic Nerve Stimulator System	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
93152		MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Stimulator System During Polysomnography	Criteria. Submit for Recommended Clinical Review			05/14/2024
		(Predetermination) to avoid post-service review.			

93152	Interrogation And Programming Of Implanted Phrenic Nerve	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
	Stimulator System During Polysomnography	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
93153	Interrogation Without Programming Of Implanted Phrenic	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Nerve Stimulator System	Criteria. Submit for Recommended Clinical Review			05/14/2024
		(Predetermination) to avoid post-service review.			
3153	Interrogation Without Programming Of Implanted Phrenic	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
	Nerve Stimulator System	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
3228	External Mobile Cardiovascular Telemetry With	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Electrocardiographic Recording Concurrent Computerized	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Real Time Data Analysis And Greater Than 24 Hours Of	submitting a Recommended Clinical Review (Predetermination)			
	Accessible Ecg Data Storage (Retrievable With Query) With	request if it is unclear if the service meets BCBSOK Medical			
	Ecg Triggered And Patient Selected Events Transmitted To A	1 ·			
	Remote Attended Surveillance Center For Up To 30 Days;				
	Review And Interpretation With Report By A Physician Or				
	Other Qualified Health Care Professional				
	other Quanteu ricalar care riolessional				
3229	External Mobile Cardiovascular Telemetry With	MP Criteria: Procedure/service reviewed to ensure each service			
	Electrocardiographic Recording Concurrent Computerized	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	Real Time Data Analysis And Greater Than 24 Hours Of	submitting a Recommended Clinical Review (Predetermination)			
	Accessible Ecg Data Storage (Retrievable With Query) With	request if it is unclear if the service meets BCBSOK Medical			
	Ecg Triggered And Patient Selected Events Transmitted To A	1 ·			
	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				
	Physician of other Qualified Health Care Professional				
3260	Programming Device Evaluation (In Person) With Iterative	MP Criteria: Procedure/service reviewed to ensure each service			
	Adjustment Of The Implantable Device To Test The Function	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of The Device And Select Optimal Permanent Programmed	submitting a Recommended Clinical Review (Predetermination)			
	Values With Analysis Review And Report By A Physician Or	request if it is unclear if the service meets BCBSOK Medical			
	Other Qualified Health Care Professional; Implantable	Policy criteria.			
	Subcutaneous Lead Defibrillator System				
3261	Interrogation Device Evaluation (In Person) With Analysis	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Care Professional Includes Connection Recording And	submitting a Recommended Clinical Review (Predetermination)			
	Disconnection Per Patient Encounter; Implantable	request if it is unclear if the service meets BCBSOK Medical			
	Subcutaneous Lead Defibrillator System	Policy criteria.			
3264	Remote Monitoring Of A Wireless Pulmonary Artery	MP Criteria: Procedure/service reviewed to ensure each service			
	Pressure Sensor For Up To 30 Days Including At Least	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	–	 ⁻
	Weekly Downloads Of Pulmonary Artery Pressure	submitting a Recommended Clinical Review (Predetermination)			
	Recordings Interpretation(S) Trend Analysis And Report(S)	request if it is unclear if the service meets BCBSOK Medical			
	By A Physician Or Other Qualified Health Care Professional	Policy criteria.			
	by A Fligstran Or Other Quaineu Health Care Professional	runcy criteria.		1	1

93278	Signal Averaged Electrocardiography (Saeca) With Or	MP Criteria: Procedure/service reviewed to ensure each service			
93278	Signal-Averaged Electrocardiography (Saecg) With Or	· · · · · · · · · · · · · · · · · · ·	—	-	-
	Without Ecg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
93356	Museerdial Strain Imaging Using Speekle Tracking Derived	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
93330	Myocardial Strain Imaging Using Speckle Tracking-Derived		-	-	-
	Assessment Of Myocardial Mechanics (List Separately In	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Addition To Codes For Echocardiography Imaging)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
93580	Percutaneous Transcatheter Closure Of Congenital	Policy criteria.			
93580		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Interatrial Communication (le Fontan Fenestration Atrial	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Septal Defect) With Implant	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
93640	Electrophysiologic Evaluation Of Single Or Dual Chamber	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		ł	
93640		· · ·	-	-	-
	Pacing Cardioverter-Defibrillator Leads Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Defibrillation Threshold Evaluation (Induction Of Arrhythmia	, , , , , , , , , , , , , , , , , , ,			
	Evaluation Of Sensing And Pacing For Arrhythmia	request if it is unclear if the service meets BCBSOK Medical			
	Termination) At Time Of Initial Implantation Or	Policy criteria.			
93641	Replacement: Electrophysiologic Evaluation Of Single Or Dual Chamber				
93041		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Pacing Cardioverter-Defibrillator Leads Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
	Evaluation Of Sensing And Pacing For Arrhythmia	request if it is unclear if the service meets BCBSOK Medical			
	Termination) At Time Of Initial Implantation Or	Policy criteria.			
	Replacement; With Testing Of Single Or Dual Chamber				
93642	Pacing Cardioverter-Defibrillator Pulse Generator Electrophysiologic Evaluation Of Single Or Dual Chamber	MP Criteria: Procedure/service reviewed to ensure each service			
55042	Transvenous Pacing Cardioverter-Defibrillator (Includes	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Defibrillation Threshold Evaluation Induction Of Arrhythmia	submitting a Recommended Clinical Review (Predetermination)			
	Evaluation Of Sensing And Pacing For Arrhythmia	request if it is unclear if the service meets BCBSOK Medical			
	Termination And Programming Or Reprogramming Of	Policy criteria.			
93644	Sensing Or Therapeutic Parameters)	MP Criteria: Procedure/service reviewed to ensure each service			
55044	Defibrillator (Includes Defibrillation Threshold Evaluation	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Induction Of Arrhythmia Evaluation Of Sensing For	submitting a Recommended Clinical Review (Predetermination)			
	Arrhythmia Termination And Programming Or	request if it is unclear if the service meets BCBSOK Medical			
	Reprogramming Of Sensing Or Therapeutic Parameters)	1 ·			
	Reprogramming of Sensing of Therapeutic Parameters)	Policy criteria.			
93660	Evaluation Of Cardiovascular Function With Tilt Table	MP Criteria: Procedure/service reviewed to ensure each service			
	Evaluation With Continuous Ecg Monitoring And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Intermittent Blood Pressure Monitoring With Or Without	submitting a Recommended Clinical Review (Predetermination)			
	Pharmacological Intervention	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		FUILY CITERIA.		1	1

93701	Bioimpedance-Derived Physiologic Cardiovascular Analysis	MP Criteria: Procedure/service reviewed to ensure each service			
55701	bioimpedance-Derived Physiologic Cardiovascular Analysis	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
93702	Diaimpadanca Spactroscopy (Pic) Extracollular Eluid Apolysis	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
95702			-	-	-
	For Lymphedema Assessment(S)	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
93740	Tomporature Cradient Studies	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
93740	Temperature Gradient Studies		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
02707	Dhusisian Os Other Qualified Health Care Drefersional	Investigational and/or Unproven Services (EIU).			
93797	Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Services For Outpatient Cardiac Rehabilitation; Without	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Continuous Ecg Monitoring (Per Session)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
00700		Policy criteria.			
93798	Physician Or Other Qualified Health Care Professional	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Services For Outpatient Cardiac Rehabilitation; With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Continuous Ecg Monitoring (Per Session)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
00700		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			
00000		clinical review.			
93886	Transcranial Doppler Study Of The Intracranial Arteries;	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Complete Study	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Limited Study	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Vasoreactivity Study	meets BCBSOK 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;	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Emboli Detection Without Intravenous Microbubble	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Injection	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;	MP Criteria: Procedure/service reviewed to ensure each service			
	Emboli Detection With Intravenous Microbubble Injection	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Time; Includes Reinforced Education Transmission Of	to utilization review. Please see the Clinical Payment and	-	_	_
	Spirometric Tracing Data Capture Analysis Of Transmitted	Coding Policy titled: Non-Reimbursable Experimental,			
	Data Periodic Recalibration And Review And Interpretation	Investigational and/or Unproven Services (EIU).			
	By A Physician Or Other Qualified Health Care Professional				
94015	Patient-Initiated Spirometric Recording Per 30-Day Period Of	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Time; Recording (Includes Hook-Up Reinforced Education	to utilization review. Please see the Clinical Payment and			
	Data Transmission Data Capture Trend Analysis And	Coding Policy titled: Non-Reimbursable Experimental,			
	Periodic Recalibration)	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	to utilization review. Please see the Clinical Payment and			
	Other Qualified Health Care Professional	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
94669	Mechanical Chest Wall Oscillation To Facilitate Lung	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Function Per Session	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Respiratory Rate Pattern And Heart Rate Per 30-Day Period	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of Time; Includes Monitor Attachment Download Of Data	submitting a Recommended Clinical Review (Predetermination)			
	Review Interpretation And Preparation Of A Report By A	request if it is unclear if the service meets BCBSOK Medical			
	Physician Or Other Qualified Health Care Professional	Policy criteria.			
94775		MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Respiratory Rate Pattern And Heart Rate Per 30-Day Period	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of Time; Monitor Attachment Only (Includes Hook-Up	submitting a Recommended Clinical Review (Predetermination)			
	Initiation Of Recording And Disconnection)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
94776		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Respiratory Rate Pattern And Heart Rate Per 30-Day Period	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of Time; Monitoring Download Of Information Receipt Of	submitting a Recommended Clinical Review (Predetermination)			
	Transmission(S) And Analyses By Computer Only	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

94777	Pediatric Home Appea Monitoring Event Recording Including	MP Criteria: Procedure/service reviewed to ensure each service			
54777	Respiratory Rate Pattern And Heart Rate Per 30-Day Period	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Of Time; Review Interpretation And Preparation Of Report	submitting a Recommended Clinical Review (Predetermination)			
	Only By A Physician Or Other Qualified Health Care	request if it is unclear if the service meets BCBSOK Medical			
	Professional	Policy criteria.			
94799	Unlisted Pulmonary Service Or Procedure	Unlisted or Undefined: Procedure/service not otherwise			
51755		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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Video When Performed Setup Patient Education And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Takedown When Performed Administered In Person By Eeg	submitting a Recommended Clinical Review (Predetermination)			
	Technologist Minimum Of 8 Channels	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95705	Electroencephalogram (Eeg) Without Video Review Of Data	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Technical Description By Eeg Technologist 2-12 Hours;	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Unmonitored	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Technical Description By Eeg Technologist 2-12 Hours; With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intermittent Monitoring And Maintenance	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95707		MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Technical Description By Eeg Technologist 2-12 Hours; With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Continuous Real-Time Monitoring And Maintenance	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95708		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Technical Description By Eeg Technologist Each Increment	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of 12-26 Hours; Unmonitored	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

95709	Electroencenhalogram (Feg) Without Video, Review Of Data	MP Criteria: Procedure/service reviewed to ensure each service			
	Technical Description By Eeg Technologist Each Increment	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	 -	-
	Of 12-26 Hours; With Intermittent Monitoring And	submitting a Recommended Clinical Review (Predetermination)			
	Maintenance	request if it is unclear if the service meets BCBSOK Medical			
	Walleenance	Policy criteria.			
95710	Electroencephalogram (Eeg) Without Video Review Of Data	MP Criteria: Procedure/service reviewed to ensure each service			
	Technical Description By Eeg Technologist Each Increment	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Of 12-26 Hours; With Continuous Real-Time Monitoring	submitting a Recommended Clinical Review (Predetermination)			
	And Maintenance	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95711	Electroencephalogram With Video (Veeg) Review Of Data	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Technical Description By Eeg Technologist 2-12 Hours;	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	Unmonitored	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Technical Description By Eeg Technologist 2-12 Hours; With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intermittent Monitoring And Maintenance	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Technical Description By Eeg Technologist 2-12 Hours; With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Continuous Real-Time Monitoring And Maintenance	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Technical Description By Eeg Technologist Each Increment	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of 12-26 Hours; Unmonitored	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Technical Description By Eeg Technologist Each Increment	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of 12-26 Hours; With Intermittent Monitoring And	submitting a Recommended Clinical Review (Predetermination)			
	Maintenance	request if it is unclear if the service meets BCBSOK Medical			
95716	Electroencephalogram With Video (Veeg) Review Of Data	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		}	
53710			-	-	-
	Technical Description By Eeg Technologist Each Increment	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of 12-26 Hours; With Continuous Real-Time Monitoring And Maintenance	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
95717	Electroencephalogram (Eeg) Continuous Recording	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
55,17	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Report 2-12 Hours Of Eeg	request if it is unclear if the service meets BCBSOK Medical			
	Recording; Without Video	Policy criteria.			
	necoruling, without video	FUILY LITERA.	1	ļ	

95718	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service			
5710		· ·	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Report 2-12 Hours Of Eeg	request if it is unclear if the service meets BCBSOK Medical			
95719	Recording; With Video (Veeg)	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
95719	Electroencephalogram (Eeg) Continuous Recording	· ·	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Each Increment Of Greater Than 12 Hours Up To	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95720	Each 24-Hour Period; Without Video	MD Criteria. Dressed un las reviewed to service ach service			
95720	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
		1 ·			
	26 Hours Of Eeg Recording Interpretation And Report After	Policy criteria.			
05721	Each 24-Hour Period; With Video (Veeg)	MD Critoria, Drocoduro (con ico regioned to encure esti			
95721	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Summary Report Complete	request if it is unclear if the service meets BCBSOK Medical			
	Study; Greater Than 36 Hours Up To 60 Hours Of Eeg	Policy criteria.			
05722	Recording Without Video				
95722	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Summary Report Complete	request if it is unclear if the service meets BCBSOK Medical			
	Study; Greater Than 36 Hours Up To 60 Hours Of Eeg	Policy criteria.			
05722	Recording With Video (Veeg)	MD Criteria. Dressed un las residued to secure as hour iss			
95723	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Summary Report Complete	request if it is unclear if the service meets BCBSOK Medical			
	Study; Greater Than 60 Hours Up To 84 Hours Of Eeg	Policy criteria.			
05724	Recording Without Video	MD Criteria: Presedure/service reviewed to ensure each anti-			
95724	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Summary Report Complete	request if it is unclear if the service meets BCBSOK Medical			
	Study; Greater Than 60 Hours Up To 84 Hours Of Eeg	Policy criteria.			
05725	Recording With Video (Veeg)	MD Criteria Dressdurg / service reviewed to serve the service			
95725	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Summary Report Complete	request if it is unclear if the service meets BCBSOK Medical			
	Study; Greater Than 84 Hours Of Eeg Recording Without	Policy criteria.			
	Video	ļ		<u> </u>	

95726	Electrophone (Fog) Continuous Deservice	MD Critoria, Dracadura (convice reviewed to ensure each east in			
95720	Electroencephalogram (Eeg) Continuous Recording	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Physician Or Other Qualified Health Care Professional	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Review Of Recorded Events Analysis Of Spike And Seizure	submitting a Recommended Clinical Review (Predetermination)			
	Detection Interpretation And Summary Report Complete	request if it is unclear if the service meets BCBSOK Medical			
	Study; Greater Than 84 Hours Of Eeg Recording With Video	Policy criteria.			
95782	(Veeg) Polysomnography; Younger Than 6 Years Sleep Staging	MP Criteria: Procedure/service reviewed to ensure each service			
55762	With 4 Or More Additional Parameters Of Sleep Attended	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	By A Technologist	submitting a Recommended Clinical Review (Predetermination)			
	By A recimologist	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95783	Polysomnography; Younger Than 6 Years Sleep Staging	MP Criteria: Procedure/service reviewed to ensure each service			
55765	With 4 Or More Additional Parameters Of Sleep With	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Initiation Of Continuous Positive Airway Pressure Therapy Or				
	Bi-Level Ventilation Attended By A Technologist	request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
95803	Actigraphy Testing Recording Analysis Interpretation And	MP Criteria: Procedure/service reviewed to ensure each service			
	Report (Minimum Of 72 Hours To 14 Consecutive Days Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Recording)	submitting a Recommended Clinical Review (Predetermination)			
	necording)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95805	Multiple Sleep Latency Or Maintenance Of Wakefulness	MP Criteria: Procedure/service reviewed to ensure each service			
	Testing Recording Analysis And Interpretation Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Physiological Measurements Of Sleep During Multiple Trials	submitting a Recommended Clinical Review (Predetermination)			
	To Assess Sleepiness	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95807	Sleep Study Simultaneous Recording Of Ventilation	MP Criteria: Procedure/service reviewed to ensure each service			
	Respiratory Effort Ecg Or Heart Rate And Oxygen Saturation	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		_
	Attended By A Technologist	submitting a Recommended Clinical Review (Predetermination)			
	, C	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95808	Polysomnography; Any Age Sleep Staging With 1-3	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Additional Parameters Of Sleep Attended By A Technologist	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	4 Or More Additional Parameters Of Sleep Attended By A	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Technologist	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	4 Or More Additional Parameters Of Sleep With Initiation Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Continuous Positive Airway Pressure Therapy Or Bilevel	submitting a Recommended Clinical Review (Predetermination)			
	Ventilation Attended By A Technologist	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

95905	Mater And On Concern Name Conduction Using	FULL Descendures (see inclusion burned by DCDCOK, Nation biost			
95905	Motor And/Or Sensory Nerve Conduction Using	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Preconfigured Electrode Array(S) Amplitude And	to utilization review. Please see the Clinical Payment and			
	Latency/Velocity Study Each Limb Includes F-Wave Study	Coding Policy titled: Non-Reimbursable Experimental,			
05040	When Performed With Interpretation And Report	Investigational and/or Unproven Services (EIU).			
95919		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Health Care Professional Interpretation And Report	to utilization review. Please see the Clinical Payment and			
	Unilateral Or Bilateral	Coding Policy titled: Non-Reimbursable Experimental,			
05054		Investigational and/or Unproven Services (EIU).			
95954	Pharmacological Or Physical Activation Requiring Physician	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Or Other Qualified Health Care Professional Attendance	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	During Eeg Recording Of Activation Phase (Eg Thiopental	submitting a Recommended Clinical Review (Predetermination)			
	Activation Test)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
95957	Digital Analysis Of Electroencephalogram (Eeg) (Eg For	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Epileptic Spike Analysis)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	And/Or Recording Of Electrodes On Brain Surface Or Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Depth Electrodes To Provoke Seizures Or Identify Vital Brain	submitting a Recommended Clinical Review (Predetermination)			
	Structures; Initial Hour Of Attendance By A Physician Or	request if it is unclear if the service meets BCBSOK Medical			
	Other Qualified Health Care Professional	Policy criteria.			
95962	Functional Cortical And Subcortical Mapping By Stimulation	MP Criteria: Procedure/service reviewed to ensure each service			
55562	And/Or Recording Of Electrodes On Brain Surface Or Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	_	submitting a Recommended Clinical Review (Predetermination)			
	Structures; Each Additional Hour Of Attendance By A	request if it is unclear if the service meets BCBSOK Medical			
	Physician Or Other Qualified Health Care Professional (List	Policy criteria.			
		Policy criteria.			
	Separately In Addition To Code For Primary Procedure)				
95965	Magnetoencephalography (Meg) Recording And Analysis;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	For Spontaneous Brain Magnetic Activity (Eg Epileptic	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Cerebral Cortex Localization)	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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	For Evoked Magnetic Fields Single Modality (Eg Sensory	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Motor Language Or Visual Cortex Localization)	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;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	For Evoked Magnetic Fields Each Additional Modality (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Sensory Motor Language Or Visual Cortex Localization)	submitting a Recommended Clinical Review (Predetermination)			
	(List Separately In Addition To Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			1

95970	Electronic Analysis Of Implanted Neurostimulator Pulse	MP Criteria: Procedure/service reviewed to ensure each service			
55570	Generator/Transmitter (Eg Contact Group[S] Interleaving	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Amplitude Pulse Width Frequency [Hz] On/Off Cycling	submitting a Recommended Clinical Review (Predetermination)			
	Burst Magnet Mode Dose Lockout Patient Selectable	request if it is unclear if the service meets BCBSOK Medical			
	Parameters Responsive Neurostimulation Detection	Policy criteria.			
	Algorithms Closed Loop Parameters And Passive	i oncy criteria.			
	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				
95971	Electronic Analysis Of Implanted Neurostimulator Pulse	MP Criteria: Procedure/service reviewed to ensure each service			
	Generator/Transmitter (Eg Contact Group[S] Interleaving	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	_	_
	Amplitude Pulse Width Frequency [Hz] On/Off Cycling	submitting a Recommended Clinical Review (Predetermination)			
	Burst Magnet Mode Dose Lockout Patient Selectable	request if it is unclear if the service meets BCBSOK Medical			
	Parameters Responsive Neurostimulation Detection	Policy criteria.			
	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				
95972	Electronic Analysis Of Implanted Neurostimulator Pulse	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Generator/Transmitter (Eg Contact Group[S] Interleaving	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Amplitude Pulse Width Frequency [Hz] On/Off Cycling	submitting a Recommended Clinical Review (Predetermination)			
	Burst Magnet Mode Dose Lockout Patient Selectable	request if it is unclear if the service meets BCBSOK Medical			
	Parameters Responsive Neurostimulation Detection	Policy criteria.			
	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				
95976	Qualified Health Care Professional	MD Criteria. Dread un la rice reviewed to anothe and to			
9766	Electronic Analysis Of Implanted Neurostimulator Pulse	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Generator/Transmitter (Eg Contact Group[S] Interleaving	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Amplitude Pulse Width Frequency [Hz] On/Off Cycling	submitting a Recommended Clinical Review (Predetermination)			
	Burst Magnet Mode Dose Lockout Patient Selectable	request if it is unclear if the service meets BCBSOK Medical			
	Parameters Responsive Neurostimulation Detection	Policy criteria.			
	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				

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	Generator System (Eg Rate Pulse Amplitude And Duration Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Configuration Of Wave Form Battery Status Electrode Selectability Output Modulation Cycling Impedance And	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	Generator/Transmitter (Eg Contact Group[S] Interleaving Amplitude Pulse Width Frequency [Hz] On/Off Cycling Burst Magnet Mode Dose Lockout Patient Selectable	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			1
95984	, .		-	-	-
	Generator/Transmitter (Eg Contact Group[S] Interleaving	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Amplitude Pulse Width Frequency [Hz] On/Off Cycling	submitting a Recommended Clinical Review (Predetermination)			
	Burst Magnet Mode Dose Lockout Patient Selectable	request if it is unclear if the service meets BCBSOK Medical			
	Parameters Responsive Neurostimulation Detection	Policy criteria.			
	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)				
95999	Unlisted Neurological Or Neuromuscular Diagnostic	Unlisted or Undefined: Procedure/service not otherwise	_	_	
	Procedure	defined or classified, and may be subject to benefit and/or			
		clinical review.			
96000	Comprehensive Computer-Based Motion Analysis By Video-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Taping And 3D Kinematics;	meets BCBSOK 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-	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Taping And 3D Kinematics; With Dynamic Plantar Pressure	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Measurements During Walking	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Other Functional Activities 1-12 Muscles	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
50003	Other Functional Activities 1 Muscle		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
96004	Povious And Interpretation Dy Develoison Or Other Overlifted	Policy criteria.			
90004	Review And Interpretation By Physician Or Other Qualified	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Health Care Professional Of Comprehensive Computer-	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Based Motion Analysis Dynamic Plantar Pressure	submitting a Recommended Clinical Review (Predetermination)			
	Measurements Dynamic Surface Electromyography During	request if it is unclear if the service meets BCBSOK Medical			
	Walking Or Other Functional Activities And Dynamic Fine	Policy criteria.			
	Wire Electromyography With Written Report				
96379	Unlisted Therapeutic Prophylactic Or Diagnostic	Unlisted or Undefined: Procedure/service not otherwise			
	Intravenous Or Intra-Arterial Injection Or Infusion	defined or classified, and may be subject to benefit and/or	_		
		clinical review.			
		cimical review.			

96547	Intraoperative Hyperthermic Intraperitoneal Chemotherapy	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	(Hipec) Procedure Including Separate Incision(S) And	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Closure When Performed; First 60 Minutes (List Separately In Addition To Code For Primary Procedure)	(Predetermination) to avoid post-service review.			
96548	Intraoperative Hyperthermic Intraperitoneal Chemotherapy	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
	(Hipec) Procedure Including Separate Incision(S) And	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Closure When Performed; Each Additional 30 Minutes (List Separately In Addition To Code For Primary Procedure)	(Predetermination) to avoid post-service review.			
96549	Unlisted Chemotherapy Procedure	Unlisted or Undefined: Procedure/service not otherwise			
50010		defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
96567	Photodynamic Therapy By External Application Of Light To	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Destroy Premalignant Lesions Of The Skin And Adjacent	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Mucosa With Application And Illumination/Activation Of	submitting a Recommended Clinical Review (Predetermination)			
	Photosensitive Drug(S) Per Day	request if it is unclear if the service meets BCBSOK Medical			
96570	Photodynamic Therapy By Endoscopic Application Of Light	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
50570	To Ablate Abnormal Tissue Via Activation Of Photosensitive	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Drug(S); First 30 Minutes (List Separately In Addition To	submitting a Recommended Clinical Review (Predetermination)			
	Code For Endoscopy Or Bronchoscopy Procedures Of Lung	request if it is unclear if the service meets BCBSOK Medical			
	And Gastrointestinal Tract)	Policy criteria.			
96571	Photodynamic Therapy By Endoscopic Application Of Light	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	To Ablate Abnormal Tissue Via Activation Of Photosensitive	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Drug(S); Each Additional 15 Minutes (List Separately In	submitting a Recommended Clinical Review (Predetermination)			
	Addition To Code For Endoscopy Or Bronchoscopy	request if it is unclear if the service meets BCBSOK Medical			
	Procedures Of Lung And Gastrointestinal Tract)	Policy criteria.			
96573	Photodynamic Therapy By External Application Of Light To	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Destroy Premalignant Lesions Of The Skin And Adjacent	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Mucosa With Application And Illumination/Activation Of	submitting a Recommended Clinical Review (Predetermination)			
	Photosensitizing Drug(S) Provided By A Physician Or Other	request if it is unclear if the service meets BCBSOK Medical			
06574	Qualified Health Care Professional Per Day	Policy criteria.			
96574	Debridement Of Premalignant Hyperkeratotic Lesion(S) (le	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Targeted Curettage Abrasion) Followed With Photodynamic Therapy By External Application Of Light To Destroy	meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination)			
	Premalignant Lesions Of The Skin And Adjacent Mucosa	request if it is unclear if the service meets BCBSOK Medical			
	With Application And Illumination/Activation Of	Policy criteria.			
	Photosensitizing Drug(S) Provided By A Physician Or Other	,			
	Oualified Health Care Professional Per Day				
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.			1

96913	Photochemotherapy (Goeckerman And/Or Puva) For Severe	MP Criteria: Procedure/service reviewed to ensure each service		T	
50515	Photoresponsive Dermatoses Requiring At Least 4-8 Hours	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Of Care Under Direct Supervision Of The Physician (Includes	submitting a Recommended Clinical Review (Predetermination)			
	Application Of Medication And Dressings)	request if it is unclear if the service meets BCBSOK Medical			
	Application of Medication And Dressings)	Policy criteria.			
96922	Excimer Laser Treatment For Psoriasis; Over 500 Sq Cm	MP Criteria: Procedure/service reviewed to ensure each service			
50522		meets BCBSOK 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-	MP Criteria: Procedure/service reviewed to ensure each service			
50501	Cellular Imaging Of Skin; Image Acquisition And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Interpretation And Report First Lesion	submitting a Recommended Clinical Review (Predetermination)			
	interpretation And Report Thist Lesion	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
96932	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	MP Criteria: Procedure/service reviewed to ensure each service		1	
50552		meets BCBSOK 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-	MP Criteria: Procedure/service reviewed to ensure each service			
50555	Cellular Imaging Of Skin; Interpretation And Report Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	First Lesion	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-	MP Criteria: Procedure/service reviewed to ensure each service			
50501	Cellular Imaging Of Skin; Image Acquisition And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Interpretation And Report Each Additional Lesion (List	submitting a Recommended Clinical Review (Predetermination)			
	Separately In Addition To Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
	Separately in Addition to code for thinary frocedure,	Policy criteria.			
96935	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	MP Criteria: Procedure/service reviewed to ensure each service			
	Cellular Imaging Of Skin; Image Acquisition Only Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Additional Lesion (List Separately In Addition To Code For	submitting a Recommended Clinical Review (Predetermination)			
	Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
	Thinki y Tocculicy	Policy criteria.			
96936	Reflectance Confocal Microscopy (Rcm) For Cellular And Sub-	MP Criteria: Procedure/service reviewed to ensure each service			
	Cellular Imaging Of Skin; Interpretation And Report Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	–	-
	Each Additional Lesion (List Separately In Addition To Code	submitting a Recommended Clinical Review (Predetermination)			
	For Primary Procedure)	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Mechanical	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.		-	-	-
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.	-	-	_

07005			1	1	1
97605	Negative Pressure Wound Therapy (Eg Vacuum Assisted	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Drainage Collection) Utilizing Durable Medical Equipment	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	(Dme) Including Topical Application(S) Wound Assessment	submitting a Recommended Clinical Review (Predetermination)			
	And Instruction(S) For Ongoing Care Per Session; Total	request if it is unclear if the service meets BCBSOK Medical			
	Wound(S) Surface Area Less Than Or Equal To 50 Square	Policy criteria.			
	Centimeters				
97606	Negative Pressure Wound Therapy (Eg Vacuum Assisted	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Drainage Collection) Utilizing Durable Medical Equipment	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	(Dme) Including Topical Application(S) Wound Assessment	submitting a Recommended Clinical Review (Predetermination)			
	And Instruction(S) For Ongoing Care Per Session; Total	request if it is unclear if the service meets BCBSOK Medical			
	Wound(S) Surface Area Greater Than 50 Square Centimeters	Policy criteria.			
97607	Negative Pressure Wound Therapy (Eg Vacuum Assisted	MP Criteria: Procedure/service reviewed to ensure each service			
	Drainage Collection) Utilizing Disposable Non-Durable	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Medical Equipment Including Provision Of Exudate	submitting a Recommended Clinical Review (Predetermination)			
	Management Collection System Topical Application(S)	request if it is unclear if the service meets BCBSOK Medical			
	Wound Assessment And Instructions For Ongoing Care Per	Policy criteria.			
	Session; Total Wound(S) Surface Area Less Than Or Equal To				
97608	50 Square Centimeters Negative Pressure Wound Therapy (Eg Vacuum Assisted	MP Criteria: Procedure/service reviewed to ensure each service			
57008		-	-	-	-
	Drainage Collection) Utilizing Disposable Non-Durable	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Medical Equipment Including Provision Of Exudate	submitting a Recommended Clinical Review (Predetermination)			
	Management Collection System Topical Application(S)	request if it is unclear if the service meets BCBSOK Medical			
	Wound Assessment And Instructions For Ongoing Care Per	Policy criteria.			
	Session; Total Wound(S) Surface Area Greater Than 50				
	Square Centimeters				
97610	Low Frequency Non-Contact Non-Thermal Ultrasound	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Including Topical Application(S) When Performed Wound	to utilization review. Please see the Clinical Payment and			
	Assessment And Instruction(S) For Ongoing Care Per Day	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
97799	Unlisted Physical Medicine/Rehabilitation Service Or	Unlisted or Undefined: Procedure/service not otherwise	-	_	_
	Procedure	defined or classified, and may be subject to benefit and/or			
		clinical review.			
97810	Acupuncture 1 Or More Needles; Without Electrical	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Stimulation Initial 15 Minutes Of Personal One-On-One	subject to utilization review.			
	Contact With The Patient				
97811	Acupuncture 1 Or More Needles; Without Electrical	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Stimulation Each Additional 15 Minutes Of Personal One-On	subject to utilization review.			
	One Contact With The Patient With Re-Insertion Of				
	Needle(S) (List Separately In Addition To Code For Primary				
	Procedure)				
97813		Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
97813		Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	_

97814	Acupuncture 1 Or More Needles: With Electrical Stimulation	Non Covered: Procedure/service not covered by BCBSOK. Not			
97814		· · · ·	-	-	-
	Each Additional 15 Minutes Of Personal One-On-One	subject to utilization review.			
	Contact With The Patient With Re-Insertion Of Needle(S)				
	(List Separately In Addition To Code For Primary Procedure)				
98962	Education And Training For Patient Self-Management By A	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Qualified Nonphysician Health Care Professional Using A	subject to utilization review.			
	Standardized Curriculum Face-To-Face With The Patient				
	(Could Include Caregiver/Family) Each 30 Minutes; 5-8				
	Patients				
98978	Remote therapeutic monitoring (eg, therapy adherence,	MP Criteria: Procedure/service reviewed against Medical Policy	_	2/29/2024	Retire effective
	therapy response); device(s) supply with scheduled (eg,	Criteria. Submit for Recommended Clinical Review			02/29/2024
	daily) recording(s) and/or programmed alert(s) transmission	(Predetermination) to avoid post-service review.			
	to monitor cognitive behavioral therapy, each 30 days				
99026	Hospital Mandated On Call Service; In-Hospital Each Hour	Non Covered: Procedure/service not covered by BCBSOK. Not			
55020		subject to utilization review.	-	-	-
99027	Hospital Mandated On Call Service; Out-Of-Hospital Each	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Hour	subject to utilization review.			
99050	Services Provided In The Office At Times Other Than	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Regularly Scheduled Office Hours Or Days When The Office	defined or classified, and may be subject to benefit and/or			
	Is Normally Closed (Eg Holidays Saturday Or Sunday) In	clinical review.			
	Addition To Basic Service				
99056	Service(S) Typically Provided In The Office Provided Out Of	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	The Office At Request Of Patient In Addition To Basic	defined or classified, and may be subject to benefit and/or			
	Service	clinical review.			
99058	Service(S) Provided On An Emergency Basis In The Office	Unlisted or Undefined: Procedure/service not otherwise	_	_	-
	Which Disrupts Other Scheduled Office Services In Addition	defined or classified, and may be subject to benefit and/or			
	To Basic Service	clinical review.			
99070	Supplies And Materials (Except Spectacles) Provided By The		-	_	-
	Physician Or Other Qualified Health Care Professional Over	defined or classified, and may be subject to benefit and/or			
	And Above Those Usually Included With The Office Visit Or	clinical review.			
	Other Services Rendered (List Drugs Trays Supplies Or				
00074	Materials Provided)				
99071		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	For The Patient'S Education At Cost To Physician Or Other	subject to utilization review.			
00075	Qualified Health Care Professional	Non Covered: Presedure/convice not covered by the Plan. Not			
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	Unlisted of Undefined: Procedure/service not otherwise			
	Qualified By Education Training Licensure/Regulation	defined or classified, and may be subject to benefit and/or			
	(When Applicable) Educational Services Rendered To	clinical review.			
	Patients In A Group Setting (Eg Prenatal Obesity Or				
	Diabetic Instructions)				

99080	Special Reports Such As Insurance Forms More Than The	Non Covered: Procedure/service not covered by the Plan. Not			
99080	Information Conveyed In The Usual Medical	subject to utilization review.	-	-	-
	·	· ·			
99082	Communications Or Standard Reporting Form Unusual Travel (Eg Transportation And Escort Of Patient)	Unlisted or Undefined Non Covered: Procedure/service not covered by the Plan. Not			
<u>99082</u>	onusual maver (Lg mansportation And Escort of Patient)	subject to utilization review.	-	-	-
99199	Unlisted Special Service Procedure Or Report	Unlisted or Undefined Unlisted or Undefined: Procedure/service not otherwise			
55155	offisted special service Procedure of Report		-	-	-
		defined or classified, and may be subject to benefit and/or clinical review.			
99360	Standby Service Requiring Prolonged Attendance Each 30	Non Covered: Procedure/service not covered by BCBSOK. Not			
55500	Minutes (Eg. Operative Standby Standby For Frozen Section		-	-	-
	For Cesarean/High Risk Delivery For Monitoring Eeg)				
	Tor cesareally right hisk belivery tor workoning Leg,				
99424	Principal Care Management Services For A Single High-Risk	Non Covered: Procedure/service not covered by BCBSOK. Not		1/1/2024	Retire effective
	Disease With The Following Required Elements: One	subject to utilization review.	-	_, _,	01/01/2024
	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.				
	Care Professional Per Calendar Month.				
99425	Principal Care Management Services For A Single High-Risk	Non Covered: Procedure/service not covered by BCBSOK. Not	_	1/1/2024	Retire effective
	Disease With The Following Required Elements: One	subject to utilization review.			01/01/2024
	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)				
	Separately in Addition to code for Filling Procedule)				

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 Demendues)	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
99400			-	-	-
	Treating Physician That Includes: Completion Of A Medical	subject to utilization review.			
	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.				
99456	Work Related Or Medical Disability Examination By Other	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	. .	subject to utilization review.			
	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				
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Personal Care	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Quantitation Of Lipoproteins Including All Five Major	to utilization review. Please see the Clinical Payment and			
	Lipoprotein Classes And Subclasses Of Hdl Ldl And Vldl By	Coding Policy titled: Non-Reimbursable Experimental,			
	Vertical Auto Profile Ultracentrifugation	Investigational and/or Unproven Services (EIU).			
0054T	Computer-Assisted Musculoskeletal Surgical Navigational	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	_
	Orthopedic Procedure With Image-Guidance Based On	to utilization review. Please see the Clinical Payment and			
	Fluoroscopic Images (List Separately In Addition To Code For	Coding Policy titled: Non-Reimbursable Experimental,			
	Primary Procedure)	Investigational and/or Unproven Services (EIU).			
0055T	Computer-Assisted Musculoskeletal Surgical Navigational	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		
	Orthopedic Procedure With Image-Guidance Based On	to utilization review. Please see the Clinical Payment and			
	Ct/Mri Images (List Separately In Addition To Code For	Coding Policy titled: Non-Reimbursable Experimental,			
	Primary Procedure)	Investigational and/or Unproven Services (EIU).			

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

01001					
0106U	Gastric Emptying Serial Collection Of 7 Timed Breath	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Specimens Non-Radioisotope Carbon-13 (13C) Spirulina	to utilization review. Please see the Clinical Payment and			
	Substrate Analysis Of Each Specimen By Gas Isotope Ratio	Coding Policy titled: Non-Reimbursable Experimental,			
	Mass Spectrometry Reported As Rate Of 13Co2 Excretion	Investigational and/or Unproven Services (EIU).			
0107T	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Interpretation Per Extremity; Using Vibration Stimuli To	to utilization review. Please see the Clinical Payment and			
	Assess Large Diameter Fiber Sensation	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0108T	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	_
	Interpretation Per Extremity; Using Cooling Stimuli To Assess	to utilization review. Please see the Clinical Payment and			
	Small Nerve Fiber Sensation And Hyperalgesia	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0109T	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Interpretation Per Extremity; Using Heat-Pain Stimuli To	to utilization review. Please see the Clinical Payment and			
	Assess Small Nerve Fiber Sensation And Hyperalgesia	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0110T	Quantitative Sensory Testing (Qst) Testing And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Interpretation Per Extremity; Using Other Stimuli To Assess	to utilization review. Please see the Clinical Payment and			
	Sensation	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0175T	Computer-Aided Detection (Cad) (Computer Algorithm	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Analysis Of Digital Image Data For Lesion Detection) With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Further Physician Review For Interpretation And Report	submitting a Recommended Clinical Review (Predetermination)			
	With Or Without Digitization Of Film Radiographic Images	request if it is unclear if the service meets BCBSOK Medical			
	Chest Radiograph(S) Performed Remote From Primary	Policy criteria.			
	Interpretation				
0184T	Excision Of Rectal Tumor Transanal Endoscopic	MP Criteria: Procedure/service reviewed to ensure each service			_
	Microsurgical Approach (le Tems) Including Muscularis	meets BCBSOK Medical Policy criteria. BCBSOK recommends			_
	Propria (le Full Thickness)	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Intraocular Pressure Sampling With Interpretation And	to utilization review. Please see the Clinical Payment and	-	-	-
	Report	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0200T	Percutaneous Sacral Augmentation (Sacroplasty) Unilateral	MP Criteria: Procedure/service reviewed to ensure each service			
	Injection(S) Including The Use Of A Balloon Or Mechanical	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Device When Used 1 Or More Needles Includes Imaging	submitting a Recommended Clinical Review (Predetermination)			
	Guidance And Bone Biopsy When Performed	request if it is unclear if the service meets BCBSOK Medical			
	Guidance And Bone Biopsy When I enormed	Policy criteria.			
0201T	Percutaneous Sacral Augmentation (Sacroplasty) Bilateral	MP Criteria: Procedure/service reviewed to ensure each service			
	Injections Including The Use Of A Balloon Or Mechanical	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Device When Used 2 Or More Needles Includes Imaging	submitting a Recommended Clinical Review (Predetermination)			
	Guidance And Bone Biopsy When Performed	request if it is unclear if the service meets BCBSOK Medical			
	Guidance And Bone Biopsy When Ferrormed	Policy criteria.			
		Policy criteria.			

0202T	Posterior Vertebral Joint(S) Arthroplasty (Eg Facet Joint[S]	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
02021			-	-	-
	Replacement) Including Facetectomy Laminectomy	to utilization review. Please see the Clinical Payment and			
	Foraminotomy And Vertebral Column Fixation Injection Of Bone Cement When Performed Including Fluoroscopy	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).			
	Single Level Lumbar Spine	investigational and/or onproven services (Ero).			
0207T	Evacuation Of Meibomian Glands Automated Using Heat	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	And Intermittent Pressure Unilateral	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Bone	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Recognition	meets BCBSOK 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		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	-
	Bilateral Including Imaging And Placement Of Bone Graft(S)	to utilization review. Please see the Clinical Payment and			
	Or Synthetic Device(S) Single Level; Cervical	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0220T	, ,	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Bilateral Including Imaging And Placement Of Bone Graft(S)	to utilization review. Please see the Clinical Payment and			
	Or Synthetic Device(S) Single Level; Thoracic	Coding Policy titled: Non-Reimbursable Experimental,			
0004		Investigational and/or Unproven Services (EIU).			
0221T	, ,	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Bilateral Including Imaging And Placement Of Bone Graft(S)	to utilization review. Please see the Clinical Payment and			
	Or Synthetic Device(S) Single Level; Lumbar	Coding Policy titled: Non-Reimbursable Experimental,			
0222T	Placement Of A Posterior Introfacet Implant(S) Unilateral Or	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
02221	, ,		-	-	-
	Bilateral Including Imaging And Placement Of Bone Graft(S)	to utilization review. Please see the Clinical Payment and			
	Or Synthetic Device(S) Single Level; Each Additional	Coding Policy titled: Non-Reimbursable Experimental,			
	Vertebral Segment (List Separately In Addition To Code For	Investigational and/or Unproven Services (EIU).			
	Primary Procedure)				

0224U	Antibody Severe Acute Respiratory Syndrome Coronavirus 2	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
022.0	(Sars-Cov-2) (Coronavirus Disease [Covid-19]) Includes	to utilization review. Please see the Clinical Payment and	-	-	-
	Titer(S) When Performed	Coding Policy titled: Non-Reimbursable Experimental,			
	file(5) when chomed	Investigational and/or Unproven Services (EIU).			
0226U	Surrogate Viral Neutralization Test (Svnt) Severe Acute	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Respiratory Syndrome Coronavirus 2 (Sars-Cov-2)	to utilization review. Please see the Clinical Payment and	-	-	-
	(Coronavirus Disease [Covid-19]) Elisa Plasma Seru	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0232T	Injection(S) Platelet Rich Plasma Any Site Including Image	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Guidance Harvesting And Preparation When Performed	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Without Extraocular Reservoir Internal Approach Into The	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Suprachoroidal Space	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Preparation Of Harvested Cells Multiple Injections One Leg	to utilization review. Please see the Clinical Payment and	-	_	-
	Including Ultrasound Guidance If Performed; Complete	Coding Policy titled: Non-Reimbursable Experimental,			
	Procedure Including Unilateral Or Bilateral Bone Marrow	Investigational and/or Unproven Services (EIU).			
	Harvest				
0264T	Intramuscular Autologous Bone Marrow Cell Therapy With	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		_
	Preparation Of Harvested Cells Multiple Injections One Leg	to utilization review. Please see the Clinical Payment and			
	Including Ultrasound Guidance If Performed; Complete	Coding Policy titled: Non-Reimbursable Experimental,			
	Procedure Excluding Bone Marrow Harvest	Investigational and/or Unproven Services (EIU).			
0265T	Intramuscular Autologous Bone Marrow Cell Therapy With	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Preparation Of Harvested Cells Multiple Injections One Leg	to utilization review. Please see the Clinical Payment and			
	Including Ultrasound Guidance If Performed; Unilateral Or	Coding Policy titled: Non-Reimbursable Experimental,			
	Bilateral Bone Marrow Harvest Only For Intramuscular	Investigational and/or Unproven Services (EIU).			
	Autologous Bone Marrow Cell Therapy	G y i x y			
0266T	Implantation Or Replacement Of Carotid Sinus Baroreflex	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Activation Device; Total System (Includes Generator	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Placement Unilateral Or Bilateral Lead Placement Intra-	submitting a Recommended Clinical Review (Predetermination)			
	Operative Interrogation Programming And Repositioning	request if it is unclear if the service meets BCBSOK Medical			
	When Performed)	Policy criteria.			
0267T	Implantation Or Replacement Of Carotid Sinus Baroreflex	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Activation Device; Lead Only Unilateral (Includes Intra-	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Operative Interrogation Programming And Repositioning	submitting a Recommended Clinical Review (Predetermination)			
	When Performed)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0268T	Implantation Or Replacement Of Carotid Sinus Baroreflex	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Activation Device; Pulse Generator Only (Includes Intra-	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Operative Interrogation Programming And Repositioning	submitting a Recommended Clinical Review (Predetermination)			
	When Performed)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

0269T	Revision Or Removal Of Carotid Sinus Baroreflex Activation	MP Criteria: Procedure/service reviewed to ensure each service		1	
02031	Device; Total System (Includes Generator Placement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· ·			
	Unilateral Or Bilateral Lead Placement Intra-Operative	submitting a Recommended Clinical Review (Predetermination)			
	Interrogation Programming And Repositioning When	request if it is unclear if the service meets BCBSOK Medical			
0270T	Performed) Revision Or Removal Of Carotid Sinus Baroreflex Activation	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
02701		· ·	-	-	-
	Device; Lead Only Unilateral (Includes Intra-Operative	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Interrogation Programming And Repositioning When	submitting a Recommended Clinical Review (Predetermination)			
	Performed)	request if it is unclear if the service meets BCBSOK Medical			
0271T	Revision Or Removal Of Carotid Sinus Baroreflex Activation	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		ł	
02711		· · · · · · · · · · · · · · · · · · ·	-	-	-
	Device; Pulse Generator Only (Includes Intra-Operative	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Interrogation Programming And Repositioning When	submitting a Recommended Clinical Review (Predetermination)			
	Performed)	request if it is unclear if the service meets BCBSOK Medical			
00707	lateration Device Evolution (In Device), Constitution	Policy criteria.		<u> </u>	
0272T	Interrogation Device Evaluation (In Person) Carotid Sinus	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Baroreflex Activation System Including Telemetric Iterative	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Communication With The Implantable Device To Monitor	submitting a Recommended Clinical Review (Predetermination)			
	Device Diagnostics And Programmed Therapy Values With	request if it is unclear if the service meets BCBSOK Medical			
	Interpretation And Report (Eg Battery Status Lead	Policy criteria.			
	Impedance Pulse Amplitude Pulse Width Therapy				
	Frequency Pathway Mode Burst Mode Therapy Start/Stop				
	Times Each Dav):				
0273T	Interrogation Device Evaluation (In Person) Carotid Sinus	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Baroreflex Activation System Including Telemetric Iterative	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Communication With The Implantable Device To Monitor	submitting a Recommended Clinical Review (Predetermination)			
	Device Diagnostics And Programmed Therapy Values With	request if it is unclear if the service meets BCBSOK Medical			
	Interpretation And Report (Eg Battery Status Lead	Policy criteria.			
	Impedance Pulse Amplitude Pulse Width Therapy				
	Frequency Pathway Mode Burst Mode Therapy Start/Stop				
	Times Each Day): With Programming				
0274T	Percutaneous Laminotomy/Laminectomy (Interlaminar	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Approach) For Decompression Of Neural Elements (With Or	to utilization review. Please see the Clinical Payment and			
	Without Ligamentous Resection Discectomy Facetectomy	Coding Policy titled: Non-Reimbursable Experimental,			
	And/Or Foraminotomy) Any Method Under Indirect Image	Investigational and/or Unproven Services (EIU).			
	Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels				
	Unilateral Or Bilateral; Cervical Or Thoracic				
0275T	Percutaneous Laminotomy/Laminectomy (Interlaminar	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	_
	Approach) For Decompression Of Neural Elements (With Or	to utilization review. Please see the Clinical Payment and			
	Without Ligamentous Resection Discectomy Facetectomy	Coding Policy titled: Non-Reimbursable Experimental,			
	And/Or Foraminotomy) Any Method Under Indirect Image	Investigational and/or Unproven Services (EIU).			
	Guidance (Eg Fluoroscopic Ct) Single Or Multiple Levels				
	Unilateral Or Bilateral: Lumbar				

0278T	Transcutaneous Electrical Modulation Pain Reprocessing (Eg	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Scrambler Therapy) Each Treatment Session (Includes	to utilization review. Please see the Clinical Payment and	-	-	-
	Placement Of Electrodes)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0308T	Insertion Of Ocular Telescope Prosthesis Including Removal	MP Criteria: Procedure/service reviewed to ensure each service			
	Of Crystalline Lens Or Intraocular Lens Prosthesis	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	_	1/14/2024	Add effective
	Measurements Of 14 Acyl Carnitines And Microbiome-	Criteria. Submit for Recommended Clinical Review			10/15/2023 retire
	Derived Metabolites Liquid Chromatography With Tandem	(Predetermination) to avoid post-service review.			effective 01/14/2024
	Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As				
	Negative Or Positive For Risk Of Metabolic Subtypes				
	Associated With Asd				
0322U	Neurology (Autism Spectrum Disorder [Asd]) Quantitative	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	1/15/2024	_	Add effective 1/15/2024
	Measurements Of 14 Acyl Carnitines And Microbiome-	to utilization review. Please see the Clinical Payment and			
	Derived Metabolites Liquid Chromatography With Tandem	Coding Policy titled: Non-Reimbursable Experimental,			
	Mass Spectrometry (Lc-Ms/Ms) Plasma Results Reported As	Investigational and/or Unproven Services (EIU).			
	Negative Or Positive For Risk Of Metabolic Subtypes				
	Associated With Asd				
0323U	Infectious Agent Detection By Nucleic Acid (Dna And Rna)	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Central Nervous System Pathogen Metagenomic Next-	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Generation Sequencing Cerebrospinal Fluid (Csf)	submitting a Recommended Clinical Review (Predetermination)			
	Identification Of Pathogenic Bacteria Viruses Parasites Or	request if it is unclear if the service meets BCBSOK Medical			
	Fungi	Policy criteria.			
0329T	Monitoring Of Intraocular Pressure For 24 Hours Or Longer	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Unilateral Or Bilateral With Interpretation And Report	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Interpretation And Report	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
00047		Investigational and/or Unproven Services (EIU).			
0331T	Myocardial Sympathetic Innervation Imaging Planar	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Qualitative And Quantitative Assessment;	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
02227	Muserelial Sympathetic Intervation Imaging Distant	Policy criteria.			
0332T	Myocardial Sympathetic Innervation Imaging Planar	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Qualitative And Quantitative Assessment; With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Tomographic Spect	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-	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	Regulatory (Epigenetic) Markers By Quantitative Polymerase	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Chain Reaction (Qpcr) Whole Blood Reported As A High Or	submitting a Recommended Clinical Review (Predetermination)			
	Low Probability Of Responding To Immune	request if it is unclear if the service meets BCBSOK Medical			
	Checkpoint–Inhibitor Therapy	Policy criteria.			
		Prior Authorization may be required per contract agreement.			
0333U	Oncology (Liver) Surveillance For Hepatocellular Carcinoma	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	(Hcc) In Highrisk Patients Analysis Of Methylation Patterns	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	On Circulating Cell-Free Dna (Cfdna) Plus Measurement Of	submitting a Recommended Clinical Review (Predetermination)			
	Serum Of Afp/Afp-L3 And Oncoprotein Des-Gammacarboxy-	request if it is unclear if the service meets BCBSOK Medical			
	Prothrombin (Dcp) Algorithm Reported As Normal Or	Policy criteria.			
	Abnormal Result	Prior Authorization may be required per contract agreement.			
0334U	Oncology (Solid Organ) Targeted Genomic Sequence	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	Analysis Formalin-Fixed Paraffinembedded (Ffpe) Tumor	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Tissue Dna Analysis 84 Or More Genes Interrogation For	submitting a Recommended Clinical Review (Predetermination)			
	Sequence Variants Gene Copy Number Amplifications Gene	request if it is unclear if the service meets BCBSOK Medical			
	Rearrangements Microsatellite Instability And Tumor	Policy criteria.			
	Mutational Burden	Prior Authorization may be required per contract agreement.			
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	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	Genome Sequence Analysis Including Small Sequence	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Changes Copy Number Variants Deletions Duplications	submitting a Recommended Clinical Review (Predetermination)			
	Mobile Element Insertions Uniparental Disomy (Upd)	request if it is unclear if the service meets BCBSOK Medical			
	Inversions Aneuploidy Mitochondrial Genome Sequence	Policy criteria.			
	Analysis With Heteroplasmy And Large Deletions Short	Prior Authorization may be required per contract agreement.			
	Tandem Repeat (Str) Gene Expansions Fetal Sample				
	Identification And Categorization Of Genetic Variants				
0336U	Rare Diseases (Constitutional/Heritable Disorders) Whole	MP Criteria: Procedure/service reviewed to ensure each service		3/31/2024	Retire effective
	Genome Sequence Analysis Including Small Sequence	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Changes Copy Number Variants Deletions Duplications	submitting a Recommended Clinical Review (Predetermination)			
	Mobile Element Insertions Uniparental Disomy (Upd)	request if it is unclear if the service meets BCBSOK Medical			
	Inversions Aneuploidy Mitochondrial Genome Sequence	Policy criteria.			
	Analysis With Heteroplasmy And Large Deletions Short	Prior Authorization may be required per contract agreement.			
	Tandem Repeat (Str) Gene Expansions Blood Or Saliva				
	Identification And Categorization Of Genetic Variants Each				
	Comparator Genome (Fg. Parent)				
0337U	Oncology (Plasma Cell Disorders And Myeloma) Circulating	MP Criteria: Procedure/service reviewed to ensure each service		_	
	Plasma Cell Immunologic Selection Identification	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Morphological Characterization And Enumeration Of	submitting a Recommended Clinical Review (Predetermination)			
	Plasma Cells Based On Differential Cd138 Cd38 Cd19 And	request if it is unclear if the service meets BCBSOK Medical			
	Cd45 Protein Biomarker Expression Peripheral Blood	Policy criteria.			
			1	1	1

02207	Tree costs at a Daniel Comments at a Constant in the				
0338T	Transcatheter Renal Sympathetic Denervation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Percutaneous Approach Including Arterial Puncture	to utilization review. Please see the Clinical Payment and			
	Selective Catheter Placement(S) Renal Artery(les)	Coding Policy titled: Non-Reimbursable Experimental,			
	Fluoroscopy Contrast Injection(S) Intraprocedural	Investigational and/or Unproven Services (EIU).			
	Roadmapping And Radiological Supervision And				
	Interpretation Including Pressure Gradient Measurements				
	Flush Aortogram And Diagnostic Renal Angiography When				
	Performed: Unilateral				
0338U	Oncology (Solid Tumor) Circulating Tumor Cell Selection	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Identification Morphological Characterization Detection	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Enumeration Based On Differential Epcam Cytokeratins	submitting a Recommended Clinical Review (Predetermination)			
	8 18 And 19 And Cd45 Protein Biomarkers And	request if it is unclear if the service meets BCBSOK Medical			
	Quantification Of Her2 Protein Biomarker–Expressing Cells	Policy criteria.			
	Peripheral Blood				
0339T	Transcatheter Renal Sympathetic Denervation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Percutaneous Approach Including Arterial Puncture	to utilization review. Please see the Clinical Payment and			
	Selective Catheter Placement(S) Renal Artery(les)	Coding Policy titled: Non-Reimbursable Experimental,			
	Fluoroscopy Contrast Injection(S) Intraprocedural	Investigational and/or Unproven Services (EIU).			
	Roadmapping And Radiological Supervision And				
	Interpretation Including Pressure Gradient Measurements				
	Flush Aortogram And Diagnostic Renal Angiography When				
	Performed: Bilateral				
0339U	Oncology (Prostate) Mrna Expression Profiling Of Hoxc6	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	And Dlx1 Reverse Transcription Polymerase Chain Reaction	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	(Rt-Pcr) First-Void Urine Following Digital Rectal	submitting a Recommended Clinical Review (Predetermination)			
	Examination Algorithm Reported As Probability Of High-	request if it is unclear if the service meets BCBSOK Medical			
	Grade Cancer	Policy criteria.			
		Prior Authorization may be required per contract agreement.			
0340U	Oncology (Pan-Cancer) Analysis Of Minimal Residual	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	Disease (Mrd) From Plasma With Assays Personalized To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Each Patient Based On Prior Next-Generation Sequencing Of	submitting a Recommended Clinical Review (Predetermination)			
	The Patient'S Tumor And Germline Dna Reported As	request if it is unclear if the service meets BCBSOK Medical			
	Absence Or Presence Of Mrd With Disease-Burden	Policy criteria.			
	Correlation If Appropriate	Prior Authorization may be required per contract agreement.			
0341U	Fetal Aneuploidy Dna Sequencing Comparative Analysis	MP Criteria: Procedure/service reviewed to ensure each service	-	3/31/2024	Retire effective
	Fetal Dna From Products Of Conception Reported As	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Normal (Euploidy) Monosomy Trisomy Or Partial	submitting a Recommended Clinical Review (Predetermination)			
	Deletion/Duplication Mosaicism And Segmental Aneuploid	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		Prior Authorization may be required per contract agreement.			
0342T	Therapeutic Apheresis With Selective Hdl Delipidation And	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Plasma Reinfusion	meets BCBSOK 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	

0342U	Oncology (Pancreatic Cancer) Multiplex Immunoassay Of C5	MP Criteria: Procedure/service reviewed to ensure each service			
	C4 Cystatin C Factor B Osteoprotegerin (Opg) Gelsolin	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Igfbp3 Ca125 And Multiplex Electrochemiluminescent	submitting a Recommended Clinical Review (Predetermination)			
	Immunoassay (Eclia) For Ca19-9 Serum Diagnostic	request if it is unclear if the service meets BCBSOK Medical			
	Algorithm Reported Qualitatively As Positive Negative Or	Policy criteria.			
		Policy criteria.			
)343U	Borderline Oncology (Prostate) Exosome-Based Analysis Of 442 Small	MP Criteria: Procedure/service reviewed to ensure each service		3/31/2024	Retire effective
05450			-	5/51/2024	03/31/2024
	Noncoding Rnas (Sncrnas) By Quantitative Reverse	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Transcription Polymerase Chain Reaction (Rt-Qpcr) Urine	submitting a Recommended Clinical Review (Predetermination)			
	Reported As Molecular Evidence Of No- Low- Intermediate-				
	Or High-Risk Of Prostate Cancer	Policy criteria.			
		Prior Authorization may be required per contract agreement.			
)344U	Hepatology (Nonalcoholic Fatty Liver Disease [Nafld])	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Semiquantitative Evaluation Of 28 Lipid Markers By Liquid	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Chromatography With Tandem Mass Spectrometry (Lc-	submitting a Recommended Clinical Review (Predetermination)			
	Ms/Ms) Serum Reported As At-Risk For Nonalcoholic	request if it is unclear if the service meets BCBSOK Medical			
	Steatohepatitis (Nash) Or Not Nash	Policy criteria.			
0345T	Transcatheter Mitral Valve Repair Percutaneous Approach	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Via The Coronary Sinus	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	Hyperactivity Disorder [Adhd]) Genomic Analysis Panel	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Variant Analysis Of 15 Genes Including Deletion/Duplication	submitting a Recommended Clinical Review (Predetermination)			
	Analysis Of Cyp2D6	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		Prior Authorization may be required per contract agreement.			
0346U	Beta Amyloid A?40 And A?42 By Liquid Chromatography	MP Criteria: Procedure/service reviewed to ensure each service			
00100		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
0347T	Placement Of Interstitial Device(S) In Bone For	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
05471	. ,		-	-	-
	Radiostereometric Analysis (Rsa)	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).		2/24/2024	
0347U	Drug Metabolism Or Processing (Multiple Conditions)	MP Criteria: Procedure/service reviewed to ensure each service	-	3/31/2024	Retire effective
	Whole Blood Or Buccal Specimen Dna Analysis 16 Gene	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Report With Variant Analysis And Reported Phenotypes	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.			
0348T	Radiologic Examination Radiostereometric Analysis (Rsa);	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Spine (Includes Cervical Thoracic And Lumbosacral When	to utilization review. Please see the Clinical Payment and			
	Performed)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			

0348U	Drug Metabolism Or Processing (Multiple Conditions)	MP Criteria: Procedure/service reviewed to ensure each service	<u> </u>	3/31/2024	Retire effective
	Whole Blood Or Buccal Specimen Dna Analysis 25 Gene	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Report With Variant Analysis And Reported Phenotypes	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.			
)349T	Radiologic Examination Radiostereometric Analysis (Rsa);	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	_
	Upper Extremity(les) (Includes Shoulder Elbow And Wrist	to utilization review. Please see the Clinical Payment and			
	When Performed)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0349U	Drug Metabolism Or Processing (Multiple Conditions)	MP Criteria: Procedure/service reviewed to ensure each service		3/31/2024	Retire effective
	Whole Blood Or Buccal Specimen Dna Analysis 27 Gene	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Report With Variant Analysis Including Reported	submitting a Recommended Clinical Review (Predetermination)			
	Phenotypes And Impacted Gene-Drug Interactions	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		Prior Authorization may be required per contract agreement.			
0350T	Radiologic Examination Radiostereometric Analysis (Rsa);	EIU: Procedure/service not reimbursed by BCBSOK. Not subject		-	-
	Lower Extremity(les) (Includes Hip Proximal Femur Knee	to utilization review. Please see the Clinical Payment and			
	And Ankle When Performed)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0350U	Drug Metabolism Or Processing (Multiple Conditions)	MP Criteria: Procedure/service reviewed to ensure each service		3/31/2024	Retire effective
	Whole Blood Or Buccal Specimen Dna Analysis 27 Gene	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Report With Variant Analysis And Reported Phenotypes	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.			
0351T		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Node Excised Tissue Each Specimen; Real-Time	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Intraoperative	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	MP Criteria: Procedure/service reviewed to ensure each service	² –	-	-
	Tumor Necrosis Factor-Related Apoptosisinducing Ligand	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
	Reactive Protein Serum Or Venous Whole Blood Algorithm	request if it is unclear if the service meets BCBSOK Medical			
	Reported As Likelihood Of Bacterial Infection	Policy criteria.			
02527		MD Criteria: Dresselver / service of the service of			
0352T	Optical Coherence Tomography Of Breast Or Axillary Lymph	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Node Excised Tissue Each Specimen; Interpretation And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Report Real-Time Or Referred	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
02527		Policy criteria.			
0353T	Optical Coherence Tomography Of Breast Surgical Cavity;	MP Criteria: Procedure/service reviewed to ensure each service	; —	-	-
	Real-Time Intraoperative	meets BCBSOK 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		_	1/1/2024	Retire effective
	Trachomatis And Neisseria Gonorrhoeae Multiplex Amplified Probe Technique Urine Vaginal Pharyngeal Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination)			1/1/2024
	Rectal Each Pathogen Reported As Detected Or Not	request if it is unclear if the service meets BCBSOK Medical			
	Detected	Policy criteria.			
0354U	Human papilloma virus (HPV), high-risk types (ie, 16, 18, 31,			3/31/2024	Retire effective
	33, 45, 52 and 58) gualitative mRNA expression of E6/E7 by	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-		03/31/2024
	quantitative polymerase chain reaction (gPCR)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0358T	Bioelectrical Impedance Analysis Whole Body Composition	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Assessment With Interpretation And Report	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	MP Criteria: Procedure/service reviewed to ensure each service	_	3/31/2024	Retire effective
	Apc Braf Ctnnb1 Kras Nras Pik3Ca Smad4 And Tp53 And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			03/31/2024
	Methylation Markers (Myo1G Kcnq5 C9Orf50 Fli1 Clip4	submitting a Recommended Clinical Review (Predetermination)			
	Znf132 And Twist1) Multiplex Quantitative Polymerase	request if it is unclear if the service meets BCBSOK Medical			
	Chain Reaction (Qpcr) Circulating Cell-Free Dna (Cfdna)	Policy criteria.			
	Plasma Report Of Risk Score For Advanced Adenoma Or				
	Colorectal Cancer				
0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna)	MP Criteria: Procedure/service reviewed to ensure each service	_	5/14/2024	Retire effective
	Gastrointestinal Pathogens 31 Bacterial Viral And Parasitic	· ·			05/14/2024
	Organisms And Identification Of 21 Associated Antibiotic-	submitting a Recommended Clinical Review (Predetermination)			
	Resistance Genes Multiplex Amplified Probe Technique	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0369U	Infectious Agent Detection By Nucleic Acid (Dna And Rna)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	5/15/2024	_	Add effective
	Gastrointestinal Pathogens 31 Bacterial Viral And Parasitic	· ·			05/15/2024
	Organisms And Identification Of 21 Associated Antibiotic-	Coding Policy titled: Non-Reimbursable Experimental,			
	Resistance Genes Multiplex Amplified Probe Technique	Investigational and/or Unproven Services (EIU).			
0375U	Oncology (Ovarian) Biochemical Assays Of 7 Proteins	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Follicle Stimulating Hormone Human Epididymis Protein 4	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Apolipoprotein A-1 Transferrin Beta-2 Macroglobulin	submitting a Recommended Clinical Review (Predetermination)			
	Prealbumin [Ie Transthyretin] And Cancer Antigen 125)	request if it is unclear if the service meets BCBSOK Medical			
	Algorithm Reported As Ovarian Cancer Risk Score	Policy criteria.			
0378T	Visual Field Assessment With Concurrent Real Time Data	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Analysis And Accessible Data Storage With Patient Initiated	to utilization review. Please see the Clinical Payment and			
	Data Transmitted To A Remote Surveillance Center For Up	Coding Policy titled: Non-Reimbursable Experimental,			
	To 30 Days; Review And Interpretation With Report By A	Investigational and/or Unproven Services (EIU).			
	Physician Or Other Qualified Health Care Professional				

0379T	Visual Field Assessment With Concurrent Real Time Data	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
03791			-	-	-
	Analysis And Accessible Data Storage With Patient Initiated	to utilization review. Please see the Clinical Payment and			
	Data Transmitted To A Remote Surveillance Center For Up	Coding Policy titled: Non-Reimbursable Experimental,			
	To 30 Days; Technical Support And Patient Instructions	Investigational and/or Unproven Services (EIU).			
	Surveillance Analysis And Transmission Of Daily And				
	Emergent Data Reports As Prescribed By A Physician Or				
0397T	Other Oualified Health Care Professional Endoscopic Retrograde Cholangiopancreatography (Ercp)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
05971			-	-	-
	With Optical Endomicroscopy (List Separately In Addition To				
	Code For Primary Procedure)	Coding Policy titled: Non-Reimbursable Experimental,			
0398T	Magnetic Resonance Image Guided High Intensity Focused	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed against Medical Policy			
05581	Ultrasound (Mrgfus) Stereotactic Ablation Lesion	Criteria. Submit for Recommended Clinical Review	-	-	-
	Intracranial For Movement Disorder Including Stereotactic	(Predetermination) to avoid post-service review.			
	Navigation And Frame Placement When Performed	(Predetermination) to avoid post-service review.			
0402T		MP Criteria: Procedure/service reviewed to ensure each service			
04021	Corneal Epithelium When Performed And Intraoperative	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Pachymetry When Performed	submitting a Recommended Clinical Review (Predetermination)			
	rachymetry when renonned	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0408T	Insertion Or Replacement Of Permanent Cardiac	MP Criteria: Procedure/service reviewed to ensure each service			
01001	Contractility Modulation System Including Contractility	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Evaluation When Performed And Programming Of Sensing	submitting a Recommended Clinical Review (Predetermination)			
	And Therapeutic Parameters; Pulse Generator With	request if it is unclear if the service meets BCBSOK Medical			
	Transvenous Electrodes	Policy criteria.			
0409T	Insertion Or Replacement Of Permanent Cardiac	MP Criteria: Procedure/service reviewed to ensure each service			
0.001	Contractility Modulation System Including Contractility	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Evaluation When Performed And Programming Of Sensing	submitting a Recommended Clinical Review (Predetermination)			
	And Therapeutic Parameters; Pulse Generator Only	request if it is unclear if the service meets BCBSOK Medical			
	And merupedie Furanciers, Fuise Generator Only	Policy criteria.			
0410T	Insertion Or Replacement Of Permanent Cardiac	MP Criteria: Procedure/service reviewed to ensure each service			
	Contractility Modulation System Including Contractility	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Evaluation When Performed And Programming Of Sensing	submitting a Recommended Clinical Review (Predetermination)			
	And Therapeutic Parameters; Atrial Electrode Only	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0411T	Insertion Or Replacement Of Permanent Cardiac	MP Criteria: Procedure/service reviewed to ensure each service			
	Contractility Modulation System Including Contractility	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	–	-
	Evaluation When Performed And Programming Of Sensing	submitting a Recommended Clinical Review (Predetermination)			
	And Therapeutic Parameters; Ventricular Electrode Only	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0412T	Removal Of Permanent Cardiac Contractility Modulation	MP Criteria: Procedure/service reviewed to ensure each service			
	System; Pulse Generator Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		T	
01101	System; Transvenous Electrode (Atrial Or Ventricular)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	System, Hunsvenous Electrode (Athar of Ventriculary	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Contractility Modulation System Pulse Generator Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Modulation Transvenous Electrode (Atrial Or Ventricular	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Lead)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Contractility Modulation Pulse Generator	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of The Device And Select Optimal Permanent Programmed	submitting a Recommended Clinical Review (Predetermination)			
	Values With Analysis Including Review And Report	request if it is unclear if the service meets BCBSOK Medical			
	Implantable Cardiac Contractility Modulation System	Policy criteria.			
0418T	Interrogation Device Evaluation (In Person) With Analysis	MP Criteria: Procedure/service reviewed to ensure each service			
	Review And Report Includes Connection Recording And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Disconnection Per Patient Encounter Implantable Cardiac	submitting a Recommended Clinical Review (Predetermination)			
	Contractility Modulation System	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0419T	Destruction Of Neurofibroma Extensive (Cutaneous Dermal	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Extending Into Subcutaneous); Face Head And Neck	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Greater Than 50 Neurofibromas	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Extending Into Subcutaneous); Trunk And Extremities	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Extensive Greater Than 100 Neurofibromas	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	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	Target And Signal Amplification Of 8 Rna Markers (Gapdh	subject to utilization review.			01/01/2024
	Smad4 Acy1 Areg Cdh1 Kras Tnfrsf10B Egln2) And Fecal				
	Hemoglobin Algorithm Reported As A Positive Or Negative				
	For Colorectal Cancer Risk				

Tactile Breast Imaging By Computer-Aided Tactile Sensors	MP Criteria: Procedure/service reviewed to ensure each service			
Unilateral Or Bilateral	-	-	_	_
	Policy criteria.			
Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Add effective
Response To Anti-Cancer Therapy Using Cell-Free Circulating	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
Dna Biomarker Comparison To A Previous Baseline Pre-	(Predetermination) to avoid post-service review.			effective 03/31/2024
Treatment Cell-Free Circulating Dna Analysis Using Next-				
Generation Sequencing Algorithm Reported As A				
Quantitative Change From Baseline Including Specific				
Alterations If Appropriate				
Psychiatry (Eg Depression Anxiety) Genomic Analysis Panel	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Add effective
Including Variant Analysis Of 26 Genes Buccal Swab Report	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
Including Metabolizer Status And Risk Of Drug Toxicity By	(Predetermination) to avoid post-service review.			effective 03/31/2024
Condition				
Genome (Eg Unexplained Constitutional Or Heritable	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Add effective
Disorder Or Syndrome) Rapid Sequence Analysis Each	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
Comparator Genome (Eg Parents Siblings)	(Predetermination) to avoid post-service review.			effective 03/31/2024
	· · · · · · · · · · · · · · · · · · ·	1/1/2024	3/31/2024	Add effective
Disorder Or Syndrome) Ultra-Rapid Sequence Analysis	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
	(Predetermination) to avoid post-service review.			effective 03/31/2024
Oncology (Breast) Targeted Hybrid-Capture Genomic	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Add effective
		,,,,	-,-,-	01/01/2024 Retire
				effective 03/31/2024
	······································			
Mutation Burden				
Drug Metabolism (Adverse Drug Reactions And Drug	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Add effective
Response) Genomic Analysis Panel Variant Analysis Of 25	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
Genes With Reported Phenotypes	(Predetermination) to avoid post-service review.			effective 03/31/2024
		. /. /202.		
	· · · · · · · · · · · · · · · · · · ·	1/1/2024	-	Add effective
				01/01/2024
	(Predetermination) to avoid post-service review.			
	MD Criteria: Presedure/convice reviewed against Medical Policy	1/1/2024	2/21/2024	Add effective
	· · · · · · · · · · · · · · · · · · ·	1/1/2024	5/ 51/ 2024	01/01/2024 Retire
				effective 03/31/2024
Algorithm Reported AS Predictive KISK Score	(Fredetermination) to avoid post-service review.			effective 03/31/2024
Drug Metabolism (Adverse Drug Reactions And Drug	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Add effective
Response) Buccal Specimen Gene-Drug Interactions	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
Variant Analysis Of 33 Genes Including Deletion/Duplication	(Predetermination) to avoid post-service review.			effective 03/31/2024
Analysis Of Cyp2D6 Including Reported Phenotypes And				1
Impacted Genedrug Interactions				
	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 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 Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome) Rapid Sequence Analysis Each Comparator Genome (Eg Parents Siblings) Genome (Eg Unexplained Constitutional Or Heritable Disorder Or Syndrome) Ultra-Rapid Sequence Analysis 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 Drug Metabolism (Adverse Drug Reactions And Drug Response) Genomic Analysis Panel Variant Analysis Of 25 Genes With Reported Phenotypes Oncology (Lung) Plasma Analysis Of 388 Proteins Using Aptamerbased Proteomics Technology Predictive Algorithm Reported As Clinical Benefit From Immune Checkpoint Inhibitor Therapy Psychiatry (Anxiety Disorders) Mrna Gene Expression Profiling By Rna Sequencing Of 15 Biomarkers Whole Blood Algorithm Reported As Predictive Risk Score 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 <td>Unilateral Or Bilateral meets BCBSOK Medical Policy criteria. BCBSOK recommends Submitting a Recommended Clinical Review (Predetermination) request IF it is unclear if the service meets BCBSOK Medical Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker Ona 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 Anoronata Psychiatry (Eg Depression Anxiety) Genomic Analysis Panel 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 reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Analysis Panel Variant Analysis Of 25 Genes 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. Oncology (Ling) Plasm Analysis of 38 Broteins Using Response) Genomic Analysis Panel Variant Analysis of 25 Genes With Reported Phenotypes MP Criteria: Procedure/service reviewed against Medi</td> <td>Unilateral Or Bilateral meets BCBSOK Medical Policy criteria. ECRSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker MP Criteria: Procedure/service reviewed against Medical Policy Treatment Cell-Free Circulating Dna Analysis Using Net- Generation Sequencing Algorithm Reported As A Quantitative Change From Baseline Including Specific Alterations. If Anoroariate MP Criteria: Procedure/service reviewed against Medical Policy 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 Including Metabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Metabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Metabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Netabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Receive Comparison Frage Sequence Analysis Fanel Circulating Tumor Dna (Cthan) Analysis Of 56 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsathile 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 Oncology (Lung) Plasma Analysis Of 388 Proteins Using Aptamerbased Protecomi</td> <td>Unlateral Or Biliteral meets BCBSOK Medical Policy criteria. meets BCBSOK Medical Policy criteria. Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker Response To Anti-Cancer Therapy Using Cell-Free Circulating Therain. Proceedine/Service reviewed against Medical Policy 1/1/2024 3/31/2024 Oncology (Pan-Solid Tumor) Analysis Using Nett- (Predetermination) to avoid post-service reviewed against Medical Policy 1/1/2024 3/31/2024 Oncology (Pan-Solid Tumor) Analysis Using Nett- (Predetermination) to avoid post-service reviewed against Medical Policy 1/1/2024 3/31/2024 Outnittative Change from Baseline Including Specific Criteria. Submit for Recommended Clinical Review 1/1/2024 3/31/2024 Psychiatry (Eg Depression Anxiety) Genomic Analysis Banel MP Criteria: Procedure/service reviewed against Medical Policy 1/1/2024 3/31/2024 Condition Genome (Eg Unexplained Constitutional Or Heritable Constitutional Clical Review MP Criteria: Procedure/service review. 3/31/2024 3/31/2024 Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Analysis Each Clical Review MP Criteria: Submit for Recommended Clinical Review 1/1/2024 3/31/2024 Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Review Cline Sequ</td>	Unilateral Or Bilateral meets BCBSOK Medical Policy criteria. BCBSOK recommends Submitting a Recommended Clinical Review (Predetermination) request IF it is unclear if the service meets BCBSOK Medical Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker Ona 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 Anoronata Psychiatry (Eg Depression Anxiety) Genomic Analysis Panel 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 reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service reviewed against Medical Policy Criteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review. Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Analysis Panel Variant Analysis Of 25 Genes 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. Oncology (Ling) Plasm Analysis of 38 Broteins Using Response) Genomic Analysis Panel Variant Analysis of 25 Genes With Reported Phenotypes MP Criteria: Procedure/service reviewed against Medi	Unilateral Or Bilateral meets BCBSOK Medical Policy criteria. ECRSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker MP Criteria: Procedure/service reviewed against Medical Policy Treatment Cell-Free Circulating Dna Analysis Using Net- Generation Sequencing Algorithm Reported As A Quantitative Change From Baseline Including Specific Alterations. If Anoroariate MP Criteria: Procedure/service reviewed against Medical Policy 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 Including Metabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Metabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Metabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Netabolizer Status And Risk Of Drug Toxicity By Condition MP Criteria: Procedure/service reviewed against Medical Policy Including Receive Comparison Frage Sequence Analysis Fanel Circulating Tumor Dna (Cthan) Analysis Of 56 Or More Genes Interrogation For Sequence Variants Gene Copy Number Amplifications Gene Rearrangements Microsathile 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 Oncology (Lung) Plasma Analysis Of 388 Proteins Using Aptamerbased Protecomi	Unlateral Or Biliteral meets BCBSOK Medical Policy criteria. meets BCBSOK Medical Policy criteria. Oncology (Pan-Solid Tumor) Analysis Of Dna Biomarker Response To Anti-Cancer Therapy Using Cell-Free Circulating Therain. Proceedine/Service reviewed against Medical Policy 1/1/2024 3/31/2024 Oncology (Pan-Solid Tumor) Analysis Using Nett- (Predetermination) to avoid post-service reviewed against Medical Policy 1/1/2024 3/31/2024 Oncology (Pan-Solid Tumor) Analysis Using Nett- (Predetermination) to avoid post-service reviewed against Medical Policy 1/1/2024 3/31/2024 Outnittative Change from Baseline Including Specific Criteria. Submit for Recommended Clinical Review 1/1/2024 3/31/2024 Psychiatry (Eg Depression Anxiety) Genomic Analysis Banel MP Criteria: Procedure/service reviewed against Medical Policy 1/1/2024 3/31/2024 Condition Genome (Eg Unexplained Constitutional Or Heritable Constitutional Clical Review MP Criteria: Procedure/service review. 3/31/2024 3/31/2024 Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Analysis Each Clical Review MP Criteria: Submit for Recommended Clinical Review 1/1/2024 3/31/2024 Oncology (Breast) Targeted Hybrid-Capture Genomic Sequence Review Cline Sequ

0440T	Ablation Percutaneous Cryoablation Includes Imaging	MP Criteria: Procedure/service reviewed to ensure each service			
	Guidance; Upper Extremity Distal/Peripheral Nerve	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Guidance; Lower Extremity Distal/Peripheral Nerve	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Guidance; Nerve Plexus Or Other Truncal Nerve (Eg Brachial	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Plexus Pudendal Nerve)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Fluorescence Spectroscopy Including Imaging Guidance (List	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Separately In Addition To Code For Primary Procedure)	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	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effective
	Sequence Analysis Panel Of 361 Genes Interrogation For	Criteria. Submit for Recommended Clinical Review			4/1/2024
	Gene Fusions Translocations Or Other Rearrangements	(Predetermination) to avoid post-service review.			
	Using Dna From Formalin-Fixed Paraffin-Embedded (Ffpe)				
	Tumor Tissue Report Of Clinically Significant Variant(S)				
0446U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle])	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effective
	Analysis Of 10 Cytokine Soluble Mediator Biomarkers By	Criteria. Submit for Recommended Clinical Review			4/1/2024
	Immunoassay Plasma Individual Components Reported	(Predetermination) to avoid post-service review.			
	With An Algorithmic Risk Score For Current Disease Activity				
0447U	Autoimmune Diseases (Systemic Lupus Erythematosus [Sle])	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
04470	Analysis Of 11 Cytokine Soluble Mediator Biomarkers By	Criteria. Submit for Recommended Clinical Review	4/1/2024	-	4/1/2024
					4/1/2024
	Immunoassay Plasma Individual Components Reported	(Predetermination) to avoid post-service review.			
	With An Algorithmic Prognostic Risk Score For Developing A Clinical Flare				
0448U	Oncology (Lung And Colon Cancer) Dna Qualitative	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effective
	Nextgeneration Sequencing Detection Of Single-Nucleotide	Criteria. Submit for Recommended Clinical Review		Ē	4/1/2024
	Variants And Deletions In Egfr And Kras Genes Formalin-	(Predetermination) to avoid post-service review.			
	Fixed Paraffinembedded (Ffpe) Solid Tumor Samples				
	Reported As Presence Or Absence Of Targeted Mutation(S)				
	With Recommended Therapeutic Options				
0449T	Insertion Of Aqueous Drainage Device Without Extraocular	MP Criteria: Procedure/service reviewed to ensure each service			
	Reservoir Internal Approach Into The Subconjunctival	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	F	-
	Space; Initial Device	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		r uncy criteria.	ļ	ļ	

0449U	Carrier Screening For Severe Inherited Conditions (Fg. Cystic	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
	Fibrosis Spinal Muscular Atrophy Beta Hemoglobinopathies		, ,	–	4/1/2024
	[Including Sickle Cell Disease] Alpha Thalassemia)	(Predetermination) to avoid post-service review.			., _, _ 0 _ 1
	Regardless Of Race Or Self-Identified Ancestry Genomic				
	Sequence Analysis Panel Must Include Analysis Of 5 Genes				
	(Cftr Smn1 Hbb Hba1 Hba2)				
0450T	Insertion Of Aqueous Drainage Device Without Extraocular	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Reservoir Internal Approach Into The Subconjunctival	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Space; Each Additional Device (List Separately In Addition To	submitting a Recommended Clinical Review (Predetermination)			
	Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0464T	Visual Evoked Potential Testing For Glaucoma With	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Interpretation And Report	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	Intraocular Retinal Electrode Array (Eg Retinal Prosthesis)	to utilization review. Please see the Clinical Payment and			
	In Person With Iterative Adjustment Of The Implantable	Coding Policy titled: Non-Reimbursable Experimental,			
	Device To Test Functionality Select Optimal Permanent	Investigational and/or Unproven Services (EIU).			
	Programmed Values With Analysis Including Visual Training				
	With Review And Report By A Qualified Health Care				
	Professional				
0473T	Device Evaluation And Interrogation Of Intraocular Retinal	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Electrode Array (Eg Retinal Prosthesis) In Person Including	to utilization review. Please see the Clinical Payment and			
	Reprogramming And Visual Training When Performed With	Coding Policy titled: Non-Reimbursable Experimental,			
	Review And Report By A Qualified Health Care Professional	Investigational and/or Unproven Services (EIU).			
0474T	Insertion Of Anterior Segment Aqueous Drainage Device	MP Criteria: Procedure/service reviewed to ensure each service			
	With Creation Of Intraocular Reservoir Internal Approach	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Into The Supraciliary Space	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Autologous Protein Solution) Any Site Including Image	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Guidance Harvesting And Preparation When Performed	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	(Tmvi) With Prosthetic Valve; Percutaneous Approach	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including Transseptal Puncture When Performed	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
1		Policy criteria.			

0484T	Transcatheter Mitral Valve Implantation/Replacement	MP Criteria: Procedure/service reviewed to ensure each service			
	(Tmvi) With Prosthetic Valve; Transthoracic Exposure (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Thoracotomy Transapical)	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		_
	Interpretation And Report; Unilateral	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Interpretation And Report; Bilateral	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	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Scleroderma In The Hands; Adipose Tissue Harvesting	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Isolation And Preparation Of Harvested Cells Including	submitting a Recommended Clinical Review (Predetermination)			
	Incubation With Cell Dissociation Enzymes Removal Of Non-	request if it is unclear if the service meets BCBSOK Medical			
	Viable Cells And Debris Determination Of Concentration	Policy criteria.			
	And Dilution Of Regenerative Cells				
0490T	Autologous Adipose-Derived Regenerative Cell Therapy For	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Scleroderma In The Hands; Multiple Injections In One Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Both Hands	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	(Extended) Cadaver Donor Lung(S) To Ex Vivo Organ	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Perfusion System Including Decannulation Separation From	submitting a Recommended Clinical Review (Predetermination)			
	The Perfusion System And Cold Preservation Of The	request if it is unclear if the service meets BCBSOK Medical			
	Allograft Prior To Implantation When Performed	Policy criteria.			
0495T	Initiation And Monitoring Marginal (Extended) Cadaver	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Donor Lung(S) Organ Perfusion System By Physician Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Qualified Health Care Professional Including Physiological	submitting a Recommended Clinical Review (Predetermination)			
	And Laboratory Assessment (Eg Pulmonary Artery Flow	request if it is unclear if the service meets BCBSOK Medical			
	Pulmonary Artery Pressure Left Atrial Pressure Pulmonary	Policy criteria.			
	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				

0496T	Initiation And Monitoring Marginal (Extended) Cadaver	MP Criteria: Procedure/service reviewed to ensure each service			
04901			-	-	-
	Donor Lung(S) Organ Perfusion System By Physician Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Qualified Health Care Professional Including Physiological	submitting a Recommended Clinical Review (Predetermination)			
	And Laboratory Assessment (Eg Pulmonary Artery Flow	request if it is unclear if the service meets BCBSOK Medical			
	Pulmonary Artery Pressure Left Atrial Pressure Pulmonary	Policy criteria.			
	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)				
0507T	Near Infrared Dual Imaging (le Simultaneous Reflective And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Transilluminated Light) Of Meibomian Glands Unilateral Or	to utilization review. Please see the Clinical Payment and			
	Bilateral With Interpretation And Report	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0509T	Electroretinography (Erg) With Interpretation And Report	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		_
	Pattern (Perg)	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
00121	Healing Including Topical Application And Dressing Care;	to utilization review. Please see the Clinical Payment and	-	-	-
	Initial Wound	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0513T	Extracorporeal Shock Wave For Integumentary Wound	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
03131			-	-	-
	Healing Including Topical Application And Dressing Care;	to utilization review. Please see the Clinical Payment and			
	Each Additional Wound (List Separately In Addition To Code	Coding Policy titled: Non-Reimbursable Experimental,			
05157	For Primary Procedure)	Investigational and/or Unproven Services (EIU).			
0515T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular	MP Criteria: Procedure/service reviewed to ensure each service	–	-	-
	Pacing Including Device Interrogation And Programming	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Imaging Supervision And Interpretation When	submitting a Recommended Clinical Review (Predetermination)			
	Performed; Complete System (Includes Electrode And	request if it is unclear if the service meets BCBSOK Medical			
	Generator [Transmitter And Battery])	Policy criteria.			
0516T	Insertion Of Wireless Cardiac Stimulator For Left Ventricular	MP Criteria: Procedure/service reviewed to ensure each service	–	-	-
	Pacing Including Device Interrogation And Programming	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Imaging Supervision And Interpretation When	submitting a Recommended Clinical Review (Predetermination)			
	Performed; Electrode Only	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

Insertion Of Wireless Cardiac Stimulator For Left Ventricular	MP Criteria: Procedure/service reviewed to ensure each service			
		-	-	-
	<i>i</i>			
		-	-	-
Tor Left Ventricular Pacing, Battery Component Only				
Pamoual And Paplacement Of Dulca Constant For Wireless				
		-	-	-
с с				
(Battery And Transmitter)				
		-	-	-
Only	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Interrogation Device Evaluation (In Person) With Analysis	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
Review And Report Includes Connection Recording And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Disconnection Per Patient Encounter Wireless Cardiac	submitting a Recommended Clinical Review (Predetermination)			
Stimulator For Left Ventricular Pacing	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Programming Device Evaluation (In Person) With Iterative	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
Adjustment Of The Implantable Device To Test The Function	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Of The Device And Select Optimal Permanent Programmed	submitting a Recommended Clinical Review (Predetermination)			
Values With Analysis Including Review And Report Wireless	request if it is unclear if the service meets BCBSOK Medical			
Cardiac Stimulator For Left Ventricular Pacing	Policy criteria.			
Endovenous Catheter Directed Chemical Ablation With	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
Balloon Isolation Of Incompetent Extremity Vein Open Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Percutaneous Including All Vascular Access Catheter	submitting a Recommended Clinical Review (Predetermination)			
Manipulation Diagnostic Imaging Imaging Guidance And	request if it is unclear if the service meets BCBSOK Medical			
Monitoring	Policy criteria.			
Insertion Or Replacement Of Intracardiac Ischemia	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
Monitoring System Including Testing Of The Lead And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Monitor Initial System Programming And Imaging	submitting a Recommended Clinical Review (Predetermination)			
Supervision And Interpretation; Complete System (Electrode	request if it is unclear if the service meets BCBSOK Medical			
And Implantable Monitor)	Policy criteria.			
Insertion Or Replacement Of Intracardiac Ischemia				
	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		
	<i>i</i>			
	- equest in the service meets bebook medical			
	For Left Ventricular Pacing; Battery Component OnlyRemoval And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Both Components (Battery And Transmitter)Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Component OnlyInterrogation Device Evaluation (In Person) With Analysis Review And Report Includes Connection Recording And Disconnection Per Patient Encounter Wireless Cardiac Stimulator For Left Ventricular PacingProgramming 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 PacingEndovenous 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 System Including Testing Of The Lead And Monitor Initial System Programming And Imaging Supervision And Interpretation; Complete System (Electrode And Implantable Monitor)	 Pacing Including Device Interrogation And Programming And Imaging Supervision And Interpretation When Performed; Both Components Of Pulse Generator (Battery And Transmitter) Only Removal Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing; Battery Component Only Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Both Components (Battery And Transmitter) Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Both Components (Battery And Transmitter) Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Components Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Battery Component Only Policy criteria. Interrogation Device Evaluation (In Person) With Analysis Review And Report Includes Connection Recording. Programming Device Evaluation (In Person) With Herative Adjustment Of The Implantable Device To Test The Function Programming Device Evaluation (In Person) With Herative Adjustment Of Incompetent Extremity Vein Open Or Percutaneous Including Review And Report Includes Connection Recording. Proderamming Battery Comparament Programmeds Values With Analysis Including Review And Report Includes Connection Recording. Programming Device Evaluation (In Person) With Herative Adjustment Of The Implantable Device To Test The Function Programming Device Evaluation (In Person) With Herative Monitoring. Propramming Standuard Percenterity	Pacing Including Device Interrogation And Programming And Imaging Supervision And Interpretation When Performed, Both Components OF Pulse Generator (Battery And Transmitter) Only meets BCBSOK Medical Policy criteria. BCBSOK Medical Pelicy criteria. 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 Medical Policy criteria. Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator For Left Ventricular Pacing Including Device Interrogation And Programming; Both Component Only MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator for Left Ventricular Pacing Including Device Interrogation And Programming; Both Component Only MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. 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 its unclear if the service meets BCBSOK Medical Policy criteria. Programming Device Evaluation (In Person) With Interative Adjustment And Perpoin Levices Cardiac Stimulator for Left Ventricular Pacing MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Programming Device	Paring Including Device Interrogation And Programming And Imaging Supervision And Interpretation View Performed; Both Components Of Pulse Generator (Battery And Transmitter) Interview (Predictermination) Part Components Of Pulse Generator For Wireless Cardiac Stimulator Mechanization Part Left Ventricular Pacing; Battery Component Only submitting a Recommended Clinical Review (Predictermination) request If it unclear if the service meets BCBSOK Medical Policy criteria. Part Left Ventricular Pacing; Battery Component Only submitting a Recommended Clinical Review (Predictermination) request If it unclear if the service wiewed to ensure each service and the service Predictermination request If it unclear if the service meets BCBSOK Medical Policy criteria. Removal And Replacement Of Pulse Generator For Wireless Submitting a Recommended Clinical Review (Predictermination) request If it unclear if the service meets BCBSOK Medical Policy criteria. Removal And Replacement Of Pulse Generator For Wireless Submitting a Recommended Clinical Review (Predictermination) request If it unclear if the service meets BCBSOK Medical Policy criteria. Removal And Replacement Of Pulse Generator For Wireless Cardiac Stimulator for Left Ventricular Pacing Including Device Interrogation And Programming: Battery Component Unclear Review Predictermination request If it unclear if the service meets BCBSOK Medical Policy criteria. Review And Report Includes Connection Recording And Decommetion Per Patient Encounter Wireless Cardiac Stamulator For Left Ventricular Pacing MC Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Medical Policy criteria. Porgramming Device Evaluation (In Person) With Intervie Submitting a Recommended Clinical Review Predictermination request If it unclear If the service meets BCBSOK Medical P

0527T	Insertion Or Replacement Of Intracardiac Ischemia	MP Criteria: Procedure/service reviewed to ensure each service			
00271	Monitoring System Including Testing Of The Lead And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Monitor Initial System Programming And Imaging	submitting a Recommended Clinical Review (Predetermination)			
	Supervision And Interpretation; Implantable Monitor Only	request if it is unclear if the service meets BCBSOK Medical			
	Supervision And interpretation, implantable Monitor Only				
0528T	Programming Device Evaluation (In Person) Of Intracardiac	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
05201	Ischemia Monitoring System With Iterative Adjustment Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Programmed Values With Analysis Review And Report				
	Programmed values with Analysis Review And Report	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	MP Criteria: Procedure/service reviewed to ensure each service			
05251	Ischemia Monitoring System With Analysis Review And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Report	submitting a Recommended Clinical Review (Predetermination)			
	Report				
		request if it is unclear if the service meets BCBSOK Medical Policy criteria.			
0530T	Removal Of Intracardiac Ischemia Monitoring System	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
05301	Including All Imaging Supervision And Interpretation;	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Complete System (Electrode And Implantable Monitor)	submitting a Recommended Clinical Review (Predetermination)			
	complete system (Electrode And Implantable Monitor)				
		request if it is unclear if the service meets BCBSOK Medical			
0531T	Removal Of Intracardiac Ischemia Monitoring System	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
05511	Including All Imaging Supervision And Interpretation;	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Electrode Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
05521	Including All Imaging Supervision And Interpretation;	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Implantable Monitor Only	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;	MP Criteria: Procedure/service reviewed to ensure each service			
	Harvesting Of Blood-Derived T Lymphocytes For	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	Per Day	request if it is unclear if the service meets BCBSOK Medical			
	i ei bay	Policy criteria.			
0538T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy;	MP Criteria: Procedure/service reviewed to ensure each service			
	Preparation Of Blood-Derived T Lymphocytes For	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	 ⁻	-
	Transportation (Eg Cryopreservation Storage)	submitting a Recommended Clinical Review (Predetermination)			
	Anaportation (EB or operconvation of orage)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0539T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy; Receipt	MP Criteria: Procedure/service reviewed to ensure each service		1	
	And Preparation Of Car-T Cells For Administration	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		Pulley citteria.	ļ		ļ

0540T	Chimeric Antigen Receptor T-Cell (Car-T) Therapy: Car-T Cell	MP Criteria: Procedure/service reviewed to ensure each service			
	Administration Autologous	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Implantation Of Adjustable Annulus Reconstruction Device	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-		-
	Percutaneous Approach Including Transseptal Puncture	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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Margin Assessment At The Time Of Partial Mastectomy	Criteria. Submit for Recommended Clinical Review			01/01/2024
	With Report	(Predetermination) to avoid post-service review.			
0547T	Bone-Material Quality Testing By Microindentation(S) Of The	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Tibia(S) With Results Reported As A Score	subject to utilization review.			
0552T	Low-Level Laser Therapy Dynamic Photonic And Dynamic	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Thermokinetic Energies Provided By A Physician Or Other	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Qualified Health Care Professional	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Through Wearable Open-Eye Eyelid Treatment Devices And	to utilization review. Please see the Clinical Payment and			
	Manual Gland Expression Bilateral	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0565T	Autologous Cellular Implant Derived From Adipose Tissue	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	For The Treatment Of Osteoarthritis Of The Knees; Tissue	to utilization review. Please see the Clinical Payment and			
	Harvesting And Cellular Implant Creation	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0566T	Autologous Cellular Implant Derived From Adipose Tissue	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	For The Treatment Of Osteoarthritis Of The Knees; Injection	to utilization review. Please see the Clinical Payment and			
	Of Cellular Implant Into Knee Joint Including Ultrasound	Coding Policy titled: Non-Reimbursable Experimental,			
	Guidance Unilateral	Investigational and/or Unproven Services (EIU).		-	
0569T	Transcatheter Tricuspid Valve Repair Percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy	_	_	-
	Approach; Initial Prosthesis	Criteria. Submit for Recommended Clinical Review			
		(Predetermination) to avoid post-service review.			
0570T	Transcatheter Tricuspid Valve Repair Percutaneous	MP Criteria: Procedure/service reviewed against Medical Policy	-	-	-
	Approach; Each Additional Prosthesis During Same Session	Criteria. Submit for Recommended Clinical Review			
	(List Separately In Addition To Code For Primary Procedure)	(Predetermination) to avoid post-service review.			
0587T	Percutaneous Implantation Or Replacement Of Integrated	MP Criteria: Procedure/service reviewed to ensure each service			
05071	Single Device Neurostimulation System For Bladder	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	Generator Including Analysis Programming And Imaging	request if it is unclear if the service meets BCBSOK Medical			
	Guidance When Performed Posterior Tibial Nerve	Policy criteria.			

				1	1
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 (le 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Interpretation And Report	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	MP Criteria: Procedure/service reviewed against Medical Policy	3/15/2024	6/30/2024	Add effective
	Commissurotomy And Drug Delivery Including Transrectal	Criteria. Submit for Recommended Clinical Review			03/15/2024 Retire
	Ultrasound And Fluoroscopy When Performed	(Predetermination) to avoid post-service review.			effective 06/30/2024
0619T	Cystourethroscopy With Transurethral Anterior Prostate	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
	Commissurotomy And Drug Delivery Including Transrectal	to pre-service review. Check EIU policy, which is one of our			07/01/2024
	Ultrasound And Fluoroscopy When Performed	Clinical Payment and Coding Policy (CPCP).			
0620T	Endovascular Venous Arterialization Tibial Or Peroneal Vein	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	With Transcatheter Placement Of Intravascular Stent	to utilization review. Please see the Clinical Payment and			
	Graft(S) And Closure By Any Method Including	Coding Policy titled: Non-Reimbursable Experimental,			
	Percutaneous Or Open Vascular Access Ultrasound	Investigational and/or Unproven Services (EIU).			
	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				
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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Ophthalmic Endoscope	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Atherosclerotic Plaque To Assess Severity Of Coronary	to utilization review. Please see the Clinical Payment and			
	Disease Using Data From Coronary Computed Tomographic	Coding Policy titled: Non-Reimbursable Experimental,			
	Angiography; Data Preparation And Transmission	Investigational and/or Unproven Services (EIU).			
	Computerized Analysis Of Data With Review Of				
	Computerized Analysis Output To Reconcile Discordant Data				
	Interpretation And Report				
0624T		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Atherosclerotic Plaque To Assess Severity Of Coronary	to utilization review. Please see the Clinical Payment and			
	Disease Using Data From Coronary Computed Tomographic				
	Angiography; Data Preparation And Transmission	Investigational and/or Unproven Services (EIU).			
0625T	Automated Quantification And Characterization Of Coronary	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	
	Atherosclerotic Plaque To Assess Severity Of Coronary	to utilization review. Please see the Clinical Payment and			
	Disease Using Data From Coronary Computed Tomographic	,			
	Angiography; Computerized Analysis Of Data From Coronary				
	Computed Tomographic Angiography	G ((((((((((

0.0007					
0626T		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Atherosclerotic Plaque To Assess Severity Of Coronary	to utilization review. Please see the Clinical Payment and			
	Disease Using Data From Coronary Computed Tomographic				
	Angiography; Review Of Computerized Analysis Output To	Investigational and/or Unproven Services (EIU).			
	Reconcile Discordant Data Interpretation And Report				
0627T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Based Product Intervertebral Disc Unilateral Or Bilateral	to utilization review. Please see the Clinical Payment and			
	Injection With Fluoroscopic Guidance Lumbar; First Level	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0628T	· · · ·	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	-
	Based Product Intervertebral Disc Unilateral Or Bilateral	to utilization review. Please see the Clinical Payment and			
	Injection With Fluoroscopic Guidance Lumbar; Each	Coding Policy titled: Non-Reimbursable Experimental,			
	Additional Level (List Separately In Addition To Code For	Investigational and/or Unproven Services (EIU).			
	Primary Procedure)				
0629T	· · · ·	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Based Product Intervertebral Disc Unilateral Or Bilateral	to utilization review. Please see the Clinical Payment and			
	Injection With Ct Guidance Lumbar; First Level	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0630T	Percutaneous Injection Of Allogeneic Cellular And/Or Tissue-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Based Product Intervertebral Disc Unilateral Or Bilateral	to utilization review. Please see the Clinical Payment and			
	Injection With Ct Guidance Lumbar; Each Additional Level	Coding Policy titled: Non-Reimbursable Experimental,			
	(List Separately In Addition To Code For Primary Procedure)	Investigational and/or Unproven Services (EIU).			
0631T	Transcutaneous Visible Light Hyperspectral Imaging	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Measurement Of Oxyhemoglobin Deoxyhemoglobin And	to utilization review. Please see the Clinical Payment and			
	Tissue Oxygenation With Interpretation And Report Per	Coding Policy titled: Non-Reimbursable Experimental,			
	Extremity	Investigational and/or Unproven Services (EIU).			
0639T	Wireless Skin Sensor Thermal Anisotropy Measurement(S)	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	And Assessment Of Flow In Cerebrospinal Fluid Shunt	to utilization review. Please see the Clinical Payment and			
	Including Ultrasound Guidance When Performed	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0640T	Noncontact Near-Infrared Spectroscopy (Eg For	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Measurement Of Deoxyhemoglobin Oxyhemoglobin And	to utilization review. Please see the Clinical Payment and			
	Ratio Of Tissue Oxygenation) Other Than For Screening For	Coding Policy titled: Non-Reimbursable Experimental,			
	Peripheral Arterial Disease Image Acquisition Interpretation	Investigational and/or Unproven Services (EIU).			
	And Report; First Anatomic Site				
0643T	Transcatheter Left Ventricular Restoration Device	MP Criteria: Procedure/service reviewed to ensure each service	_	-	_
	Implantation Including Right And Left Heart Catheterization	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Left Ventriculography When Performed Arterial	submitting a Recommended Clinical Review (Predetermination)			
	Approach	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0645T	Transcatheter Implantation Of Coronary Sinus Reduction	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Device Including Vascular Access And Closure Right Heart	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Catheterization Venous Angiography Coronary Sinus	submitting a Recommended Clinical Review (Predetermination)			
	Angiography Imaging Guidance And Supervision And	request if it is unclear if the service meets BCBSOK Medical			
	Interpretation When Performed	Policy criteria.			

Transcatheter Tricuspid Value Implantation	MP Criteria: Procedure/cervice reviewed to onsure each convice			
		-	-	-
	<i>i</i>			
5				
		-	-	-
	<i>i</i>			
Of The Implantable Device To Test The Function Of The	submitting a Recommended Clinical Review (Predetermination)			
Device And Select Optimal Permanently Programmed Values	request if it is unclear if the service meets BCBSOK Medical			
With Analysis Review And Report By A Physician Or Other	Policy criteria.			
Qualified Health Care Professional				
Magnetically Controlled Capsule Endoscopy Esophagus	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
		_		-
· · · · ·				
Anterior Lumbar Or Thoracolumbar Vertebral Body				
		-	-	-
Tethening, op to 7 vertebra segments				
Anterior Lumbar Or Thoracolumbar Vertebral Body				
		-	-	-
Tethening, a of More vertebrar segments				
Electrical Impedance Spectroscopy Of 1 Or Mara Skin			-	
		-	-	-
Lesions For Automated Melanoma Risk Score				
		-	-	-
From Cadaver Donor				
	Coding Policy titled: Non-Reimbursable Experimental,			
	Investigational and/or Unproven Services (EIU).			
Donor Hysterectomy (Including Cold Preservation); Open		-	-	-
From Living Donor	to utilization review. Please see the Clinical Payment and			
	Coding Policy titled: Non-Reimbursable Experimental,			
	Investigational and/or Unproven Services (EIU).			
Donor Hysterectomy (Including Cold Preservation);	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
Laparoscopic Or Robotic From Living Donor	to utilization review. Please see the Clinical Payment and			
	Coding Policy titled: Non-Reimbursable Experimental,			
	Investigational and/or Unproven Services (EIU).			
Donor Hysterectomy (Including Cold Preservation); Recipient				
Uterus Allograft Transplantation From Cadaver Or Living	to utilization review. Please see the Clinical Payment and			
Donor	Coding Policy titled: Non-Reimbursable Experimental,			
	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 Magnetically Controlled Capsule Endoscopy Esophagus Through Stomach Including Intraprocedural Positioning Of Capsule With Interpretation And Report Anterior Lumbar Or Thoracolumbar Vertebral Body Tethering; Up To 7 Vertebral Segments Electrical Impedance Spectroscopy Of 1 Or More Skin Lesions For Automated Melanoma Risk Score Donor Hysterectomy (Including Cold Preservation); Open From Living Donor From Living Donor Donor Hysterectomy (Including Cold Preservation); Laparoscopic Or Robotic From Living Donor Donor Hysterectomy (Including Cold Preservation); Recipient Uterus Allograft Transplantation From Cadaver Or Living	[Tvi)/Replacement With Prosthetic Valve Percutaneous meets BCBSOK Medical Policy criteria. BCBSOK recommends Approach Including Right Heatt Catheterization Temporary Submitting a Recommended Clinical Review (Predetermination) request If it is unclear if the service meets BCBSOK Medical Programming Device Evaluation (Remote) Of Subcutaneous MP Criteria: Procedure/service reviewed to ensure each service Of The Implantable Device To Test The Function Of The submitting a Recommended Clinical Review (Predetermination) Device And Select Optimal Permanently Programmed Values submitting a Recommended Clinical Review (Predetermination) Device And Select Optimal Permanently Programmed Values request if it is unclear if the service meets BCBSOK Medical Qualified Health Care Professional EU: Procedure/service not reimbursed by BCBSOK. Not subject Through Stomach Including Intraprocedural Positioning Of Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EU). EU: Procedure/service not reimbursed by BCBSOK. Not subject Tethering: Up To 7 Vertebral Segments EU: Procedure/service not reimbursed by BCBSOK. Not subject Leisting a Recommended Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EU). MP Criteria: Procedure/service not reimbursed by BCBSOK. Not subject to	Thiyl/Replacement With Prosthetic Value Percutaneous meets BCBSOK Medical Policy criteria. ESBOK recommends Approach Including Right Heart Catheterization Temporary submitting a Recommended Clinical Review (Predetermination) Programming Device Evaluation (Remote) Of Subcutaneous Policy criteria. Or The Implantable Device To Test The Function Of The Device And Select Optimal Permanently Frogrammed Values With Analysis Review And Report By A Physician Or Other Policy criteria. Qualified Health Care Professional Policy criteria. Magnetically Controlled Capsule Endocopy Esophagu EU: Procedure/Service not reimbursed by BCBSOK. Not subject Through Stomach Including Intraprocedural Positioning Of Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EU). Anterior Lumbar Or Thoracolumbar Vertebral Body EU: Procedure/Service not reimbursable by BCBSOK. Not subject Tethering: By Or More Vertebral Segments EU: Procedure/Service not reimbursable Experimental, Investigational and/or Unproven Services (EU). Anterior Lumbar Or Thoracolumbar Vertebral Body EU: Procedure/Service not reimbursable Scips Physica (EU). Electrical Impedance Spectroscopy Of 1 Or More Sin MP Criteria: Procedure/Service not reimbursable Scips Physica (EU). Electrical Impedance Spectroscopy Of 1 Or More Sin MP Criteria: Procedure/Service not reimbursable by BCBSOK. Not subject	(Triv)/Replacement With Prosthetic Value Percutaneous mests RESSOK Medical Policy criteria. RESSOK recommends Approach Including Right Heart Catheterization Temporary mests RESSOK Medical Policy criteria. Programming Device Evaluation (Remote) Of Subcuraneous Policy criteria. Prod and the evaluation (Remote) Of Subcuraneous Policy criteria. Of The Implantable Device For Test The function Of The subcurst reviewed to ensure each service _ _ Of The Implantable Device For Test The function Of The subcurst reviewed (Pedetermination) _ Device And Select Optimal Permanently Programmed Values request if it is unclear if the service meets BCBSOK Medical Policy criteria. _ Qualified Health Care Professional EUI: Procedure/Service not reimbursed by BCBSOK. Not Subject _ _ Through Senset Including Rintargorecountar Resistion of O the colling Policy titled: Non-Reimbursable Experimental, Investsational and/or Unproven Services (EU). _ _ Anterior Lumbar Or Thoracolumbar Vertebral Body Envice Tervice not reimbursed by BCBSOK. Not Subject

0668T	Backbanch Standard Prenaration Of Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
00081	Uterine Allograft Prior To Transplantation Including	to utilization review. Please see the Clinical Payment and	-	-	-
	Dissection And Removal Of Surrounding Soft Tissues And	Coding Policy titled: Non-Reimbursable Experimental,			
	Preparation Of Uterine Vein(S) And Uterine Artery(les) As	Investigational and/or Unproven Services (EIU).			
	Necessary	investigational and/or onproven services (Lio).			
0669T	Backbench Reconstruction Of Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Uterus Allograft Prior To Transplantation; Venous	to utilization review. Please see the Clinical Payment and	-	-	_
	Anastomosis Each	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0670T	Backbench Reconstruction Of Cadaver Or Living Donor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	_
	Uterus Allograft Prior To Transplantation; Arterial	to utilization review. Please see the Clinical Payment and			
	Anastomosis Each	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0672T	Endovaginal Cryogen-Cooled Monopolar Radiofrequency	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	-	_
	Remodeling Of The Tissues Surrounding The Female Bladder	to utilization review. Please see the Clinical Payment and			
	Neck And Proximal Urethra For Urinary Incontinence	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
0692T	Therapeutic Ultrafiltration	MP Criteria: Procedure/service reviewed against Medical Policy	5/1/2024	-	Add effective
		Criteria. Submit for Recommended Clinical Review			5/1/2024
		(Predetermination) to avoid post-service review.			
0714T	Transperineal Laser Ablation Of Benign Prostatic Hyperplasia	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Including Imaging Guidance	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Analysis And Generation Of Coronary Artery Disease Risk	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Score	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
07477		Policy criteria.			
0717T	Autologous Adipose-Derived Regenerative Cell (Adrc)	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Therapy For Partial Thickness Rotator Cuff Tear; Adipose	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Tissue Harvesting Isolation And Preparation Of Harvested	submitting a Recommended Clinical Review (Predetermination)			
	Cells Including Incubation With Cell Dissociation Enzymes	request if it is unclear if the service meets BCBSOK Medical			
	Filtration Washing And Concentration Of Adrcs	Policy criteria.			
0718T	Autologous Adipose-Derived Regenerative Cell (Adrc)	MP Criteria: Procedure/service reviewed to ensure each service			1
	Therapy For Partial Thickness Rotator Cuff Tear; Injection	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Into Supraspinatus Tendon Including Ultrasound Guidance	submitting a Recommended Clinical Review (Predetermination)			
	Unilateral	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
0719T	Posterior Vertebral Joint Replacement Including Bilateral	MP Criteria: Procedure/service reviewed to ensure each service			
-	Facetectomy Laminectomy And Radical Discectomy	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	–
	Including Imaging Guidance Lumbar Spine Single Segment	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Nerves Without Implantation	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Characterization Including Interpretation And Report	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		_
	Obtained Without Concurrent Ct Examination Of Any	submitting a Recommended Clinical Review (Predetermination)			
	, Structure Contained In Previously Acquired Diagnostic	request if it is unclear if the service meets BCBSOK Medical			
	Imaging	Policy criteria.			
0722T	Quantitative Computed Tomography (Ct) Tissue	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Characterization Including Interpretation And Report	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Obtained With Concurrent Ct Examination Of Any Structure	submitting a Recommended Clinical Review (Predetermination)			
	Contained In The Concurrently Acquired Diagnostic Imaging	request if it is unclear if the service meets BCBSOK Medical			
	Dataset (List Separately In Addition To Code For Primary	Policy criteria.			
	Procedure)				
0723T	Quantitative Magnetic Resonance	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Cholangiopancreatography (Qmrcp) Including Data	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Preparation And Transmission Interpretation And Report	submitting a Recommended Clinical Review (Predetermination)			
	Obtained Without Diagnostic Magnetic Resonance Imaging	request if it is unclear if the service meets BCBSOK Medical			
	(Mri) Examination Of The Same Anatomy (Eg Organ Gland	Policy criteria.			
	Tissue Target Structure) During The Same Session				
0724T	Quantitative Magnetic Resonance	MP Criteria: Procedure/service reviewed to ensure each service			
	Cholangiopancreatography (Qmrcp) Including Data	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Preparation And Transmission Interpretation And Report	submitting a Recommended Clinical Review (Predetermination)			
	Obtained With Diagnostic Magnetic Resonance Imaging	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
	Tissue Target Structure) (List Separately In Addition To Code				
	For Primary Procedure)				
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Unilateral	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Initial Programming	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Subsequent Programming	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Tomography (Oct) Guidance	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
07047	A considering Al Decisi Part 1 Diana and 1 di 2000	Policy criteria.		
0731T	Augmentative Ai-Based Facial Phenotype Analysis With	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Report	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
07227		Policy criteria.		
0732T	Immunotherapy Administration With Electroporation	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Intramuscular	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
0733T	Remote Real-Time Motion Capture-Based	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
07331	Neurorehabilitative Therapy Ordered By A Physician Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	Other Qualified Health Care Professional; Supply And	submitting a Recommended Clinical Review (Predetermination)		
	Technical Support Per 30 Days	request if it is unclear if the service meets BCBSOK Medical		
	reclinical support Per So Days	Policy criteria.		
0734T	Remote Real-Time Motion Capture-Based	MP Criteria: Procedure/service reviewed to ensure each service		
0.011	Neurorehabilitative Therapy Ordered By A Physician Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	Other Qualified Health Care Professional; Treatment	submitting a Recommended Clinical Review (Predetermination)		
	Management Services By A Physician Or Other Qualified	request if it is unclear if the service meets BCBSOK Medical		
	Health Care Professional Per Calendar Month	Policy criteria.		
0735T		MP Criteria: Procedure/service reviewed to ensure each service		
	Therapy Applicator For Intraoperative Radiation Therapy	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	(lort) Concurrent With Primary Craniotomy (List Separately	submitting a Recommended Clinical Review (Predetermination)		
	In Addition To Code For Primary Procedure)	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		
1		Policy criteria.		

0740T	Remote Autonomous Algorithm-Based Recommendation	MP Criteria: Procedure/service reviewed against Medical Policy			
	System For Insulin Dose Calculation And Titration; Initial Set-		-	-	-
	Up And Patient Education	(Predetermination) to avoid post-service review.			
0741T	Remote Autonomous Algorithm-Based Recommendation	MP Criteria: Procedure/service reviewed against Medical Policy			
07411	System For Insulin Dose Calculation And Titration; Provision	Criteria. Submit for Recommended Clinical Review	-	-	-
	Of Software Data Collection Transmission And Storage Each 30 Days	(Predetermination) to avoid post-service review.			
0743T	Bone Strength And Fracture Risk Using Finite Element	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
07431		to utilization review. Please see the Clinical Payment and	-	-	-
	With Concurrent Vertebral Fracture Assessment Utilizing	Coding Policy titled: Non-Reimbursable Experimental,			
	Data From A Computed Tomography Scan Retrieval And	Investigational and/or Unproven Services (EIU).			
	Transmission Of The Scan Data Measurement Of Bone				
	Strength And Bmd And Classification Of Any Vertebral				
	Fractures With Overall Fracture-Risk Assessment				
0744T	Interpretation And Report Insertion Of Bioprosthetic Valve Open Femoral Vein	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
07441			-	-	-
	Including Duplex Ultrasound Imaging Guidance When	to utilization review. Please see the Clinical Payment and			
	Performed Including Autogenous Or Nonautogenous Patch	Coding Policy titled: Non-Reimbursable Experimental,			
	Graft (Eg Polyester Eptfe Bovine Pericardium) When	Investigational and/or Unproven Services (EIU).			
0745T	Performed	MD Criteria: Dresedure (convice reviewed to ensure each convice			
07451	Cardiac Focal Ablation Utilizing Radiation Therapy For	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Arrhythmia; Noninvasive Arrhythmia Localization And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Mapping Of Arrhythmia Site (Nidus) Derived From	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
	Scan) And Electrical Data (Eg 12-Lead Ecg Data) And	Policy criteria.			
07467	Identification Of Areas Of Avoidance				
0746T	Cardiac Focal Ablation Utilizing Radiation Therapy For	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Arrhythmia; Conversion Of Arrhythmia Localization And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
	Radiation Treatment Plan	request if it is unclear if the service meets BCBSOK Medical			
07.477		Policy criteria.			
0747T	Cardiac Focal Ablation Utilizing Radiation Therapy For	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Arrhythmia; Delivery Of Radiation Therapy Arrhythmia	meets BCBSOK 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		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
		to utilization review. Please see the Clinical Payment and			
	Fistula Curettage Closure Of Internal Openings)	Coding Policy titled: Non-Reimbursable Experimental,			
07647	A solution Alexa (the site Electron conditions on Dist. D	Investigational and/or Unproven Services (EIU).			
0764T	Assistive Algorithmic Electrocardiogram Risk-Based	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Assessment For Cardiac Dysfunction (Eg Low-Ejection	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fraction Pulmonary Hypertension Hypertrophic	submitting a Recommended Clinical Review (Predetermination)			
	Cardiomyopathy); Related To Concurrently Performed	request if it is unclear if the service meets BCBSOK Medical			
	Electrocardiogram (List Separately In Addition To Code For	Policy criteria.			
	Primary Procedure)				

0765T	Assistive Algorithmic Electrocardiogram Risk-Based	MP Criteria: Procedure/service reviewed to ensure each service			
07031	Assessment For Cardiac Dysfunction (Eg. Low-Ejection	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Fraction Pulmonary Hypertension Hypertrophic	submitting a Recommended Clinical Review (Predetermination)			
	Cardiomyopathy); Related To Previously Performed	request if it is unclear if the service meets BCBSOK Medical			
	Electrocardiogram	Policy criteria.			
0766T	Transcutaneous Magnetic Stimulation By Focused Low-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
0,001		to utilization review. Please see the Clinical Payment and	-	-	-
	Identification And Marking Of The Treatment Location	Coding Policy titled: Non-Reimbursable Experimental,			
	Including Noninvasive Electroneurographic Localization	Investigational and/or Unproven Services (EIU).			
	(Nerve Conduction Localization) When Performed; First	investigational and/or onproven services (Ero).			
	Nerve				
0767T	Transcutaneous Magnetic Stimulation By Focused Low-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Frequency Electromagnetic Pulse Peripheral Nerve With	to utilization review. Please see the Clinical Payment and	-	-	_
	Identification And Marking Of The Treatment Location	Coding Policy titled: Non-Reimbursable Experimental,			
	Including Noninvasive Electroneurographic Localization	Investigational and/or Unproven Services (EIU).			
	(Nerve Conduction Localization) When Performed; Each				
	Additional Nerve (List Separately In Addition To Code For				
	Primary Procedure)				
0770T		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	In Addition To Code For Primary Procedure)	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	By The Same Physician Or Other Qualified Health Care	to utilization review. Please see the Clinical Payment and			
	Professional Performing The Diagnostic Or Therapeutic	Coding Policy titled: Non-Reimbursable Experimental,			
	Service That The Vr Procedural Dissociation Supports	Investigational and/or Unproven Services (EIU).			
	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				
0772T		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	_
	By The Same Physician Or Other Qualified Health Care	to utilization review. Please see the Clinical Payment and			
	Professional Performing The Diagnostic Or Therapeutic	Coding Policy titled: Non-Reimbursable Experimental,			
	Service That The Vr Procedural Dissociation Supports	Investigational and/or Unproven Services (EIU).			
	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)				

0773T	Virtual Deplity (V/r) Proceedings Disconsisting Comission Devided	FILL Dropoduro (convice not reinstrumed by DCDCOK, Notes Litera			
07731	Virtual Reality (Vr) Procedural Dissociation Services Provided	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	By A Physician Or Other Qualified Health Care Professional	to utilization review. Please see the Clinical Payment and			
	Other Than The Physician Or Other Qualified Health Care	Coding Policy titled: Non-Reimbursable Experimental,			
	Professional Performing The Diagnostic Or Therapeutic	Investigational and/or Unproven Services (EIU).			
	Service That The Vr Procedural Dissociation Supports; Initial				
	15 Minutes Of Intraservice Time Patient Age 5 Years Or				
	Older				
0774T	Virtual Reality (Vr) Procedural Dissociation Services Provided	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	_
	By A Physician Or Other Qualified Health Care Professional	to utilization review. Please see the Clinical Payment and			
	Other Than The Physician Or Other Qualified Health Care	Coding Policy titled: Non-Reimbursable Experimental,			
	Professional Performing The Diagnostic Or Therapeutic	Investigational and/or Unproven Services (EIU).			
	Service That The Vr Procedural Dissociation Supports; Each				
	Additional 15 Minutes Intraservice Time (List Separately In				
	Addition To Code For Primary Service)				
0776T		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		
	Placement Of A Mechanical Temperature-Controlled Cooling	to utilization review. Please see the Clinical Payment and			
	Device To The Neck Over Carotids And Head Including	Coding Policy titled: Non-Reimbursable Experimental,			
	Monitoring (Eg. Vital Signs And Sport Concussion	Investigational and/or Unproven Services (EIU).			
	Assessment Tool 5 [Scat5]) 30 Minutes Of Treatment				
0777T	Real-Time Pressure-Sensing Epidural Guidance System (List	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Separately In Addition To Code For Primary Procedure)	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Application Of Inertial Measurement Unit (Imu) Sensors For	to utilization review. Please see the Clinical Payment and	-	-	-
	Measurement Of Multi-Joint Range Of Motion Posture Gait	Coding Policy titled: Non-Reimbursable Experimental,			
	And Muscle Function	Investigational and/or Unproven Services (EIU).			
0779T	Gastrointestinal Myoelectrical Activity Study Stomach	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
07701	Through Colon With Interpretation And Report	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	MP Criteria: Procedure/service reviewed to ensure each service			
0,001	Into Lower Gastrointestinal Tract	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
0701T	Dranch concern. Divid On Flavible, With Jacont's s. Of	Policy criteria.			
0781T	Bronchoscopy Rigid Or Flexible With Insertion Of	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Esophageal Protection Device And Circumferential	to utilization review. Please see the Clinical Payment and			
	Radiofrequency Destruction Of The Pulmonary Nerves	Coding Policy titled: Non-Reimbursable Experimental,			
	Including Fluoroscopic Guidance When Performed; Bilateral	Investigational and/or Unproven Services (EIU).			
	Mainstem Bronchi				
0782T	Bronchoscopy Rigid Or Flexible With Insertion Of	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Esophageal Protection Device And Circumferential	to utilization review. Please see the Clinical Payment and			
	Radiofrequency Destruction Of The Pulmonary Nerves	Coding Policy titled: Non-Reimbursable Experimental,			
	Including Fluoroscopic Guidance When Performed;	Investigational and/or Unproven Services (EIU).			
	Unilateral Mainstem Bronchus				

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

0792T	Application Of Silver Diamine Fluoride 38% By A Physician	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Or Other Qualified Health Care Professional	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.	-	-	-

07007	Transaction Demonstration Constraints and Characteristic	MD Criteria: Descelues (comission of the second s		1	1
0799T	Transcatheter Removal Of Permanent Dual-Chamber	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Leadless Pacemaker Including Imaging Guidance (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fluoroscopy Venous Ultrasound Right Atrial Angiography	submitting a Recommended Clinical Review (Predetermination)			
	Right Ventriculography Femoral Venography) When	request if it is unclear if the service meets BCBSOK Medical			
	Performed; Right Atrial Pacemaker Component	Policy criteria.			
0800T	Transcatheter Removal Of Permanent Dual-Chamber	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Leadless Pacemaker Including Imaging Guidance (Eg	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fluoroscopy Venous Ultrasound Right Atrial Angiography	submitting a Recommended Clinical Review (Predetermination)			
	Right Ventriculography Femoral Venography) When	request if it is unclear if the service meets BCBSOK Medical			
	Performed; Right Ventricular Pacemaker Component (When	Policy criteria.			
	Part Of A Dual-Chamber Leadless Pacemaker System)				
0801T	Transcatheter Removal And Replacement Of Permanent	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Dual-Chamber Leadless Pacemaker Including Imaging	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		
	Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial	submitting a Recommended Clinical Review (Predetermination)			
	Angiography Right Ventriculography Femoral Venography)	request if it is unclear if the service meets BCBSOK Medical			
	And Device Evaluation (Eg. Interrogation Or Programming)	Policy criteria.			
	When Performed; Dual-Chamber System (le Right Atrial				
	And Right Ventricular Pacemaker Components)				
	, the higher ventricular racemarker components)				
0802T	Transcatheter Removal And Replacement Of Permanent	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Dual-Chamber Leadless Pacemaker Including Imaging	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial	submitting a Recommended Clinical Review (Predetermination)			
	Angiography Right Ventriculography Femoral Venography)	request if it is unclear if the service meets BCBSOK Medical			
	And Device Evaluation (Eg Interrogation Or Programming)	Policy criteria.			
	When Performed; Right Atrial Pacemaker Component				
0803T	Transcatheter Removal And Replacement Of Permanent	MP Criteria: Procedure/service reviewed to ensure each service			
00001	Dual-Chamber Leadless Pacemaker Including Imaging	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial	submitting a Recommended Clinical Review (Predetermination)			
	Angiography Right Ventriculography Femoral Venography)	request if it is unclear if the service meets BCBSOK Medical			
	And Device Evaluation (Eg. Interrogation Or Programming)	Policy criteria.			
	When Performed; Right Ventricular Pacemaker Component	Folicy citteria.			
	(When Part Of A Dual-Chamber Leadless Pacemaker System)				
0804T	Programming Device Evaluation (In Person) With Iterative	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Adjustment Of Implantable Device To Test The Function Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Device And To Select Optimal Permanent Programmed	submitting a Recommended Clinical Review (Predetermination)			
	Values With Analysis Review And Report By A Physician Or	request if it is unclear if the service meets BCBSOK Medical			
	Other Qualified Health Care Professional Leadless	Policy criteria.			
	Pacemaker System In Dual Cardiac Chambers				
0805T	Transcatheter Superior And Inferior Vena Cava Prosthetic	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Valve Implantation (Ie Caval Valve Implantation [Cavi]);	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Percutaneous Femoral Vein Approach	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	MP Criteria: Procedure/service reviewed to ensure each service			
00001	Valve Implantation (le Caval Valve Implantation [Cavi]);	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Open Femoral Vein Approach	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
		to utilization review. Please see the Clinical Payment and	-	_	-
	Cinefluorograph Images; In Combination With Previously	Coding Policy titled: Non-Reimbursable Experimental,			
	Acquired Computed Tomography (Ct) Images Including Data				
	Preparation And Transmission Quantification Of Pulmonary				
	Tissue Ventilation Data Review Interpretation And Report				
0808T	Pulmonary Tissue Ventilation Analysis Using Software-Based	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Processing Of Data From Separately Captured	to utilization review. Please see the Clinical Payment and			
	Cinefluorograph Images; In Combination With Computed	Coding Policy titled: Non-Reimbursable Experimental,			
	Tomography (Ct) Images Taken For The Purpose Of	Investigational and/or Unproven Services (EIU).			
	Pulmonary Tissue Ventilation Analysis Including Data				
	Preparation And Transmission Quantification Of Pulmonary				
	Tissue Ventilation Data Review Interpretation And Report				
0810T	Subretinal Injection Of A Pharmacologic Agent Including	MP Criteria: Procedure/service reviewed to ensure each service			
00101	Vitrectomy And 1 Or More Retinotomies	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	vicicetoni y vina 1 or more recurrotornico	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	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Electronic Equipment); Set-Up And Patient Education On	subject to utilization review.			01/01/2024
	Use Of Equipment				
0812T	Remote Multi-Day Complex Uroflowmetry (Eg Calibrated	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Electronic Equipment); Device Supply With Automated	subject to utilization review.			01/01/2024
	Report Generation Up To 10 Days				
0813T	Esophagogastroduodenoscopy Flexible Transoral With	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
	Volume Adjustment Of Intragastric Bariatric Balloon	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
		(Predetermination) to avoid post-service review.	- / . /		effective 06/30/2024
0813T	Esophagogastroduodenoscopy Flexible Transoral With	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	-	Add effective
	Volume Adjustment Of Intragastric Bariatric Balloon	to pre-service review. Check EIU policy, which is one of our			07/01/2024
0814T	Percutaneous Injection Of Calcium-Based Biodegradable	Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
00111	Osteoconductive Material Proximal Femur Including	Criteria. Submit for Recommended Clinical Review	1, 1, 2027	-	01/01/2024
	Imaging Guidance Unilateral	(Predetermination) to avoid post-service review.			01/01/2024
0816T	Open Insertion Or Replacement Of Integrated	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review	-, -,	-, 30, 202 .	01/01/2024 Retire
		(Predetermination) to avoid post-service review.			effective 06/30/2024
	Receiver Including Analysis Programming And Imaging				Chective 00/30/2024
	Guidance When Performed Posterior Tibial Nerve;				
	Subcutaneous		1		

0816T	Open Insertion Or Replacement Of Integrated	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024		Add effective
	Neurostimulation System For Bladder Dysfunction Including	to pre-service review. Check EIU policy, which is one of our			07/01/2024
	Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or	Clinical Payment and Coding Policy (CPCP).			
	Receiver Including Analysis Programming And Imaging				
	Guidance When Performed Posterior Tibial Nerve;				
	Subcutaneous				
)817T	Open Insertion Or Replacement Of Integrated	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Neurostimulation System For Bladder Dysfunction Including	Criteria. Submit for Recommended Clinical Review		_	01/01/2024
	Electrode(S) (Eg Array Or Leadless) And Pulse Generator Or				
	Receiver Including Analysis Programming And Imaging	· ····			
	Guidance When Performed Posterior Tibial Nerve;				
	Subfascial				
818T		MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
	For Bladder Dysfunction Including Analysis Programming	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
	And Imaging When Performed Posterior Tibial Nerve;	(Predetermination) to avoid post-service review.			effective 06/30/2024
	Subcutaneous	· · · · · · · · · · · · · · · · · · ·			,, -
818T	Revision Or Removal Of Integrated Neurostimulation System	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024		Add effective
	For Bladder Dysfunction Including Analysis Programming	to pre-service review. Check EIU policy, which is one of our			07/01/2024
	And Imaging When Performed Posterior Tibial Nerve;	Clinical Payment and Coding Policy (CPCP).			
	Subcutaneous				
819T	Revision Or Removal Of Integrated Neurostimulation System	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	For Bladder Dysfunction Including Analysis Programming	Criteria. Submit for Recommended Clinical Review			01/01/2024
	And Imaging When Performed Posterior Tibial Nerve;	(Predetermination) to avoid post-service review.			
	Subfascial				
820T	Continuous In-Person Monitoring And Intervention (Eg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Psychotherapy Crisis Intervention) As Needed During	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Psychedelic Medication Therapy; First Physician Or Other	(Predetermination) to avoid post-service review.			
	Qualified Health Care Professional Each Hour				
821T	Continuous In-Person Monitoring And Intervention (Eg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Psychotherapy Crisis Intervention) As Needed During	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Psychedelic Medication Therapy; Second Physician Or Other	(Predetermination) to avoid post-service review.			
	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)				
822T	Continuous In-Person Monitoring And Intervention (Eg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Psychotherapy Crisis Intervention) As Needed During	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Psychedelic Medication Therapy; Clinical Staff Under The	(Predetermination) to avoid post-service review.			
	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)				
857T	Opto-Acoustic Imaging Breast Unilateral Including Axilla	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	When Performed Real-Time With Image Documentation	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Augmentative Analysis And Report (List Separately In	(Predetermination) to avoid post-service review.			
	Addition To Code For Primary Procedure)				

0858T	Externally Applied Transcranial Magnetic Stimulation With	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Concomitant Measurement Of Evoked Cortical Potentials	Criteria. Submit for Recommended Clinical Review	-, -,	-	01/01/2024
	With Automated Report	(Predetermination) to avoid post-service review.			01, 01, 101
0861T	Removal Of Pulse Generator For Wireless Cardiac Stimulator	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	For Left Ventricular Pacing; Both Components (Battery And	Criteria. Submit for Recommended Clinical Review	,,,-	-	01/01/2024
	Transmitter)	(Predetermination) to avoid post-service review.			01, 01, 101
0862T	Relocation Of Pulse Generator For Wireless Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Stimulator For Left Ventricular Pacing Including Device	Criteria. Submit for Recommended Clinical Review	-/ -/	-	01/01/2024
	Interrogation And Programming; Battery Component Only	(Predetermination) to avoid post-service review.			01, 01, 101
0863T	Relocation Of Pulse Generator For Wireless Cardiac	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Stimulator For Left Ventricular Pacing Including Device	Criteria. Submit for Recommended Clinical Review	_, _, _ = = = :	-	01/01/2024
	Interrogation And Programming; Transmitter Component	(Predetermination) to avoid post-service review.			01,01,2021
	Only	(Tredetermination) to avoid post-service review.			
0864T	Low-Intensity Extracorporeal Shock Wave Therapy Involving	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
	Corpus Cavernosum Low Energy	Criteria. Submit for Recommended Clinical Review	-, -, -0 :	0,00,2021	01/01/2024 Retire
	colpus cavellosani Low Energy	(Predetermination) to avoid post-service review.			effective 06/30/2024
0864T	I ow-Intensity Extracorporeal Shock Wave Therapy Involving	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024		Add effective
00041	Corpus Cavernosum Low Energy	to pre-service review. Check EIU policy, which is one of our	77172024	-	07/01/2024
	corpus cavernosum Low Energy	Clinical Payment and Coding Policy (CPCP).			0770172024
0865T	Quantitative Magnetic Resonance Image (Mri) Analysis Of	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
08031	The Brain With Comparison To Prior Magnetic Resonance	Criteria. Submit for Recommended Clinical Review	1/1/2024	-	01/01/2024
					01/01/2024
	(Mr) Study(les) Including Lesion Identification	(Predetermination) to avoid post-service review.			
	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				
0866T	Quantitative Magnetic Resonance Image (Mri) Analysis Of	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
	The Brain With Comparison To Prior Magnetic Resonance	Criteria. Submit for Recommended Clinical Review			01/01/2024
	(Mr) Study(les) Including Lesion Detection Characterization	(Predetermination) to avoid post-service review.			
	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)				
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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	(Medicaid Only)	subject to utilization review.			
A0080	Non-Emergency Transportation Per Mile - Vehicle Provided	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	By Volunteer (Individual Or Organization) With No Vested	subject to utilization review.			
	Interest				
A0090	Non-Emergency Transportation Per Mile - Vehicle Provided	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	By Individual (Family Member Self Neighbor) With Vested	subject to utilization review.			
	Interest				

	- - -
-	-
-	
-	-
_	
-	
	-
-	-
-	-
-	-
-	-
-	-
-	-
-	-
-	-
-	-
-	-
-	-
-	-

A0431	Ambulance Service Conventional Air Services Transport	MP Criteria: Procedure/service reviewed to ensure each service			
A0431	One Way (Rotary Wing)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	one way (notary wing)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A0432	Paramedic Intercent (Pi) Pural Area, Transport Furnished Pu	Policy criteria. Non Covered: Procedure/service not covered by BCBSOK. Not			
A0432	A Volunteer Ambulance Company Which Is Prohibited By	subject to utilization review.	-	-	-
		subject to utilization review.			
A0435	State Law From Billing Third Party Payers Fixed Wing Air Mileage Per Statute Mile	MP Criteria: Procedure/service reviewed to ensure each service			
A0433	Theu wing An Wileage Fer Statute Wile	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A0436	Rotary Wing Air Mileage Per Statute Mile	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
A0450	Rotary wing All Mileage Per Statute Mile		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A0888	Nensevered Archideres Mileses Der Mile (F. C., For Miles	Policy criteria.			
A0888		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
40000	Traveled Beyond Closest Appropriate Facility)	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,			
10001		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			
A2007		to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
A2008	Theragenesis Per Square Centimeter	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
A2008	Theragenesis Per Square Centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
		,			
		Coding Policy titled: Non-Reimbursable Experimental,			
A2009	Symphony Dar Square Continutor	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
A2009	Symphony Per Square Centimeter		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
42010	Ania Des Causes Castingatos	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,			
10011		Investigational and/or Unproven Services (EIU).	1		
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	Developed Class Fact	FUL Developed to for the second by DCDCOK Notes birth			
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 XI 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	4/1/2024		Add effective
		to pre-service review. Check EIU policy, which is one of our			04/01/2024
		Clinical Payment and Coding Policy (CPCP).			
A4100	Skin Substitute Fda Cleared As A Device Not Otherwise	MP Criteria: Procedure/service reviewed to ensure each service			
	Specified	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Continuous Glucose Monitor (Cgm) Includes All Supplies	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	And Accessories 1 Month Supply = 1 Unit Of Service	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	Criteria. Submit for Recommended Clinical Review	-	-	-
		(Predetermination) to avoid post-service review.			
A4342	Accessories For Patient Inserted Indwelling Intraurethral	MP Criteria: Procedure/service reviewed against Medical Policy			
	Drainage Device With Valve Replacement Only Each	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	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
	Electrical Nerve Stimulator Controller Each	Criteria. Submit for Recommended Clinical Review	1/ 1/ 2021	-	4/1/2024
		(Predetermination) to avoid post-service review.			1, 1, 2021
A4453	Rectal Catheter For Use With The Manual Pump-Operated	MP Criteria: Procedure/service reviewed to ensure each service			
A4433	Enema System Replacement Only	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Replacement Only Each	subject to utilization review.	1, 1, 202 1	-	01/01/2024
A4458	Enema Bag With Tubing Reusable	Non Covered: Procedure/service not covered by BCBSOK. Not			01/01/2024
		subject to utilization review.	-	-	-
A4468	Exsufflation Belt Includes All Supplies And Accessories	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review	-, -,	-	01/01/2024
		(Predetermination) to avoid post-service review.			01/01/2021
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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Stimulates Peripheral Nerves Of The Upper Arm	Criteria. Submit for Recommended Clinical Review	-, -,	0, 1, 202 .	05/14/2024
		(Predetermination) to avoid post-service review.			00, 1, 202
A4540	Distal Transcutaneous Electrical Nerve Stimulator	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
	Stimulates Peripheral Nerves Of The Upper Arm	to pre-service review. Check EIU policy, which is one of our		_	05/15/2024
		Clinical Payment and Coding Policy (CPCP).			,,
A4541	Monthly Supplies For Use Of Device Coded At E0733	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
-	· · /····	Criteria. Submit for Recommended Clinical Review		-	01/01/2024
		(Predetermination) to avoid post-service review.			,, -•- ·
A4542	Supplies And Accessories For External Upper Limb Tremor	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Stimulator Of The Peripheral Nerves Of The Wrist	Criteria. Submit for Recommended Clinical Review	-, -, -, -, -, -, -, -, -, -, -, -, -, -	3, 2., 202.	05/14/2024
	call det of the respictor de ves of the whist	(Predetermination) to avoid post-service review.			00/11/2024
		תו ובעבובו וווומנוטוון נט מיטוע אטגראבו יונב וביוביי.			

A4542	Supplies And Accessories For External Upper Limb Tremor	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
	Stimulator Of The Peripheral Nerves Of The Wrist	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Device Used For Cancer Treatment Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	1/14/2024	Retire effective
	Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends			1/14/2024
		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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	1/15/2024	-	Add effective
	Replacement Only	to utilization review. Please see the Clinical Payment and			01/15/2024
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
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		Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Nmes)	subject to utilization review.			
A4596	Cranial Electrotherapy Stimulation (Ces) System Supplies	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	And Accessories Per Month	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Replacement Only Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
14620	Dealers and Dettering Madially Newsons	Policy criteria.		_	
A4630	Replacement Batteries Medically Necessary	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
A4638	Transcutaneous Electrical Stimulator Owned By Patient Replacement Battery For Patient-Owned Ear Pulse	subject to utilization review. MP Criteria: Procedure/service reviewed to ensure each service			
A4030	Generator Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		. . ,			
		request if it is unclear if the service meets BCBSOK Medical			
A4639	Replacement Pad For Infrared Heating Pad System Each	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
UJJ	Replacement Fau for initialed fielding Fau system Eddi	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
		investigational and/or onproven 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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	And Stethoscope	subject to utilization review.			
A4663	Blood Pressure Cuff Only	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
44042		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			
44020	Clause Charile Der Dein	clinical review.			
A4930	Gloves Sterile Per Pair	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
44024	Over Thermony extent Deverties, Any Type, Fach	subject to utilization review.			
A4931	Oral Thermometer Reusable Any Type Each	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
44022	Destal Thermometer, Deutschle, Arriting, Fach	subject to utilization review.			
A4932	Rectal Thermometer Reusable Any Type Each	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
45507	For Dishotics Only. Not Otherwise Creatilied Medification	subject to utilization review.			
A5507	For Diabetics Only Not Otherwise Specified Modification	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	(Including Fitting) Of Off-The-Shelf Depth-Inlay Shoe Or	defined or classified, and may be subject to benefit and/or			
46000	Custom-Molded Shoe Per Shoe	clinical review.			
A6000	Non-Contact Wound Warming Douice And Warming	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	The Non-Contact Wound Warming Device And Warming Card	to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental,			
	Calu	Investigational and/or Unproven Services (EIU).			
A6261	Wound Filler Gel/Paste Per Fluid Ounce Not Otherwise	Unvestigational and/or Unproven Services (EIU).			
10201	Specified	defined or classified, and may be subject to benefit and/or	-	-	-
	openieu	clinical review.			
A6262	Wound Filler Dry Form Per Gram Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise			
	treater mer bry rom rer stum not otherwise specified	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Electrical Pump Includes All Supplies And Accessories	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Material For Use With Suction Pump Per Month	subject to utilization review.			
A6591	External Urinary Catheter; Non-Disposable For Use With	Non Covered: Procedure/service not covered by BCBSOK. Not			

A7020	Interface For Cough Stimulating Device Includes All	MP Criteria: Procedure/service reviewed to ensure each service		I	
	Components Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	components replacement only	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	MP Criteria: Procedure/service reviewed to ensure each service		1	
A7025	Replacement For Use With Patient Owned Equipment Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Replacement for ose with ratient owned Equipment Each	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	MP Criteria: Procedure/service reviewed to ensure each service			
A7020	Replacement For Use With Patient Owned Equipment Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Replacement for ose with Patient Owned Equipment Each	-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A7047	Oral Interface Used With Despiratory Systian Dyma. Each	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Valve	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	Non Covered: Procedure/service not covered by the Plan. Not	_	_	_
	Otherwise Specified	subject to utilization review.			
		Unlisted or Undefined			
A9153	Multiple Vitamins With Or Without Minerals And Trace	Non Covered: Procedure/service not covered by the Plan. Not	-	_	-
	Elements Oral Per Dose Not Otherwise Specified	subject to utilization review.			
		Unlisted or Undefined			
A9180	Pediculosis (Lice Infestation) Treatment Topical For	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	Administration By Patient/Caretaker	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Accessories And Components Any Type Each	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Wrap Any Type	subject to utilization review.			
A9279	Monitoring Feature/Device Stand-Alone Or Integrated Any	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Type Includes All Accessories Components And Electronics	defined or classified, and may be subject to benefit and/or			
	Not Otherwise Classified	clinical review.			

A9280	Alert Or Alarm Device Not Otherwise Classified	Unlisted or Undefined: Procedure/service not otherwise			
A9200	Alert Of Alarm Device Not Otherwise classified	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			
AJ201	Reaching/Grabbing Device Any Type Any Length Lach	subject to utilization review.	-	-	-
A9285	Inversion/Eversion Correction Device	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-		
AJ20J	inversion/eversion correction bevice	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject		1/31/2024	Retire effective
~J2J1	Fda Cleared Per Course Of Treatment	to utilization review. Please see the Clinical Payment and	-	1/31/2024	1/31/2024
		Coding Policy titled: Non-Reimbursable Experimental,			1/31/2024
		Investigational and/or Unproven Services (EIU).			
A9291	Prescription Digital Cognitive And/Or Behavioral Therapy	MP Criteria: Procedure/service reviewed against Medical Policy	2/1/2024		Add effective
~5251	Fda Cleared Per Course Of Treatment	Criteria. Submit for Recommended Clinical Review	2/1/2024	-	02/01/2024
	rua cleared Per Course of Treatment	(Predetermination) to avoid post-service review.			02/01/2024
A9300	Exercise Equipment	Non Covered: Procedure/service not covered by BCBSOK. Not			
A9300		subject to utilization review.	-	-	-
A9515	Choline C-11 Diagnostic Per Study Dose Up To 20	MP Criteria: Procedure/service reviewed to ensure each service			
A9313	Millicuries		_	-	-
	Minicuries	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A9579	Injection Gadolinium-Based Magnetic Resonance Contrast	Policy criteria. Unlisted or Undefined: Procedure/service not otherwise			
A9579	, ,		-	-	-
	Agent Not Otherwise Specified (Nos) Per MI	defined or classified, and may be subject to benefit and/or			
A9580	Sodium Fluoride F-18 Diagnostic Per Study Dose Up To 30	clinical review. MP Criteria: Procedure/service reviewed to ensure each service			
A9380	Millicuries	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Minicuries				
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A9582	Iodine I-123 Iobenguane Diagnostic Per Study Dose Up To	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
A9362	15 Millicuries		-	-	—
	15 Milliculies	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A9588	Elucialeurine E 10 Discreteria 1 Milliouria	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
A9588	Fluciclovine F-18 Diagnostic 1 Millicurie		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
10506	Callium Co 68 Constatida Diagraphia (Illugais) (Million da	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	Unlisted or Undefined: Procedure/service not otherwise			
A9597		· ·	-	-	-
	Diagnostic For Tumor Identification Not Otherwise	defined or classified, and may be subject to benefit and/or			
A9598	Classified Positron Emission Tomography Radiopharmaceutical	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
A9596		· ·	-	-	-
	Diagnostic For Non-Tumor Identification Not Otherwise	defined or classified, and may be subject to benefit and/or			
A9601	Classified Flortaucipir F 18 Injection Diagnostic 1 Millicurie	clinical review. MP Criteria: Procedure/service reviewed to ensure each service			
A9601	FIOR aucipir F 18 Injection Diagnostic 1 Minicune	· ·	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
A9602	Elveradore E 10. Discretis Der Milliourie	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
A9602	Fluorodopa F-18 Diagnostic Per Millicurie		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
10000	First Colored E 40. Disconstitut 4 Millionais	Prior Authorization may be required per contract agreement.	4 /4 /2024		A data Constitue
A9608	Flotufolastat F 18 Diagnostic 1 Millicurie	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
10000		(Predetermination) to avoid post-service review.	4 /4 /2024		
A9609	Fludeoxyglucose F18 Up To 15 Millicuries	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
10000		(Predetermination) to avoid post-service review.			
A9698	Non-Radioactive Contrast Imaging Material Not Otherwise	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Classified Per Study	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			
10000	Calling Co. CO. Constatistic Disconstitution (Learning). A	clinical review.			
A9800	Gallium Ga-68 Gozetotide Diagnostic (Locametz) 1	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Millicurie	meets BCBSOK 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	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Component Of Another Hcpcs Code	defined or classified, and may be subject to benefit and/or			
		clinical review.			
A9999	Miscellaneous Dme Supply Or Accessory Not Otherwise	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Specified	defined or classified, and may be subject to benefit and/or			
		clinical review.			
B4102	Enteral Formula For Adults Used To Replace Fluids And	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Electrolytes (E.G. Clear Liquids) 500 Ml = 1 Unit	subject to utilization review.			
B4103	Enteral Formula For Pediatrics Used To Replace Fluids And	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Electrolytes (E.G. Clear Liquids) 500 Ml = 1 Unit	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	MP Criteria: Procedure/service reviewed to ensure each service			
64105	Feeding Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
B4149	Enteral Formula Manufactured Blenderized Natural Foods	Policy criteria.			
64149		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	With Intact Nutrients Includes Proteins Fats Carbohydrates	subject to utilization review.			
	Vitamins And Minerals May Include Fiber Administered				
	Through An Enteral Feeding Tube 100 Calories = 1 Unit				
B4150	Enteral Formula Nutritionally Complete With Intact	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Nutrients Includes Proteins Fats Carbohydrates Vitamins	subject to utilization review.			
	And Minerals May Include Fiber Administered Through An				
	Enteral Feeding Tube 100 Calories = 1 Unit				
B4152	Enteral Formula Nutritionally Complete Calorically Dense	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	(Equal To Or Greater Than 1. 5 Kcal/MI) With Intact	subject to utilization review.			
	Nutrients Includes Proteins Fats Carbohydrates Vitamins				
	And Minerals May Include Fiber Administered Through An				
	Enteral Feeding Tube 100 Calories = 1 Unit				
B4153	Enteral Formula Nutritionally Complete Hydrolyzed	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Proteins (Amino Acids And Peptide Chain) Includes Fats	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Carbohydrates Vitamins And Minerals May Include Fiber	submitting a Recommended Clinical Review (Predetermination)			
	Administered Through An Enteral Feeding Tube 100	request if it is unclear if the service meets BCBSOK Medical			
	Calories = 1 Unit	Policy criteria.			
B4154	Enteral Formula Nutritionally Complete For Special	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Metabolic Needs Excludes Inherited Disease Of Metabolism	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Includes Altered Composition Of Proteins Fats	submitting a Recommended Clinical Review (Predetermination)			
	Carbohydrates Vitamins And/Or Minerals May Include	request if it is unclear if the service meets BCBSOK Medical			
	Fiber Administered Through An Enteral Feeding Tube 100	Policy criteria.			
	Calories = 1 Unit				
B4155	Enteral Formula Nutritionally Incomplete/Modular	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Nutrients Includes Specific Nutrients Carbohydrates (E. G.	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Glucose Polymers) Proteins/Amino Acids (E. G. Glutamine	submitting a Recommended Clinical Review (Predetermination)			
	Arginine) Fat (E. G. Medium Chain Triglycerides) Or	request if it is unclear if the service meets BCBSOK Medical			
	Combination Administered Through An Enteral Feeding	Policy criteria.			
	Tube 100 Calories = 1 Unit				
B4157	Enteral Formula Nutritionally Complete For Special	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Metabolic Needs For Inherited Disease Of Metabolism	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Includes Proteins Fats Carbohydrates Vitamins And	submitting a Recommended Clinical Review (Predetermination)			
	Minerals May Include Fiber Administered Through An	request if it is unclear if the service meets BCBSOK Medical			
	Enteral Feeding Tube 100 Calories = 1 Unit	Policy criteria.			
B4158		MP Criteria: Procedure/service reviewed to ensure each service	_	L	
	Intact Nutrients Includes Proteins Fats Carbohydrates	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		
	Vitamins And Minerals May Include Fiber And/Or Iron	submitting a Recommended Clinical Review (Predetermination)			
	Administered Through An Enteral Feeding Tube 100	request if it is unclear if the service meets BCBSOK Medical			

Enteral Formula For Pediatrics Nutritionally Complete Sou	MP Criteria: Procedure/service reviewed to ensure each service			
, , , ,		-	-	-
	· · · · · · · · · · · · · · · · · · ·			
	-			
		_	-	-
Enteral Formula For Pediatrics Hydrolyzed/Amino Acids	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
And Peptide Chain Proteins Includes Fats Carbohydrates	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Vitamins And Minerals May Include Fiber Administered	submitting a Recommended Clinical Review (Predetermination)			
Through An Enteral Feeding Tube 100 Calories = 1 Unit	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
Enteral Formula For Pediatrics Special Metabolic Needs For	MP Criteria: Procedure/service reviewed to ensure each service	_	-	_
Inherited Disease Of Metabolism Includes Proteins Fats	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
Carbohydrates Vitamins And Minerals May Include Fiber	submitting a Recommended Clinical Review (Predetermination)			
Administered Through An Enteral Feeding Tube 100	request if it is unclear if the service meets BCBSOK Medical			
Calories = 1 Unit	Policy criteria.			
	· · ·	_	-	-
50% Or Less (500 MI = 1 Unit) - Homemix				
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
		-	-	-
Unit) - Homemix				
		-	-	-
(500 IVII = 1 UNIT) - Homemix				
	, , , , , , , , , , , , , , , , , , ,			
	-			
Parenteral Nutrition Solution: Amino Acid. 7% Through 8, 5%				
		-	-	-
	· · · · · · · · · · · · · · · · · · ·			
Parenteral Nutrition Solution: Amino Acid Greater Than 8				
		-	-	-
	Policy criteria.			
	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 Enteral Formula For Pediatrics Nutritionally Complete Calorically Dense (Equal To Or Greater Than 0.7 Kcal/MI) With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit 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 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 Parenteral Nutrition Solution: Carbohydrates (Dextrose) S0% Or Less (500 MI = 1 Unit) - Homemix Parenteral Nutrition Solution; Amino Acid 3. 5% (500 MI = 1 Unit) - Homemix Parenteral Nutrition Solution; Amino Acid 5. 5% Through 7% (500 MI = 1 Unit) - Homemix	Based With Intact Nutrients Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Fiber And/Or Iron Administered Through An Enteral Feeding Tube Enteral Formula For Pediatrics Nutritionally Complete Calorically Dense (Equal To Or Greater Than 0.7 Kcal/MI) meets BCBSOK Medical Policy criteria. Betrefal Formula For Pediatrics Nutritionally Complete Calorically Dense (Equal To Or Greater Than 0.7 Kcal/MI) MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Betrefal Formula For Pediatrics Hydrolyzed/Amino Acids And Peptide Chain Proteins Includes Frats Carbohydrates Vitamins And Minerals May Include Filer Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit Prough An Enteral Feeding Tube 100 Calories = 1 Unit Prough An Enteral Feeding Tube 100 Calories = 1 Unit Proteck Proteins Includes Proteins Fats Carbohydrates Vitamins And Minerals May Include Filer Administered Through An Enteral Feeding Tube 100 Calories = 1 Unit Parenteral Nutrition Solution: Carbohydrates (Decource) So% Or Less (500 MI = 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. Parenteral Nutrition Solution; Amino Acid 3. 5% (500 MI = 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 Kedical Policy criteria. Parenteral Nutrition Solution; Amino Acid 7% Through 7% (S00 MI = 1 Unit) - Homemix MP Criteria: Procedure/Service reviewed to ensure each service meets BCBSOK Medical Pol	Based With Intact Nutriten's Includes Proteins Fais meets BCSDK Medical Policy criteria. BCSDK recommends Carbohydrates Vitamins And Minerals May Include Fiber meets BCSDK Medical Clinical Review (Predetermination) 100 Calories = 1 Unit Proteins Forcedure/service reviewed to ensure each service Catorically Dense (Equal To Or Greater Than 0.7 Kcal/MI) WC Citteria: Procedure/service reviewed to ensure each service Catorically Dense (Equal To Or Greater Than 0.7 Kcal/MI) WE Citteria: Procedure/service reviewed to ensure each service With Intact Nutrition Indues Proteins Includes Proteins Factorbulydrates Submitting a Recommended Clinical Review (Predetermination) Vitamins And Minerals May Include Fiber Administered MP Criteria: Procedure/service reviewed to ensure each service _ meets BCSDK Medical Policy criteria. Enteral Formula For Pediatrics Hydrolyzed/Amino Acids MP Criteria: Procedure/service reviewed to ensure each service _ meets BCSDK Medical Policy criteria. Inherited Torough An Enteral Feeding Tube 100 Calories = 1 Unit Protecharis: Procedure/service reviewed to ensure each service _ meets BCSDK Medical Policy criteria. Parenteral Formula For Pediatrics Special Metabolic Needs FOF MP Criteria: Procedure/service reviewed to ensure each service _ meets BCSDK Medical Policy criteria. Parenteral Formula For Pediatrics Special Metabolic Needs FOF MP Criteria: Procedure/service reviewed to ensure each service _ meets BCSDK Medical Policy criteria. <td>Based With Intact Nutrients Includes Proteins Fais meets CCBSOK Medical Policy criteria. BCBSOK recommeds </td>	Based With Intact Nutrients Includes Proteins Fais meets CCBSOK Medical Policy criteria. BCBSOK recommeds

B4180	Parenteral Nutrition Solution; Carbohydrates (Dextrose)	MP Criteria: Procedure/service reviewed to ensure each service		
D-100	Greater Than 50% (500 MI=1 Unit) - Homemix	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		-		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
B4185	Derenteral Nutrition Solution, Not Otherwise Specified, 10	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
84185	Parenteral Nutrition Solution Not Otherwise Specified 10	_	-	-
	Grams Lipids	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Carbohydrates With Electrolytes Trace Elements And	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Vitamins Including Preparation Any Strength 52 To 73	submitting a Recommended Clinical Review (Predetermination)		
	Grams Of Protein - Premix	request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
B4197	Parenteral Nutrition Solution; Compounded Amino Acid And	MP Criteria: Procedure/service reviewed to ensure each service	_	_
	Carbohydrates With Electrolytes Trace Elements And	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Vitamins Including Preparation Any Strength 74 To 100	submitting a Recommended Clinical Review (Predetermination)		
	Grams Of Protein - Premix	request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
B4199	Parenteral Nutrition Solution; Compounded Amino Acid And	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Carbohydrates With Electrolytes Trace Elements And	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Vitamins Including Preparation Any Strength Over 100	submitting a Recommended Clinical Review (Predetermination)		
	Grams Of Protein - Premix	request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
B4216	Parenteral Nutrition; Additives (Vitamins Trace Elements	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Heparin Electrolytes) Homemix Per Day	meets BCBSOK 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	ł	
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
			ļ	I

B5000	Parenteral Nutrition Solution Compounded Amino Acid And	MP Criteria: Procedure/service reviewed to ensure each service			
55000	Carbohydrates With Electrolytes Trace Elements And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Vitamins Including Preparation Any Strength Renal-	submitting a Recommended Clinical Review (Predetermination)			
	Aminosyn-Rf Nephramine Renamine-Premix	request if it is unclear if the service meets BCBSOK Medical			
	Annuosyn-ki Nephrannie kenannie-Fremix	Policy criteria.			
B5100	Parenteral Nutrition Solution Compounded Amino Acid And	MP Criteria: Procedure/service reviewed to ensure each service			
20100	Carbohydrates With Electrolytes Trace Elements And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Vitamins Including Preparation Any Strength Hepatic	submitting a Recommended Clinical Review (Predetermination)			
	Hepatamine-Premix	request if it is unclear if the service meets BCBSOK Medical			
	nepatanine-rienix	Policy criteria.			
B5200	Parenteral Nutrition Solution Compounded Amino Acid And	MP Criteria: Procedure/service reviewed to ensure each service			
20200	Carbohydrates With Electrolytes Trace Elements And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	Chain Amino Acids-Freamine-Hbc-Premix	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			
20001		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(E.G. Metal Polymer)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Device Bladed Sheathed (Insertable)	Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			

C1726	Cath Bal Dil Non-Vascular	MP Criteria: Procedure/service reviewed to ensure each service		
01/20		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
C1761	Catheter Transluminal Intravascular Lithotripsy Coronary	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
C1/01		meets BCBSOK 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		
01/04		meets BCBSOK 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-	MP Criteria: Procedure/service reviewed to ensure each service		
01.07	Rechargeable	meets BCBSOK 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		
01//0		meets BCBSOK 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		
1		Policy criteria.		

C1817	Septal Defect Imp Sys	MP Criteria: Procedure/service reviewed to ensure each service			
C101/	Septar Delett IIIp Sys	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
61010		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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Rechargeable Battery And Charging System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	With Rechargeable Battery And Charging System	meets BCBSOK 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-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Rechargeable With Transvenous Sensing And Stimulation	to utilization review. Please see the Clinical Payment and			
	Leads	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	3/15/2024	_	Add effectuce
		Criteria. Submit for Recommended Clinical Review			03/15/2024
		(Predetermination) to avoid post-service review.			
C1825	Generator Neurostimulator (Implantable) Non-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Rechargeable With Carotid Sinus Baroreceptor Stimulation	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Lead(S)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	Ĺ	
	Feedback Loop Leads And All Implantable Components	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	With Rechargeable Battery And Charging System	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
C1827	Generator Neurostimulator (Implantable) Non-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Rechargeable With Implantable Stimulation Lead And	to utilization review. Please see the Clinical Payment and	-	-	-
	External Paired Stimulation Controller	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			

C1831	Interbody Cage Anterior Lateral Or Posterior Personalized	MP Criteria: Procedure/service reviewed to ensure each service			
	(Implantable)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	5/	/14/2024	Retire effective
	Application And All System Components	meets BCBSOK Medical Policy criteria. BCBSOK recommends			05/14/2024
		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	EIU: Procedure/service not reimbursed by the Plan. Not subject 5/1	.5/2024 _		Add effective
	Application And All System Components	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
C1833	Monitor Cardiac Including Intracardiac Lead And All System	MP Criteria: Procedure/service reviewed to ensure each service _	_		_
l	Components (Implantable)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
1		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	MP Criteria: Procedure/service reviewed to ensure each service _	_		_
	With Delivery Catheter Including All System Components	meets BCBSOK 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	Unlisted or Undefined: Procedure/service not otherwise			
02000	Per Source	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
C2699	Brachytherapy Source Non-Stranded Not Otherwise	Unlisted or Undefined: Procedure/service not otherwise			
	Specified Per Source	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	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Sg Cm Or Less Wound Surface Area	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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Legs Total Wound Surface Area Up To 100 Sq Cm; Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Additional 25 Sq Cm Wound Surface Area Or Part Thereof	submitting a Recommended Clinical Review (Predetermination)			
	(List Separately In Addition To Code For Primary Procedure)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
C5273	Application Of Low Cost Skin Substitute Graft To Trunk Arms	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Legs Total Wound Surface Area Greater Than Or Equal To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	100 Sq Cm; First 100 Sq Cm Wound Surface Area Or 1% Of	submitting a Recommended Clinical Review (Predetermination)			
	Body Area Of Infants And Children	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
C5274	Application Of Low Cost Skin Substitute Graft To Trunk Arms	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Legs Total Wound Surface Area Greater Than Or Equal To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	100 Sq Cm; Each Additional 100 Sq Cm Wound Surface Area	submitting a Recommended Clinical Review (Predetermination)			
	Or Part Thereof Or Each Additional 1% Of Body Area Of	request if it is unclear if the service meets BCBSOK Medical			
	Infants And Children Or Part Thereof (List Separately In	Policy criteria.			
	Addition To Code For Primary Procedure)				
C5275		MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And/Or Multiple Digits Total Wound Surface Area Up To 100	submitting a Recommended Clinical Review (Predetermination)			
	Sq Cm; First 25 Sq Cm Or Less Wound Surface Area	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
C5276	Application Of Low Cost Skin Substitute Graft To Face Scalp	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
	Sq Cm; Each Additional 25 Sq Cm Wound Surface Area Or	request if it is unclear if the service meets BCBSOK Medical			
	Part Thereof (List Separately In Addition To Code For	Policy criteria.			
05077	Primary Procedure)				
C5277	Application Of Low Cost Skin Substitute Graft To Face Scalp	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Eyelids Mouth Neck Ears Orbits Genitalia Hands Feet	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And/Or Multiple Digits Total Wound Surface Area Greater	submitting a Recommended Clinical Review (Predetermination)			
	Than Or Equal To 100 Sq Cm; First 100 Sq Cm Wound	request if it is unclear if the service meets BCBSOK Medical			
1	Surface Area Or 1% Of Body Area Of Infants And Children	Policy criteria.			
				ļ	

C5278	Application Of Low Cost Skin Substitute Graft To Face Scalp	MP Criteria: Procedure/service reviewed to ensure each service			
00270	Evelids Mouth Neck Ears Orbits Genitalia Hands Feet	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	And/Or Multiple Digits Total Wound Surface Area Greater	submitting a Recommended Clinical Review (Predetermination)			
	Than Or Equal To 100 Sq Cm; Each Additional 100 Sq Cm	request if it is unclear if the service meets BCBSOK Medical			
	Wound Surface Area Or Part Thereof Or Each Additional 1%				
		Folicy criteria.			
	Of Body Area Of Infants And Children Or Part Thereof (List				
	Separately In Addition To Code For Primary Procedure)				
09160	Injection, daxibotulinumtoxina-lanm, 1 unit	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Retire effective
		Criteria. Submit for Recommended Clinical Review			03/31/2024
		(Predetermination) to avoid post-service review.			
0161	Injection, aflibercept hd, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Retire effective
		Criteria. Submit for Recommended Clinical Review			03/31/2024
		(Predetermination) to avoid post-service review.			
C9163	Injection, talquetamab-tgvs, 0.25 mg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Retire effective
		Criteria. Submit for Recommended Clinical Review			03/31/2024
		(Predetermination) to avoid post-service review.			
09165	Injection, elranatamab-bcmm, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	3/31/2024	Retire effective
		Criteria. Submit for Recommended Clinical Review			03/31/2024
		(Predetermination) to avoid post-service review.			
9166	Injection Secukinumab Intravenous 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
	,	Criteria. Submit for Recommended Clinical Review		-	4/1/2024
		(Predetermination) to avoid post-service review.			, , -
09168	Injection, mirikizumab-mrkz, 1 mg	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review		-	4/1/2024
		(Predetermination) to avoid post-service review.			
09354	Acellular Pericardial Tissue Matrix Of Non-Human Origin	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	(Veritas) Per Square Centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
09356	Tendon Porous Matrix Of Cross-Linked Collagen And	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Glycosaminoglycan Matrix (Tenoglide Tendon Protector	to utilization review. Please see the Clinical Payment and	-	-	-
	Sheet) Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental,			
	Sheet) Tel Square centimeter	Investigational and/or Unproven Services (EIU).			
9358	Dermal Substitute Native Non-Denatured Collagen Fetal	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Bovine Origin (Surgimend Collagen Matrix) Per 0.5 Square	to utilization review. Please see the Clinical Payment and	-	-	-
	Centimeters	Coding Policy titled: Non-Reimbursable Experimental,			
	Centimeters				
9360	Dermal Substitute Native Non-Denatured Collagen	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
.9300			-	-	-
	Neonatal Bovine Origin (Surgimend Collagen Matrix) Per 0.5				
	Square Centimeters	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
09363	c ,	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Square Centimeter	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			
05504		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			
C3333		contract agreement.	-	-	-
C9734	Focused Ultrasound Ablation/Therapeutic Intervention	MP Criteria: Procedure/service reviewed to ensure each service			
09734			-	-	-
	Other Than Uterine Leiomyomata With Magnetic	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Resonance (Mr) Guidance	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
C9739	Cystourethroscopy With Insertion Of Transprostatic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
C9739			-	-	-
	Implant; 1 To 3 Implants	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
C0740		Policy criteria.			
C9740	Cystourethroscopy With Insertion Of Transprostatic	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Implant; 4 Or More Implants	meets BCBSOK 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		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	Nerve Root(S) Including Partial Facetectomy Foraminotomy				
	And Excision Of Herniated Intervertebral Disc And Repair Of	Coding Policy titled: Non-Reimbursable Experimental,			
	Annular Defect With Implantation Of Bone Anchored	Investigational and/or Unproven Services (EIU).			
	Annular Closure Device Including Annular Defect				
	Measurement Alignment And Sizing Assessment And Image				
	Guidance: 1 Interspace Lumbar				
C9764	Revascularization Endovascular Open Or Percutaneous Any	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Vessel(S); With Intravascular Lithotripsy Includes	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Angioplasty Within The Same Vessel(S) When Performed	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
C9765		MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Vessel(S); With Intravascular Lithotripsy And Transluminal	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Stent Placement(S) Includes Angioplasty Within The Same	submitting a Recommended Clinical Review (Predetermination)			
	Vessel(S) When Performed	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
C9766	Revascularization Endovascular Open Or Percutaneous Any	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Vessel(S); With Intravascular Lithotripsy And Atherectomy	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Includes Angioplasty Within The Same Vessel(S) When	submitting a Recommended Clinical Review (Predetermination)			
	Performed	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

C9767	Revascularization Endovascular Open Or Percutaneous Any	MP Criteria: Procedure/service reviewed to ensure each service			
0,00	Vessel(S); With Intravascular Lithotripsy And Transluminal	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Stent Placement(S) And Atherectomy Includes Angioplasty	submitting a Recommended Clinical Review (Predetermination)			
	Within The Same Vessel(S) When Performed	request if it is unclear if the service meets BCBSOK Medical			
	within the same vessel(s) when renormed	Policy criteria.			
C9768	Endoscopic Ultrasound-Guided Direct Measurement Of	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
00/00	Hepatic Portosystemic Pressure Gradient By Any Method	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
	(List separately in Addition to code for Primary Procedure)	Investigational and/or Unproven Services (EIU).			
C9769	Cystourethroscopy With Insertion Of Temporary Prostatic	MP Criteria: Procedure/service reviewed to ensure each service			
05705	Implant/Stent With Fixation/Anchor And Incisional Struts	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		.			
		request if it is unclear if the service meets BCBSOK Medical			
C9772	Revascularization Endovascular Open Or Percutaneous	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
05772	Tibial/Peroneal Artery(les) With Intravascular Lithotripsy	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
	Includes Angioplasty Within The Same Vessel (S) When				
C9773	Performed Revascularization Endovascular Open Or Percutaneous	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
C9773	· · · · · · · · · · · · · · · · · · ·		-	-	-
	Tibial/Peroneal Artery(les); With Intravascular Lithotripsy	to utilization review. Please see the Clinical Payment and			
	And Transluminal Stent Placement(S) Includes Angioplasty	Coding Policy titled: Non-Reimbursable Experimental,			
C0774	Within The Same Vessel(S) When Performed	Investigational and/or Unproven Services (EIU).			
C9774	Revascularization Endovascular Open Or Percutaneous	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Tibial/Peroneal Artery(les); With Intravascular Lithotripsy	to utilization review. Please see the Clinical Payment and			
	And Atherectomy Includes Angioplasty Within The Same	Coding Policy titled: Non-Reimbursable Experimental,			
	Vessel (S) When Performed	Investigational and/or Unproven Services (EIU).			
C9775	Revascularization Endovascular Open Or Percutaneous	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Tibial/Peroneal Artery(Ies); With Intravascular Lithotripsy	to utilization review. Please see the Clinical Payment and			
	And Transluminal Stent Placement(S) And Atherectomy	Coding Policy titled: Non-Reimbursable Experimental,			
	Includes Angioplasty Within The Same Vessel (S) When	Investigational and/or Unproven Services (EIU).			
	Performed				
C9777	Esophageal Mucosal Integrity Testing By Electrical	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Impedance Transoral Includes Esophagoscopy Or	to utilization review. Please see the Clinical Payment and			
	Esophagogastroduodenoscopy	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
C9780	Insertion Of Central Venous Catheter Through Central	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Inside-Out Technique) Including Imaging Guidance	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)	MP Criteria: Procedure/service reviewed against Medical Policy	2/1/2024		Add effective
	Class Ii Or Iii Heart Failure Or Canadian Cardiovascular	Criteria. Submit for Recommended Clinical Review		-	02/01/2024
	Society (Ccs) Class lii Or Iv Chronic Refractory Angina;	(Predetermination) to avoid post-service review.			,,
	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				
C9784	Gastric Restrictive Procedure Endoscopic Sleeve	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Gastroplasty With Esophagogastroduodenoscopy And	to utilization review. Please see the Clinical Payment and	-	-	_
	Intraluminal Tube Insertion If Performed Including All	Coding Policy titled: Non-Reimbursable Experimental,			
	System And Tissue Anchoring Components	Investigational and/or Unproven Services (EIU).			
C9785	Endoscopic Outlet Reduction Gastric Pouch Application	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	With Endoscopy And Intraluminal Tube Insertion If	to utilization review. Please see the Clinical Payment and	-	-	_
	Performed Including All System And Tissue Anchoring	Coding Policy titled: Non-Reimbursable Experimental,			
	Components	Investigational and/or Unproven Services (EIU).			
C9786	Echocardiography Image Post Processing For Computer	MP Criteria: Procedure/service reviewed against Medical Policy			
	Aided Detection Of Heart Failure With Preserved Ejection	Criteria. Submit for Recommended Clinical Review	-	-	_
	Fraction Including Interpretation And Report	(Predetermination) to avoid post-service review.			
C9787	Gastric Electrophysiology Mapping With Simultaneous	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Patient Symptom Profiling	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Cardiac Procedure Using Data From Cardiac Computed	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Tomographic Angiography With Report	(Predetermination) to avoid post-service review.			
C9794	Therapeutic Radiology Simulation-Aided Field Setting;	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Complex Including Acquisition Of Pet And Ct Imaging Data	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Required For Radiopharmaceutical-Directed Radiation	(Predetermination) to avoid post-service review.			
	Therapy Treatment Planning (I.E. Modeling)				
C9795	Stereotactic Body Radiation Therapy Treatment Delivery	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Per Fraction To 1 Or More Lesions Including Image	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Guidance And Real-Time Positron Emissions-Based Delivery	(Predetermination) to avoid post-service review.			
	Adjustments To 1 Or More Lesions Entire Course Not To				
	Exceed 5 Fractions				
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	6/30/2024	retire effectuce
	(Excluding Anorectal Fistula) With Plug (E.G. Porcine Small	Criteria. Submit for Recommended Clinical Review			06/30/2024
	Intestine Submucosa [Sis])	(Predetermination) to avoid post-service review.			
C9796	Repair Of Enterocutaneous Fistula Small Intestine Or Colon	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	-	Add effective
	(Excluding Anorectal Fistula) With Plug (E.G. Porcine Small	to pre-service review. Check EIU policy, which is one of our			07/01/2024
	Intestine Submucosa [Sis])	Clinical Payment and Coding Policy (CPCP).			

C9898	Radiolabeled Product Provided During A Hospital Inpatient	Unlisted or Undefined: Procedure/service not otherwise			
	Stay	defined or classified, and may be subject to benefit and/or	-	-	_
	,	clinical review.			
C9899	Implanted Prosthetic Device Payable Only For Inpatients	Unlisted or Undefined: Procedure/service not otherwise	_	_	
	Who Do Not Have Inpatient Coverage	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	1/1/2024	_	Add effective
		subject to utilization review.	[· ·	_	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	1/1/2024		Add effective
		subject to utilization review.			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 Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Non-Restorability	subject to utilization review.			01/01/2024
D2991	Application Of Hydroxyapatite Regeneration Medicament -	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Per Tooth	subject to utilization review.			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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Dynamic Navigation	Criteria. Submit for Recommended Clinical Review			01/01/2024
	, ,	(Predetermination) to avoid post-service review.			
D7999	Unspecified Oral Surgery Procedure By Report	Unlisted or Undefined: Procedure/service not otherwise	_		
		defined or classified, and may be subject to benefit and/or	_		
		clinical review.			
D8999	Unspecified Orthodontic Procedure By Report	Unlisted or Undefined: Procedure/service not otherwise			
		defined or classified, and may be subject to benefit and/or	-	_	-
		clinical review.			
D9938	Fabrication Of A Custom Removable Clear Plastic Temporary	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Aesthetic Appliance	subject to utilization review.		_	01/01/2024
D9939	Placement Of A Custom Removable Clear Plastic Temporary	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Aesthetic Appliance	subject to utilization review.		_	01/01/2024
D9954	Fabrication And Delivery Of Oral Appliance Therapy (Oat)	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Morning Repositioning Device	Criteria. Submit for Recommended Clinical Review		_	01/01/2024
		(Predetermination) to avoid post-service review.			
D9955	Oral Appliance Therapy (Oat) Titration Visit	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review		_	01/01/2024
		(Predetermination) to avoid post-service review.			
D9956	Administration Of Home Sleep Apnea Test	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review		_	01/01/2024
		(Predetermination) to avoid post-service review.			
D9957	Screening For Sleep Related Breathing Disorders	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
D9999	Unspecified Adjunctive Procedure By Report	Unlisted or Undefined: Procedure/service not otherwise	_		
		defined or classified, and may be subject to benefit and/or			
		clinical review.			
E0152	Walker Battery Powered Wheeled Folding Adjustable Or	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
	Fixed Height	Criteria. Submit for Recommended Clinical Review			4/1/2024
		(Predetermination) to avoid post-service review.			
E0181	Powered Pressure Reducing Mattress Overlay/Pad	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Alternating With Pump Includes Heavy Duty	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Pump Includes Heavy Duty	meets BCBSOK 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			
10104	by Flessure Wattless		-	-	-
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	² –	_	-
	Mattress Length And Width	meets BCBSOK 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	² –	_	_
		meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Includes All Components And Accessories	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	<u>.</u>		
20101		meets BCBSOK Medical Policy criteria. BCBSOK recommends	· [-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0196	Gel Pressure Mattress	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20190		meets BCBSOK Medical Policy criteria. BCBSOK recommends	- -	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50217	Mater Circulation Hast Ded With Duran	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	FILL: Procedure/service not reimbursed by PCDSOK. Not subject			
EU221	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,			
E0225	Hudrocollator Unit Includes Dads	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
EUZZS	Hydrocollator Unit Includes Pads	-	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0231	Non Contact Wound Warming Daviso (Tomporature Control	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
EU231	Non-Contact Wound Warming Device (Temperature Control		-	-	-
	Unit Ac Adapter And Power Cord) For Use With Warming	to utilization review. Please see the Clinical Payment and			
	Card And Wound Cover	Coding Policy titled: Non-Reimbursable Experimental,			
E0232	Warming Card For Use With The Non Contact Wound	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
EU232	0		-	-	-
	Warming Device And Non Contact Wound Warming Wound	to utilization review. Please see the Clinical Payment and			
	Cover	Coding Policy titled: Non-Reimbursable Experimental,			
E0236	Dump For Water Circulating Red	Investigational and/or Unproven Services (EIU).			
EU236	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			
E0239	Hydrocollator Unit Portable	Policy criteria.			
E0239	Hydrocollator Onit 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			
E0240	Dath (Showar Chair With Or Without Wheels Any Size	Policy criteria.			
E0240	Bath/Shower Chair With Or Without Wheels Any Size	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
E0241	Bath Tub Wall Rail Each	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
20241			-	-	-
E0242	Bath Tub Rail Floor Base	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
EU242	Batti Tub Rali Floor Base		-	-	-
E0243	Toilet Rail Each	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
EU245			-	-	-
E0244	Raised Toilet Seat	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
E0244	Kaiseu Tollet Seat		-	-	-
E0245	Tub Stool Or Bench	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
60245			-	-	-
E0246	Transfer Tub Rail Attachment	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
10240		subject to utilization review.	-	-	-
E0247	Transfer Bonch For Tub Or Toilot With Or Without Commode	Non Covered: Procedure/service not covered by BCBSOK. Not			
10247			-	-	-
E0248	Opening Transfer Bench Heavy Duty For Tub Or Toilet With Or	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
10240			-	-	-
	Without Commode Opening	subject to utilization review.			

E0249	Pad For Water Circulating Heat Unit For Replacement Only	MP Criteria: Procedure/service reviewed to ensure each service			
20249	Pad For Water Circulating Heat Onit For Replacement Only		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0250	Hospital Bed Fixed Height With Any Type Side Rails With	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E0250			-	-	-
	Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0251	Hernital Rod Fixed Height With Any Type Side Dails	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		1	
EU251	Hospital Bed Fixed Height With Any Type Side Rails		-	-	-
	Without Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50355	Licenitel Ded Mariable Licent 1914 - With American City	Policy criteria.			
E0255	Hospital Bed Variable Height Hi-Lo With Any Type Side	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Rails With Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50356	Hereitel Deid Merichle Heitele Hitte Mittel Art. The Olde	Policy criteria.			
E0256	Hospital Bed Variable Height Hi-Lo With Any Type Side	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Rails Without Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50260	User its Ded. Consi Electric (Used And East Adjustment)	Policy criteria.			
E0260	Hospital Bed Semi-Electric (Head And Foot Adjustment)	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	With Any Type Side Rails With Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50261	User its Ded. Consi Electric (Used And East Adjustment)	Policy criteria.			
E0261	Hospital Bed Semi-Electric (Head And Foot Adjustment)	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	With Any Type Side Rails Without Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50265		Policy criteria.			
E0265	Hospital Bed Total Electric (Head Foot And Height	MP Criteria: Procedure/service reviewed to ensure each service	–	-	-
	Adjustments) With Any Type Side Rails With Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
500.00		Policy criteria.			
E0266	Hospital Bed Total Electric (Head Foot And Height	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Adjustments) With Any Type Side Rails Without Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		
20270	Circulating And Stryker Frame With Mattress	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	circulating And Stryker Hume With Mattress	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		
20271		meets BCBSOK 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		
20272		meets BCBSOK 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		
20275		meets BCBSOK 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		
20274		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		
	Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		
	Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			_
	Without Mattress	meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Without Side Rails With Mattress	meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Without Side Rails Without Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Adjustments). Without Side Rails With Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Adjustments) Without Side Rails Without Mattress	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Without Top Enclosure	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50201	Usersited Ded. Users, Duty, Estre Mide, Mith Mainht Conseiter	Policy criteria.			
E0301		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Greater Than 350 Pounds But Less Than Or Equal To 600	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds With Any Type Side Rails Without Mattress	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0302	Hochital Rod, Extra Hoan, Duty, Extra Wido, With Weight	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		ł	
EU3UZ	Hospital Bed Extra Heavy Duty Extra Wide With Weight	· ·	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Without Mattress	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		1	

Hospital Bed, Heavy Duty, Extra Wide, With Weight Canacity	MP Criteria: Procedure/service reviewed to ensure each service			
		-	-	-
Pounds with Any Type side Kans with Mattless				
Hospital Bed Extra Heavy Duty Extra Wide With Weight				
		-	-	-
With Mattress				
Bed Side Rails, Half Length				
		-	-	-
Bed Side Rails Full Length				
bed side hais i di Length		-	-	-
Bed Accessory: Board Table Or Support Device Any Type				
bed Accessory. Board Table of Support Device Any Type		-	-	-
Safety Enclosure Frame/Canony For Use With Hospital Bed				
		-	-	-
	-			
Hospital Bed Pediatric Manual 360 Degree Side Enclosures				
		_	-	-
	·			
Hospital Bed Pediatric Electric Or Semi-Electric 360 Degree				
		-	-	-
Nonpowered Advanced Pressure Reducing Mattress				
		-	-	-
	Policy criteria.			
	Greater Than 350 Pounds But Less Than Or Equal To 600 Pounds With Any Type Side Rails With Mattress Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress Bed Side Rails Half Length Bed Side Rails Full Length Bed Accessory: Board Table Or Support Device Any Type Safety Enclosure Frame/Canopy For Use With Hospital Bed Any Type Hospital Bed Pediatric Manual 360 Degree Side Enclosures Top Of Headboard	Greater Than 350 Pounds But Less Than Or Equal To 600 meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. Hospital Bed Extra Heavy Duty Extra Wide With Weight MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. 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. Bed Side Rails Full Length MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Bed Side Rails Full Length MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Bed Accessory: Board Table Or Support Device Any Type MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. 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. Hospital Bed Pediatric Manual 360 Degree Side Enclosures MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. Hospital Bed Pediatric Electric Or Semi-Electr	Greater Than 350 Pounds: But Less Than 0° Equal To 600 meets BCBSOK Medical Policy criteria. BCBSOK recommends Pounds: With Any Type Side Rails: With Mattress submitting a Recommended Clinical Review (Predetermination) request fit is unclear if the service meets BCBSOK Medical Policy criteria. Policy criteria. Hospital Bed Extra Heavy Duty Extra Wide: With Weight: MP Criteria: Procedure/service reviewed to ensure each service	Greater Than 350 Pounds But Less Than Or Equal To 600 meets DCISOK Medical Policy criteria. BCISOK recommends Pounds With Any Type Side Rails With Mattress submitting a Recommended Clinical Review (Predetermination) Hospital Bed Extra Heavy Duty Extra Wide With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress MP Criteria. RCISOK Medical Policy criteria. RCISOK Medical Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service meets RCISOK Medical Policy criteria. RCISOK Medical Policy criteria. Bed Side Rails Full Length MP Criteria: Procedure/service reviewed to ensure each service meets RCISOK Medical Policy criteria. RCISOK Medical Policy criteria. Bed Side Rails Full Length MP Criteria: Procedure/service reviewed to ensure each service meets BCISOK Medical Policy criteria. RCISOK Medical Policy criteria. Bed Accessory: Board Table Or Support Device Any Type MP Criteria: Procedure/service reviewed to ensure each service meets BCISOK Medical Policy criteria. RCISOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCISOK Medical Policy criteria. Safety Enclosure Frame/Canopy For Use With Hospital Bed Any Type MP Criteria: Procedure/service reviewed to ensure each service meets BCISOK Medical Policy criteria. RCISOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCISOK Medical Po

E0446	Topical Oxygen Delivery System Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise			
	Includes All Supplies And Accessories	defined or classified, and may be subject to benefit and/or	-	-	-
		clinical review.			
E0468	Home Ventilator Dual-Function Respiratory Device Also	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
	Performs Additional Function Of Cough Stimulation Includes		, , -	_	4/1/2024
	All Accessories Components And Supplies For All Functions	(Predetermination) to avoid post-service review.			., _, _ ~
E0471	Respiratory Assist Device Bi-Level Pressure Capability With	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Back-Up Rate Feature Used With Noninvasive Interface E.	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	G. Nasal Or Facial Mask (Intermittent Assist Device With	submitting a Recommended Clinical Review (Predetermination)			
	Continuous Positive Airway Pressure Device)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
E0481	Intrapulmonary Percussive Ventilation System And Related	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Accessories	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Airway Pressure	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Anterior And/Or Posterior Thoracic Region Receiving	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Simultaneous External Oscillation Includes All Accessories	submitting a Recommended Clinical Review (Predetermination)			
	And Supplies Each	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
E0484	Oscillatory Positive Expiratory Pressure Device Non-Electric	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Any Type Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Collapsibility Adjustable Or Non-Adjustable Prefabricated	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Includes Fitting And Adjustment	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Collapsibility Adjustable Or Non-Adjustable Custom	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fabricated Includes Fitting And Adjustment	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Device/Appliance For Neuromuscular Electrical Stimulation	to utilization review. Please see the Clinical Payment and	-	-	_
	Of The Tongue Muscle Controlled By Hardware Remote	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
E0491	Oral Device/Appliance For Neuromuscular Electrical	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Stimulation Of The Tongue Muscle Used In Conjunction	to utilization review. Please see the Clinical Payment and	-	-	_
	With The Power Source And Control Electronics Unit	Coding Policy titled: Non-Reimbursable Experimental,			
	Controlled By Hardware Remote 90-Day Supply	Investigational and/or Unproven Services (EIU).			
E0492	Power Source And Control Electronics Unit For Oral	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Device/Appliance For Neuromuscular Electrical Stimulation	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Of The Tongue Muscle Controlled By Phone Application	(Predetermination) to avoid post-service review.			
E0493	Oral Device/Appliance For Neuromuscular Electrical	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Stimulation Of The Tongue Muscle Used In Conjunction	Criteria. Submit for Recommended Clinical Review			01/01/2024
	With The Power Source And Control Electronics Unit	(Predetermination) to avoid post-service review.			
	Controlled By Phone Application 90-Day Supply	, , , , , , , , , , , , , , , , , , ,			
E0530	Electronic Positional Obstructive Sleep Apnea Treatment	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	With Sensor Includes All Components And Accessories Any	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Туре	(Predetermination) to avoid post-service review.			
E0616	Implantable Cardiac Event Recorder With Memory Activator	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	And Programmer	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Analysis	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Each	subject to utilization review.			

E0625	Patient Lift Bathroom Or Toilet Not Otherwise Classified	MP Criteria: Procedure/service reviewed to ensure each service			
20025	Tatient Ent Datifoldin of Tollet Not Otherwise classified	meets BCBSOK 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			
E0627	Seat Lift Mechanism Electric Any Type	clinical review. MP Criteria: Procedure/service reviewed to ensure each service			
10027	Seat Lift Mechanism Lieutic Any Type	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0629	Seat Lift Mechanism Non-Electric Any Type	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20029	Seat Lift Mechanism Non-Electric Any Type		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50025	Detient Lift Fleetric With Cent Or Cline	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			
E0636	Multiporitional Datient Curport System With Integrated Life	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20030			-	-	-
	Patient Accessible Controls	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50027	Compliantian Cit To Stand Engrand (Table Contour Any Cias	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E0637	Combination Sit To Stand Frame/Table System Any Size	· · ·	-	-	-
	Including Pediatric With Seat Lift Feature With Or Without	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Wheels	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50620	Standing France (Table Systems, One Desition (F.C. Unvield	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E0638	Standing Frame/Table System One Position (E.G. Upright		-	-	-
	Supine Or Prone Stander) Any Size Including Pediatric With	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Or Without Wheels	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50620		Policy criteria.			
E0639	Patient Lift Moveable From Room To Room With	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Disassembly And Reassembly Includes All	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Components/Accessories	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		1	

E0640	Patient Lift Fixed System Includes All	MP Criteria: Procedure/service reviewed to ensure each service		1	
20040	Components/Accessories	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	components/Accessories	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-	MP Criteria: Procedure/service reviewed to ensure each service		1	
20041	Way Stander) Any Size Including Pediatric With Or Without	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Wheels	submitting a Recommended Clinical Review (Predetermination)			
	Wheels	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
E0642	Standing Frame/Table System Mobile (Dynamic Stander)	MP Criteria: Procedure/service reviewed to ensure each service			
	Any Size Including Pediatric	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Calibrated Gradient Pressure	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Calibrated Gradient Pressure	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Pneumatic Compressor Half Arm	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Compressor Trunk	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Compressor Chest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		
20000	Pneumatic Compressor Full Leg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
	The analice compressor if an Eeg	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	MP Criteria: Procedure/service reviewed to ensure each service		
	Pneumatic Compressor Full Arm	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	
	Pneumatic Compressor Half Leg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Compressor Full Leg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Compressor Full Arm	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Compressor Half Leg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	-
	Compressor Integrated 2 Full Legs And Trunk	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
F0671	Cogmontal Cradient Processo Prosumatic Appliance Full Log	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	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
10072	Segmental Gradient Fressure Friedmatic Appliance Full Affil	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
1				
l		Policy criteria.	ļ	ļ

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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	_
	Inflation/Deflation Cycle For Arterial Insufficiency	to utilization review. Please see the Clinical Payment and			
	(Unilateral Or Bilateral System)	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
E0676	Intermittent Limb Compression Device (Includes All	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Accessories) Not Otherwise Specified	meets BCBSOK 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	1/1/2024	-	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
E0679	Non-Pneumatic Sequential Compression Garment Half Leg	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
E0680	Non-Pneumatic Compression Controller With Sequential	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
	Calibrated Gradient Pressure	Criteria. Submit for Recommended Clinical Review			01/01/2024
50001	New Description Companying Constralley Mitheast Calibrated	(Predetermination) to avoid post-service review.	1/1/2024		Add effective
E0681		MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	
	Gradient Pressure	Criteria. Submit for Recommended Clinical Review			01/01/2024
E0682	Non-Pneumatic Sequential Compression Garment Full Arm	(Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
20082	Non-Priedmatic Sequential Compression Garment Full Arm	Criteria. Submit for Recommended Clinical Review	1/1/2024	-	
					01/01/2024
E0691	Ultraviolet Light Therapy System Includes Bulbs/Lamps	(Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed to ensure each service			
20091	Timer And Eye Protection; Treatment Area 2 Square Feet Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Less	-			
	Less	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0692	Ultraviolet Light Therapy System Panel Includes	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20072	Bulbs/Lamps Timer And Eye Protection 4 Foot Panel	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	buids Lamps Timer And Eye Protection 4 Pool Pallel	submitting a Recommended Clinical Review (Predetermination)			
		с , , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

E0693	Ultraviolet Light Therapy System Panel Includes	MP Criteria: Procedure/service reviewed to ensure each service			
	Bulbs/Lamps Timer And Eye Protection 6 Foot Panel	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Cabinet Includes Bulbs/Lamps Timer And Eye Protection	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Two Lead Localized Stimulation	subject to utilization review.			
E0730	Transcutaneous Electrical Nerve Stimulation (Tens) Device	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Four Or More Leads For Multiple Nerve Stimulation	subject to utilization review.			
E0731	Form Fitting Conductive Garment For Delivery Of Tens Or	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Nmes (With Conductive Fibers Separated From The Patient'S	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Skin By Layers Of Fabric)	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	1/1/2024	5/14/2024	Retire effective
		Criteria. Submit for Recommended Clinical Review			05/14/2024
		(Predetermination) to avoid post-service review.			
E0732	Cranial Electrotherapy Stimulation (Ces) System Any Type	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
		to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
E0733	Transcutaneous Electrical Nerve Stimulator For Electrical	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	-	Add effective
	Stimulation Of The Trigeminal Nerve	Criteria. Submit for Recommended Clinical Review			01/01/2024
50724		(Predetermination) to avoid post-service review.	4 /4 /2024	F /4 A /202 A	
E0734	External Upper Limb Tremor Stimulator Of The Peripheral	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Nerves Of The Wrist	Criteria. Submit for Recommended Clinical Review			05/14/2024
E0734	Eutomol Linner Lineb Tremen Chinaulater Of The Device and	(Predetermination) to avoid post-service review.	F /1F /2024		Add effective
EU/34	External Upper Limb Tremor Stimulator Of The Peripheral	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	
	Nerves Of The Wrist	to pre-service review. Check EIU policy, which is one of our			05/15/2024
E0735	Non-Invasive Vagus Nerve Stimulator	Clinical Payment and Coding Policy (CPCP). MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
E0755	Non-invasive vagus Nerve stimulator	Criteria. Submit for Recommended Clinical Review	1/1/2024	-	01/01/2024
					01/01/2024
E0736	Transcutaneous Tibial Nerve Stimulator	(Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
10/30		Criteria. Submit for Recommended Clinical Review	7/ 1/ 2024	-	4/1/2024
		(Predetermination) to avoid post-service review.			4/1/2024
E0739	Rehab System With Interactive Interface Providing Active	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
20733	Assistance In Rehabilitation Therapy Includes All	Criteria. Submit for Recommended Clinical Review	7/ 1/ 2024	-	4/1/2024
	Components And Accessories Motors Microprocessors	(Predetermination) to avoid post-service review.			4/1/2024
		(Fredetermination) to avoid post-service review.			
	Sensors		ļ		

E0740	Non-Implanted Pelvic Floor Electrical Stimulator Complete	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	System	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			
E0747	Osteogenesis Stimulator Electrical Non-Invasive Other	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20747	Than Spinal Applications	meets BCBSOK 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-	MP Criteria: Procedure/service reviewed to ensure each service			
	Invasive	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	_
	Power Electromagnetic Energy Treatment Device	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50760		Policy criteria.			
E0762	Transcutaneous Electrical Joint Stimulation Device System	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Includes All Accessories	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
20704	Stimulation Of Sequential Muscle Groups Of Ambulation	to utilization review. Please see the Clinical Payment and	-	-	-
	With Computer Control Used For Walking By Spinal Cord	Coding Policy titled: Non-Reimbursable Experimental,			
	Injured Entire System After Completion Of Training	Investigational and/or Unproven Services (EIU).			
	Program	······································			
E0766	Electrical Stimulation Device Used For Cancer Treatment	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Includes All Accessories Any Type	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			ļ
E0769	5	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Device Not Otherwise Classified	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	Unlisted or Undefined: Procedure/service not otherwise			
	Of Nerve And/Or Muscle Groups Any Type Complete	defined or classified, and may be subject to benefit and/or	-	-	-
	System Not Otherwise Specified	clinical review.			
E0782	Infusion Pump Implantable Non-Programmable (Includes	MP Criteria: Procedure/service reviewed to ensure each service			
	All Components E. G. Pump Catheter Connectors Etc.)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	(Includes All Components E. G. Pump Catheter	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Connectors Etc.)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	With Implantable Infusion Pump Replacement	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	(Excludes Implantable Intraspinal Catheter)	meets BCBSOK 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	, , , ,	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Adjustment Using Therapeutic Continuous Glucose Sensing	meets BCBSOK 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,			
500.40		Investigational and/or Unproven Services (EIU).			
E0849	Traction Equipment Cervical Free-Standing Stand/Frame	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Pneumatic Applying Traction Force To Other Than Mandible				
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			

50050	Tradition Changel, Free Changeling, Constraint Tradition				
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,			
50055		Investigational and/or Unproven Services (EIU).			
E0855	Cervical Traction Equipment Not Requiring Additional Stand	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Or Frame	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
50056		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,			
50000	Tractice Conviewant Quardaan Convied	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,			
E0890	Traction Frame Attached To Footboard Pelvic Traction	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
20890			-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
E0920	Fracture Frame Attached To Bed Includes Weights	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
20920	Flacture Flame Attached To bed includes weights	meets BCBSOK 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			
20000	The the tree standing metades weights	meets BCBSOK 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 Lise On Knee	MP Criteria: Procedure/service reviewed to ensure each service			
20000	Only	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Than Knee	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)			
l		request if it is unclear if the service meets BCBSOK Medical			
1		Policy criteria.			

E0942	Cervical Head Harness/Halter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
20042	cervical field framessy france	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
E0944	Pelvic Belt/Harness/Boot	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
20344	reivic beit/flamess/boot	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
E0946	Fracture Frame Dual With Cross Bars Attached To Bed (E.	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
20040	G. Balken 4 Poster)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	G. Baikell 4 Postel)	submitting a Recommended Clinical Review (Predetermination)			
		, , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
E0947	Fracture Frame Attachments For Complex Pelvic Traction	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20347		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0948	Fracture Frame Attachments For Complex Cervical Traction	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20940			-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0950	Wheelcheir Accessory, Tray, Each	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
20950	Wheelchair Accessory Tray Each		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E0953	Wheelchair Accessory Lateral Thigh Or Knee Support Any	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E0953			-	-	-
	Type Including Fixed Mounting Hardware Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
F00F4	Wheelsheir Accessery Feet Day, Any Type Includes	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E0954	Wheelchair Accessory Foot Box Any Type Includes	· · ·	-	-	-
	Attachment And Mounting Hardware Each Foot	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
F00FF	Wheeleheir Accessory Hendreth Cushinged Arts Torre	Policy criteria.			
E0955	Wheelchair Accessory Headrest Cushioned Any Type	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Including Fixed Mounting Hardware Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
1		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		l	

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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Each	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Manual Wheelchair To Motorized Wheelchair Joystick	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Control	submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
E0984		MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Manual Wheelchair To Motorized Wheelchair Tiller Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Assist System	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Pair	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Assembly Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
1		Policy criteria.		

50000		MD Otherin December (see the state of the st			1
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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Without Shear Reduction	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	With Mechanical Shear Reduction	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	With Power Shear Reduction	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Tilt And Recline Without Shear Reduction	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Tilt And Recline With Mechanical Shear Reduction	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	_
	Tilt And Recline With Power Shear Reduction	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Mechanically Linked Leg Elevation System Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pushrod And Leg Rest Each	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

E1010	Wheelchair Accessory Addition To Dower Costing System	MB Critoria: Procedure/convice reviewed to ensure each earlier		F	
E1010	Wheelchair Accessory Addition To Power Seating System	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Power Leg Elevation System Including Leg Rest Pair	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54.04.2	Multi-selected and a second selection of the Decision Constraint Constraints	Policy criteria.			
E1012	Wheelchair Accessory Addition To Power Seating System	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	System Any Type Each	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54000		Policy criteria.			
E1028	Wheelchair Accessory Manual Swingaway Retractable Or	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Removable Mounting Hardware For Joystick Other Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Interface Or Positioning Accessory	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Greater	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	 _	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Including 300 Lbs	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	MP Criteria: Procedure/service reviewed to ensure each service	-	 _	-
	Integrated Seat Operated By Caregiver Patient Weight	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Capacity Greater Than 300 Lbs	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	And Including 300 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Capacity Greater Than 300 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
21050	Away Detachable Elevating Leg Rests	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Away Detachable Lievating Leg Nests	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Length Swing Away Detachable Elevating Legrests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Length) Swing Away Detachable Footrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Detachable Elevating Leg Rest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Arms Swing Away Detachable Elevating Leg Rests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Detachable Foot Rests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54000		Policy criteria.			
E1086	Hemi-Wheelchair Detachable Arms Desk Or Full Length	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Swing Away Detachable Footrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E1087	High Strength Lightweight Wheelchair Fixed Full Length	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
L100/			-	-	-
	Arms Swing Away Detachable Elevating Leg Rests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E1088	High Strength Lightweight Wheelchair Detachable Arms	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
-1000	Desk Or Full Length Swing Away Detachable Elevating Leg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Rests	submitting a Recommended Clinical Review (Predetermination)			
	110303	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		FUNCY CITCHIA.	1	P	

E1089	High Strength Lightweight Wheelchair Fixed Length Arms	MP Criteria: Procedure/service reviewed to ensure each service			
	Swing Away Detachable Footrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Desk Or Full Length Swing Away Detachable Foot Rests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Full Length) Swing Away Detachable Elevating Leg Rests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Length Arms Swing Away Detachable Footrests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Away Detachable Elevating Leg Rests	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Length) Elevating Leg Rest	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Away Detachable Footrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54440	Wheelsheits Detected Assoc Deck Or 5 Ill south Colina	Policy criteria.			
E1140	5 5	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Away Detachable Footrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E1150	Wheelchair Detachable Arms Deck Or Full Length Swing	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E1120	5 5		-	-	-
	Away Detachable Elevating Legrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		I	

E1160	Wheelchair Fixed Full Length Arms Swing Away Detachable	MP Criteria: Procedure/service reviewed to ensure each service			
	Elevating Legrests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Detachable Elevating Legrests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Footrests Or Legrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Length) Without Footrests Or Legrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	—	-	-
	Length) Swing Away Detachable Footrests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	—	-	-
	Length) Swing Away Detachable Elevating Legrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54405		Policy criteria.			
E1195		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Detachable Elevating Legrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
51200	Anna Maralakata Finada Bulanati Anna Cata A	Policy criteria.			
E1200	Amputee Wheelchair Fixed Full Length Arms Swing Away	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Detachable Footrest	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		Į	

E1220	Wheelchair; Specially Sized Or Constructed (Indicate Brand	MP Criteria: Procedure/service reviewed to ensure each service		
	Name Model Number If Any) And Justification	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Greater Than 15 Degrees But Less Than 80 Degrees) Each	meets BCBSOK 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	, , , ,	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Greater Than 80 Degrees) Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
54007		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		
F1220	Enocial Dock Llaight For Whasters:	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)		
l		request if it is unclear if the service meets BCBSOK Medical		
p		Policy criteria.		

E1229	Wheelchair Pediatric Size Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service			
	Wheelchair Pediatric Size Not Otherwise Specified		-	-	-
		meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Specify Brand Name And Model Number	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	With Seating System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	With Seating System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Without Seating System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Without Seating System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Seating System	meets BCBSOK Medical Policy criteria. BCBSOK recommends	[-	 -	-
	Seating System	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E1238	Wheelchair Pediatric Size Folding Adjustable Without	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
L1238	Seating System	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Seating System	submitting a Recommended Clinical Review (Predetermination)			
		, , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
E1239	Power Wheelchair Pediatric Size Not Otherwise Specified	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E1239	Power wheelchair Pediatric Size Not Otherwise Specified		-	-	-
		meets BCBSOK 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			
54040		clinical review.			
E1240	Lightweight Wheelchair Detachable Arms (Desk Or Full	MP Criteria: Procedure/service reviewed to ensure each service	° -	-	-
	Length) Swing Away Detachable Elevating Legrest	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54250	Links with Mathematics from the Ultraneth Association Association	Policy criteria.			
E1250		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Detachable Footrest	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
54000		Policy criteria.			
E1260	Lightweight Wheelchair Detachable Arms (Desk Or Full	MP Criteria: Procedure/service reviewed to ensure each service		-	-
	Length) Swing Away Detachable Footrest	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	² –	-	-
	Detachable Elevating Legrests	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	² –	-	-
	Length) Elevating Legrests	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

E1285	Heavy Duty Wheelchair Fixed Full Length Arms Swing Away	MP Criteria: Procedure/service reviewed to ensure each service			
	Detachable Footrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Length) Swing Away Detachable Footrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Legrest	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Construction	meets BCBSOK 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	1/1/2024	-	Add effective
		subject to utilization review.			01/01/2024
E1310	Whirlpool Non-Portable (Built-In Type)	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
54200	Describe Marilian Excitation of Million Research	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			
51620	Table Here distant Casters For The Dillette Distant Casters	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.	1	<u> </u>	

E1632	Wearable Artificial Kidney Each	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
E1052	Wearable Artificial Kulley Each		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
E1699	Dialysis Equipment Not Otherwise Specified	Investigational and/or Unproven Services (EIU). Unlisted or Undefined: Procedure/service not otherwise			
E1099	Dialysis Equipment Not Otherwise specified		-	-	-
		defined or classified, and may be subject to benefit and/or			
F1700	Inv. Matien Debekilitetian Custom	clinical review. EIU: Procedure/service not reimbursed by BCBSOK. Not subject		-	
E1700	Jaw Motion Rehabilitation System		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
54704		Investigational and/or Unproven Services (EIU).			
E1701	Replacement Cushions For Jaw Motion Rehabilitation	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	System Pkg. Of 6	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
54700		Investigational and/or Unproven Services (EIU).			
E1702	Replacement Measuring Scales For Jaw Motion	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Rehabilitation System Pkg. Of 200	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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	Alternative Communication Device	subject to utilization review.			
E1905	Virtual Reality Cognitive Behavioral Therapy Device (Cbt)	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Including Pre-Programmed Therapy Software	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Ear Endolymphatic Fluid	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Width Greater Than Or Equal To 20 Inches And Less Than 24	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Inches	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Width 24-27 Inches	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Depth 20 To Less Than 22 Inches	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
22204	Depth 22 To 25 Inches	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Depth 22 10 25 inches	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	MP Criteria: Procedure/service reviewed to ensure each service			
22200	Complete Replacement Only Each	meets BCBSOK 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			
22207	Wheelenan Accessory cruten And cane Holder Eden	meets BCBSOK 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			
22205		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Any Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Propulsion Tire Any Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Propulsion Tire (Removable) Any Type Any Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	L	
	Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	Ĺ	
	Tire Any Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Any Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Size Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Each	meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Propulsion Tire Any Size Replacement Only Each	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service _	_	-
	Tire (Removable) Any Size Replacement Only Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
52222		Policy criteria.		
E2222		MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Tire With Integrated Wheel Any Size Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Each	submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
52220	NALL STATE STATE AS A STATE AND A STATE AS	Policy criteria.		
E2228		MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Lock Complete Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
53330	Manual Wheelebeir Assessmy Manual Standing Custors	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)		
1		request if it is unclear if the service meets BCBSOK Medical		
l		Policy criteria.		

E2231	Manual Wheelchair Accessory Solid Seat Support Base	MP Criteria: Procedure/service reviewed to ensure each service			
	(Replaces Sling Seat) Includes Any Type Mounting Hardware		-	-	-
	(Replaces sing sear) includes Any Type Mounting nardware	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2291	Back Planar For Pediatric Size Wheelchair Including Fixed	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
	Attaching Hardware	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Attaching hardware	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Attaching Hardware	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
22233	Fixed Attaching Hardware	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2294	Seat Contoured For Pediatric Size Wheelchair Including	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
22234	Fixed Attaching Hardware	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
22233	Dynamic Seating Frame Allows Coordinated Movement Of	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Multiple Positioning Features	submitting a Recommended Clinical Review (Predetermination)			
	Multiple Positioning Leatures	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
E2298	Complex Rehabilitative Power Wheelchair Accessory Power	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effectuce
22230	Seat Elevation System Any Type	Criteria. Submit for Recommended Clinical Review	4/1/2024	-	04/01/2024
	Seat Lievation System Any Type	(Predetermination) to avoid post-service review.			04/01/2024
E2300	Wheelchair accessory, power seat elevation system, any	MP Criteria: Procedure/service reviewed to ensure each service		3/31/2024	Retire effective
22300	type	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	5/51/2024	03/31/2024
	type	submitting a Recommended Clinical Review (Predetermination)			03/31/2024
		request if it is unclear if the service meets BCBSOK Medical			
E2301	Wheelchair Accessory Power Standing System Any Type	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
22001	wheelchair Accessory Tower standing system Any Type	meets BCBSOK 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	Dower Wheelshair Accessory Electronic Connection	MB Criteria: Precedure/convice reviewed to ensure each convice			
E2310	Power Wheelchair Accessory Electronic Connection	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Between Wheelchair Controller And One Power Seating	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	System Motor Including All Related Electronics Indicator	submitting a Recommended Clinical Review (Predetermination)			
	Feature Mechanical Function Selection Switch And Fixed	request if it is unclear if the service meets BCBSOK Medical			
52244	Mounting Hardware	Policy criteria.			
E2311	Power Wheelchair Accessory Electronic Connection	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Between Wheelchair Controller And Two Or More Power	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Seating System Motors Including All Related Electronics	submitting a Recommended Clinical Review (Predetermination)			
	Indicator Feature Mechanical Function Selection Switch	request if it is unclear if the service meets BCBSOK Medical			
	And Fixed Mounting Hardware	Policy criteria.			
E2312	Power Wheelchair Accessory Hand Or Chin Control	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Interface Mini-Proportional	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	_
	Expandable Controller	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Remote Joystick Nonproportional Including All Related	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Electronics Mechanical Stop Switch And Fixed Mounting	submitting a Recommended Clinical Review (Predetermination)			
	Hardware	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
E2322	Power Wheelchair Accessory Hand Control Interface	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Multiple Mechanical Switches Nonproportional Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	All Related Electronics Mechanical Stop Switch And Fixed	submitting a Recommended Clinical Review (Predetermination)			
	Mounting Hardware	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
E2323	Power Wheelchair Accessory Specialty Joystick Handle For	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Hand Control Interface Prefabricated	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Interface	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Nonproportional Including All Related Electronics	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		
	Mechanical Stop Switch And Manual Swingaway Mounting	submitting a Recommended Clinical Review (Predetermination)			
	Hardware	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		1	

E2326	Power Wheelchair Accessory Breath Tube Kit For Sip And	MP Criteria: Procedure/service reviewed to ensure each service			
22320	Puff Interface	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
22027	Mechanical Proportional Including All Related Electronics	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Mechanical Direction Change Switch And Fixed Mounting	submitting a Recommended Clinical Review (Predetermination)			
	Hardware	request if it is unclear if the service meets BCBSOK Medical			
	Hurdware	Policy criteria.			
E2328	Power Wheelchair Accessory Head Control Or Extremity	MP Criteria: Procedure/service reviewed to ensure each service			
	Control Interface Electronic Proportional Including All	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Related Electronics And Fixed Mounting Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Contact Switch Mechanism Nonproportional Including All	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	–	_
	Related Electronics Mechanical Stop Switch Mechanical	submitting a Recommended Clinical Review (Predetermination)			
	Direction Change Switch Head Array And Fixed Mounting	request if it is unclear if the service meets BCBSOK Medical			
	Hardware	Policy criteria.			
E2330	Power Wheelchair Accessory Head Control Interface	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Proximity Switch Mechanism Nonproportional Including All	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Related Electronics Mechanical Stop Switch Mechanical	submitting a Recommended Clinical Review (Predetermination)			
	Direction Change Switch Head Array And Fixed Mounting	request if it is unclear if the service meets BCBSOK Medical			
	Hardware	Policy criteria.			
E2331	Power Wheelchair Accessory Attendant Control	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Proportional Including All Related Electronics And Fixed	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Mounting Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Width 20-23 Inches	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Width 24-27 Inches	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	
E2342	Power Wheelchair Accessory Nonstandard Seat Frame	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Depth 20 Or 21 Inches	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
EZ343	Depth 22-25 Inches		-	-	-
	Depth 22-25 inches	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2351	Dower Wheelsheir Accessory Flastronic Interface To	Policy criteria.		1	
E2351	Power Wheelchair Accessory Electronic Interface To	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Control Interface	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
52250	Device M/hoolehein Accesses Creve 24 New Cooled Lood	Policy criteria.			
E2358		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Acid Battery Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50050		Policy criteria.			
E2359	Power Wheelchair Accessory Group 34 Sealed Lead Acid	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Battery Each (E.G. Gel Cell Absorbed Glassmat)	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Battery Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
500.01		Policy criteria.			
E2361		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Each (E. G. Gel Cell Absorbed Glassmat)	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Acid Battery Each	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Battery Each (E. G. Gel Cell Absorbed Glassmat)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	
E2364	Power Wheelchair Accessory U-1 Non-Sealed Lead Acid	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Battery Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			[]
22303			-	-	-
	Each (E. G. Gel Cell Absorbed Glassmat)	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2366	Power Wheelchair Accessory Battery Charger Single Mode	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E2300			-	-	-
	For Use With Only One Battery Type Sealed Or Non-Sealed	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Each	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2367	Power Wheelchair Accessory Battery Charger Dual Mode	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		ł	
E2307			-	-	-
	For Use With Either Battery Type Sealed Or Non-Sealed	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Each	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2371	Power Wheelchair Accessory Group 27 Sealed Lead Acid	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		}	
22371			-	-	-
	Battery (E.G. Gel Cell Absorbed Glassmat) Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2372	Power Wheelchair Accessory Group 27 Non-Sealed Lead	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E2372			-	-	-
	Acid Battery Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2373	Power Wheelchair Accessory Hand Or Chin Control	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
22373	Interface Compact Remote Joystick Proportional Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
		<i>i</i>			
	Fixed Mounting Hardware	submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical			
E2374	Power Wheelchair Accessory Hand Or Chin Control	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		<u> </u>	
L2J/4	Interface Standard Remote Joystick (Not Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Controller) Proportional Including All Related Electronics	<i>i</i>			
	,	submitting a Recommended Clinical Review (Predetermination)			
	And Fixed Mounting Hardware Replacement Only	request if it is unclear if the service meets BCBSOK Medical			
E2375	Power Wheelchair Accessory Non-Expandable Controller	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
22373	Including All Related Electronics And Mounting Hardware	meets BCBSOK Medical Policy criteria. BCBSOK recommends	—	-	-
		<i>i</i>			
	Replacement Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2276	Dower Wheelshair Accessony Expandable Controller	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		<u> </u>	
E2376	Power Wheelchair Accessory Expandable Controller		-	-	-
	Including All Related Electronics And Mounting Hardware	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Replacement Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

E2377	Power Wheelchair Accessory Expandable Controller	MP Criteria: Procedure/service reviewed to ensure each service			
EZ3//	Power Wheelchair Accessory Expandable Controller		-	-	-
	Including All Related Electronics And Mounting Hardware	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Upgrade Provided At Initial Issue	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
53307		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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Stationary Or Portable	meets BCBSOK 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-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Recorded Messages Less Than Or Equal To 8 Minutes	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Recording Time	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-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Recorded Messages Greater Than 8 Minutes But Less Than	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Or Equal To 20 Minutes Recording Time	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-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Recorded Messages Greater Than 20 Minutes But Less Than	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Or Equal To 40 Minutes Recording Time	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-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Recorded Messages Greater Than 40 Minutes Recording	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Time	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Message Formulation By Spelling And Access By Physical	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Contact With The Device	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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Multiple Methods Of Message Formulation And Multiple	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Methods Of Device Access	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Computer Or Personal Digital Assistant	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Computer of Personal Digital Assistant	· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2512	Accessory For Speech Generating Device Mounting System	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
22312	Accessory For Speech Generating Device Woulding System		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2599	Accessory For Speech Generating Device Not Otherwise	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		1	
E2599		· ·	-	-	-
	Classified	meets BCBSOK 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			
59.699		clinical review.			
E2602	General Use Wheelchair Seat Cushion Width 22 Inches Or	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Greater Any Depth	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
52602		Policy criteria.			
E2603	Skin Protection Wheelchair Seat Cushion Width Less Than	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	22 Inches Any Depth	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50004		Policy criteria.		l	
E2604	Skin Protection Wheelchair Seat Cushion Width 22 Inches	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Or Greater Any Depth	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
50.005		Policy criteria.			
E2605	Positioning Wheelchair Seat Cushion Width Less Than 22	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Inches Any Depth	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
53535		Policy criteria.			
E2606	Positioning Wheelchair Seat Cushion Width 22 Inches Or	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Greater Any Depth	meets BCBSOK 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 Wheelshair Seat Cushian	MP Critoria: Procedure/convice reviewed to ensure each convice			
E2007	Skin Protection And Positioning Wheelchair Seat Cushion	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Width Less Than 22 Inches Any Depth	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Width 22 Inches Or Greater Any Depth	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Inches Any Height Including Any Type Mounting Hardware	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Greater Any Height Including Any Type Mounting Hardware	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Than 22 Inches Any Height Including Any Type Mounting	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Inches Or Greater Any Height Including Any Type Mounting	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Width Less Than 22 Inches Any Height Including Any Type	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Mounting Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Width 22 Inches Or Greater Any Height Including Any Type	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Mounting Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Including Any Type Mounting Hardware	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Lateral Supports Width Less Than 22 Inches Any Height	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including Any Type Mounting Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Lateral Supports Width 22 Inches Or Greater Any Height	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including Any Type Mounting Hardware	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Less Than 22 Inches Any Depth	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
52622		Policy criteria.			
E2623		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	22 Inches Or Greater Any Depth	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
22024	Adjustable Width Less Than 22 Inches Any Depth	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Aujustable Width Less than 22 milles Any Depth	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Adjustable Width 22 Inches Or Greater Any Depth	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Attached To Wheelchair Balanced Adjustable	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
22027	Attached To Wheelchair Balanced Adjustable Rancho Type	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Attached to wheelchair balanced Aujustable Kancho Type	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	MP Criteria: Procedure/service reviewed to ensure each service			
22020	Attached To Wheelchair Balanced Reclining	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Attached to wheelenan balanced heelining	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	MP Criteria: Procedure/service reviewed to ensure each service			
22025	Attached To Wheelchair Balanced Friction Arm Support	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
	(Friction Dampening To Proximal And Distal Joints)				
		request if it is unclear if the service meets BCBSOK Medical			
E2630	Wheelchair Accessory Shoulder Elbow Mobile Arm Support	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
L2030	Monosuspension Arm And Hand Support Overhead Elbow	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		<i>i</i>			
	Forearm Hand Sing Support Toke Type Suspension Support	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2631	Wheelchair Accessory Addition To Mobile Arm Support	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
22031			-	-	-
	Elevating Proximal Arm	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2632	Wheelchair Accessory Addition To Mobile Arm Support	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
E2032	,		-	-	-
	Offset Or Lateral Rocker Arm With Elastic Balance Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
E2633	Wheelcheir Accessory, Addition To Mehilo Arm Support	Policy criteria.			
E2033	Wheelchair Accessory Addition To Mobile Arm Support	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Supinator	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
52000	Creath Malure Madulation Custom Any Type Industing All	Policy criteria.	1/1/2024	5/14/2024	Dating offersting
E3000	Speech Volume Modulation System Any Type Including All	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	5/14/2024	Retire effective
	Components And Accessories	Criteria. Submit for Recommended Clinical Review			05/14/2024
E3000	Speech Volume Modulation System Any Type Industries All	(Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024		Add effective
E3000	Speech Volume Modulation System Any Type Including All		5/15/2024	-	
	Components And Accessories	to pre-service review. Check EIU policy, which is one of our			05/15/2024
G0127	Trimming Of Dystrophic Noils, Any Number	Clinical Payment and Coding Policy (CPCP).			
00127	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	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effective
	Provider/Supplier Acquisition And Clinical Supervision Of	Criteria. Submit for Recommended Clinical Review	, , -	-	4/1/2024
	Oral Administration Of Miglustat In Preparation Of Receipt	(Predetermination) to avoid post-service review.			., _,
	Of Cipaglucosidase Alfa-Atga	······································			
G0151	Services Performed By A Qualified Physical Therapist In The	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Home Health Or Hospice Setting Each 15 Minutes	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	The Home Health Or Hospice Setting Each 15 Minutes	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Pathologist In The Home Health Or Hospice Setting Each 15	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Minutes	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Assistant In The Home Health Or Hospice Setting Each 15	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Minutes	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Assistant In The Home Health Or Hospice Setting Each 15	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Minutes	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
G0159		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Home Health Setting In The Establishment Or Delivery Of A	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Safe And Effective Physical Therapy Maintenance Program	submitting a Recommended Clinical Review (Predetermination)			
	Each 15 Minutes	request if it is unclear if the service meets BCBSOK Medical			
00100		Policy criteria.			
G0160		MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	The Home Health Setting In The Establishment Or Delivery	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Of A Safe And Effective Occupational Therapy Maintenance	submitting a Recommended Clinical Review (Predetermination)			
	Program Each 15 Minutes	request if it is unclear if the service meets BCBSOK Medical			
<u>co1c1</u>		Policy criteria.			
G0161	Services Performed By A Qualified Speech-Language	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Pathologist In The Home Health Setting In The	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Establishment Or Delivery Of A Safe And Effective Speech-	submitting a Recommended Clinical Review (Predetermination)			
	Language Pathology Maintenance Program Each 15	request if it is unclear if the service meets BCBSOK Medical			
	Minutes	Policy criteria.		ļ	

G0166	External Counternulsation Der Treatment Servier	MB Critoria: Procedure/convice reviewed to ensure as the service			1 1
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			
G0176	Activity Therapy Such As Music Dance Art Or Play	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
00170	Therapies Not For Recreation Related To The Care And	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
	Treatment Of Patient'S Disabling Mental Health Problems	submitting a Recommended Clinical Review (Predetermination)			
	Per Session (45 Minutes Or More)	request if it is unclear if the service meets BCBSOK Medical			
G0177	Training And Educational Services Related To The Care And	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
00177	Treatment Of Patient'S Disabling Mental Health Problems	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
	Per Session (45 Minutes Or More)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
G0235	Pet Imaging Any Site Not Otherwise Specified	Policy criteria. Unlisted Procedure; May require Prior Authorization per			
00255	Pet imaging Any site Not Otherwise specified	contract agreement.	-	-	-
G0255	Current Perception Threshold/Sensory Nerve Conduction	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
00233	Test (Snct) Per Limb Any Nerve	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
60270	Image-Guided Lumbar Decompression (Pild) Or Placebo-	subject to utilization review.	-	-	-
	Control Performed In An Approved Coverage With				
	Evidence Development (Ced) Clinical Trial				
G0281	Electrical Stimulation (Unattended) To One Or More Areas	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	For Chronic Stage Iii And Stage Iv Pressure Ulcers Arterial	to utilization review. Please see the Clinical Payment and	-	-	-
	Ulcers Diabetic Ulcers And Venous Statsis Ulcers Not	Coding Policy titled: Non-Reimbursable Experimental,			
	Demonstrating Measurable Signs Of Healing After 30 Days	Investigational and/or Unproven Services (EIU).			
	Of Conventional Care As Part Of A Therapy Plan Of Care				
G0282	Electrical Stimulation (Unattended) To One Or More Areas	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	For Wound Care Other Than Described In G0281	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	For Indication(S) Other Than Wound Care As Part Of A	subject to utilization review.			
	Therapy Plan Of Care				
G0293	Noncovered Surgical Procedure(S) Using Conscious Sedation	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Regional General Or Spinal Anesthesia In A Medicare	subject to utilization review.			
	Qualifying Clinical Trial Per Day				
G0294	Noncovered Procedure(S) Using Either No Anesthesia Or	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Local Anesthesia Only In A Medicare Qualifying Clinical Trial	subject to utilization review.			
	Per Day				

G0295	Electromagnetic Therapy To One Or More Areas For	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
G0295	Wound Care Other Than Described In G0329 Or For Other	to utilization review. Please see the Clinical Payment and	-	-	-
	Uses	Coding Policy titled: Non-Reimbursable Experimental,			
	Uses	Investigational and/or Unproven Services (EIU).			
G0302	Pre-Operative Pulmonary Surgery Services For Preparation	MP Criteria: Procedure/service reviewed to ensure each service			
00002	For Lyrs Complete Course Of Services To Include A	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Minimum Of 16 Days Of Services	submitting a Recommended Clinical Review (Predetermination)			
	Within of 10 Days of Schrees	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
G0303	Pre-Operative Pulmonary Surgery Services For Preparation	MP Criteria: Procedure/service reviewed to ensure each service			
	For Lvrs 10 To 15 Days Of Services	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	For Lvrs 1 To 9 Days Of Services	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Minimum Of 6 Days Of Services	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Health Care Professional When The Vaccine(S) Is Not	subject to utilization review.			
	Administered On The Same Date Of Service 5 To 15 Mins				
	Time (This Code Is Used For Medicaid Billing Purposes)				
G0311	Immunization Counseling By A Physician Or Other Qualified	Non Covered: Procedure/service not covered by BCBSOK. Not			
00311	Health Care Professional When The Vaccine(S) Is Not	subject to utilization review.	-	-	-
	Administered On The Same Date Of Service 16-30 Mins	subject to utilization review.			
	Time (This Code Is Used For Medicaid Billing Purposes)				
G0312	Immunization Counseling By A Physician Or Other Qualify	Non Covered: Procedure/service not covered by BCBSOK. Not	_		_
	Ed Health Care Professional When The Vaccine(S) Is Not	subject to utilization review.			
	Administered On The Same Date Of Service For Ages Under				
	21 5 To 15 Mins Time (This Code Is Used For Medicaid				
	Billing Purposes)				
G0313	Immunization Counseling By A Physician Or Other Qualified	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Health Care Professional When The Vaccine(S) Is Not	subject to utilization review.			
	Administered On The Same Date Of Service For Ages Under				
	21 16-30 Mins Time (This Code Is Used For Medicaid Billing				
	Purposes)				

G0314 G0315	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) Immunization Counseling By A Physician Or Other Qualified	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
G0316		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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	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)	subject to utilization review.			-
G0329	Electromagnetic Therapy To One Or More Areas For Chronic Stage lii 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	MP Criteria: Procedure/service reviewed to ensure each service	1		
60422	· ·		-	-	-
	Continuous Ecg Monitoring With Exercise Per Session	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
G0423	Intensive Cardiac Rehabilitation; With Or Without	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
00423		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Continuous Ecg Monitoring; Without Exercise Per Session	· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
G0428	Collagen Meniscus Implant Procedure For Filling Meniscal	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
00428	Defects (E.G. Cmi Collagen Scaffold Menaflex)	to utilization review. Please see the Clinical Payment and	-	-	-
	Defects (E.G. Chill Collagen Scarloid Menalex)	Coding Policy titled: Non-Reimbursable Experimental,			
G0429	Dermal Filler Injection(S) For The Treatment Of Facial	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
00425	Lipodystrophy Syndrome (Lds) (E.G. As A Result Of Highly	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Active Antiretroviral Therapy.)	submitting a Recommended Clinical Review (Predetermination)			
	Active Antifetroviral Therapy.)	, , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
G0448	Insertion Or Replacement Of A Permanent Pacing	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
00448	Cardioverter-Defibrillator System With Transvenous Lead(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Single Or Dual Chamber With Insertion Of Pacing Electrode	submitting a Recommended Clinical Review (Predetermination)			
	0 0	request if it is unclear if the service meets BCBSOK Medical			
	Cardiac Venous System For Left Ventricular Pacing	Policy criteria.			
G0455	Preparation With Instillation Of Fecal Microbiota By Any	MP Criteria: Procedure/service reviewed to ensure each service			
00433	Method Including Assessment Of Donor Specimen	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Method including Assessment of Donor Speciment	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Product For Non-Diabetic Chronic Wounds/Ulcers Including		-	-	-
	As Applicable Phlebotomy Centrifugation Or Mixing And All				
	Other Preparatory Procedures Administration And	Investigational and/or Unproven Services (EIU).			
	Dressings Per Treatment				
G0465	Autologous Platelet Rich Plasma (Prp) Or Other Blood-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Derived Product For Diabetic Chronic Wounds/Ulcers Using		-	-	-
	An Fda-Cleared Device For This Indication (Includes As	Coding Policy titled: Non-Reimbursable Experimental,			
	Applicable Administration Dressings Phlebotomy	Investigational and/or Unproven Services (EIU).			
	Centrifugation Or Mixing And All Other Preparatory	().			
	Procedures Per Treatment)				
G0516		MP Criteria: Procedure/service reviewed to ensure each service			
	More (Services For Subdermal Rod Implant)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
0001/	More (Services For Subdermal Implants)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Implants 4 Or More (Services For Subdermal Implants)	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Structured Assessment (E.G. Audit Dast) And Brief	subject to utilization review.			
	Intervention 5-14 Minutes				
G2082	Office Or Other Outpatient Visit For The Evaluation And	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Management Of An Established Patient That Requires The	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Supervision Of A Physician Or Other Qualified Health Care	submitting a Recommended Clinical Review (Predetermination)			
	Professional And Provision Of Up To 56 Mg Of Esketamine	request if it is unclear if the service meets BCBSOK Medical			
	Nasal Self-Administration Includes 2 Hours Post-	Policy criteria.			
	Administration Observation				
G2083	Office Or Other Outpatient Visit For The Evaluation And	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Management Of An Established Patient That Requires The	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Supervision Of A Physician Or Other Qualified Health Care	submitting a Recommended Clinical Review (Predetermination)			
	Professional And Provision Of Greater Than 56 Mg	request if it is unclear if the service meets BCBSOK Medical			
	Esketamine Nasal Self-Administration Includes 2 Hours Post-	Policy criteria.			
G3002	Administration Observation Chronic Pain Management And Treatment Monthly Bundle	Non Covered: Procedure/service not covered by BCBSOK. Not			
05002	Including Diagnosis; Assessment And Monitoring;	subject to utilization review.	-	-	-
	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.)				
	G3002 30 Minutes Must Be Met Or Exceeded.)				

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	Non Covered: Procedure/service not covered by BCBSOK. Not subject to utilization review.	-	-	-
	Addition To Code For G3002. When Using G3003 15				
	C C				
G8395	Minutes Must Be Met Or Exceeded.) Left Ventricular Ejection Fraction (Lvef) >= 40% Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
08333	Documentation As Normal Or	subject to utilization review.	-	-	-
G8396	Left Ventricular Ejection Fraction (Lvef) Not Performed Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
08550	Documented	subject to utilization review.	-	-	-
G8397	Dilated Macular Or Fundus Exam Performed Including	Non Covered: Procedure/service not covered by BCBSOK. Not			
08337	Documentation Of The	subject to utilization review.	-	-	-
G8399	Patient With Documented Results Of A Central Dual-Energy	Non Covered: Procedure/service not covered by BCBSOK. Not			
00000	X-Ray Absorptiometry (Dxa) Ever Being Performed	subject to utilization review.	-	-	-
G8400	Patient With Central Dual-Energy X-Ray Absorptiometry	Non Covered: Procedure/service not covered by BCBSOK. Not			
08400	(Dxa) Results Not Documented Reason Not Given	subject to utilization review.	-	-	-
G8404	Lower Extremity Neurological Exam Performed And	Non Covered: Procedure/service not covered by BCBSOK. Not			
00404	Documented	subject to utilization review.	-	-	-
G8405	Lower Extremity Neurological Exam Not Performed	Non Covered: Procedure/service not covered by BCBSOK. Not			
08403	Lower Extremity Neurological Exam Not Performed	subject to utilization review.	-	-	-
G8410	Footwear Evaluation Performed And Documented	Non Covered: Procedure/service not covered by BCBSOK. Not			
08410	Tootwear Evaluation Ferrormed And Documented	subject to utilization review.	-	-	-
G8415	Footwear Evaluation Was Not Performed	Non Covered: Procedure/service not covered by BCBSOK. Not			
00413	rootwear Evaluation was not renormed	subject to utilization review.	-	-	-
G8416	Clinician Documented That Patient Was Not An Eligible	Non Covered: Procedure/service not covered by BCBSOK. Not			
00410	Candidate For Footwear	subject to utilization review.	-	-	-
G8417		Non Covered: Procedure/service not covered by BCBSOK. Not			
00117	Up Plan Is Documented	subject to utilization review.	-	-	-
G8418		Non Covered: Procedure/service not covered by BCBSOK. Not			
00.120	Up Plan Is Documented	subject to utilization review.	-	-	-
G8419		Non Covered: Procedure/service not covered by BCBSOK. Not			
00.120	Plan Documented No Reason Given	subject to utilization review.	-	-	-
G8420	Bmi Is Documented Within Normal Parameters And No	Non Covered: Procedure/service not covered by BCBSOK. Not			
00.20	Follow-Up Plan Is Required	subject to utilization review.	-	-	-
G8421	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by BCBSOK. Not			
00.111		subject to utilization review.	-	-	-
G8427	Eligible Clinician Attests To Documenting In The Medical	Non Covered: Procedure/service not covered by BCBSOK. Not			
00.127		subject to utilization review.	-	-	-
	Current Medications				
G8428	Current List Of Medications Not Documented As Obtained	Non Covered: Procedure/service not covered by BCBSOK. Not			
		subject to utilization review.	-	-	-
	Given				
G8430	Documentation Of A Medical Reason(S) For Not	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Documenting Updating Or Reviewing The Patient'S Current		-	-	-
	Medications List (E.G. Patient Is In An Urgent Or Emergent				
	Medical Situation)				
G8431	Screening For Depression Is Documented As Being Positive	Non Covered: Procedure/service not covered by BCBSOK. Not			
	And A Follow-Up Plan Is Documented	subject to utilization review.	-	-	_

C0422	Description Conservation Net Description Description	New Coursed, Dreading / or instanting and an and he DCDCOV. Not			
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	Non Covered: Procedure/service not covered by BCBSOK. Not			
00100	Patient Or Medical Reason	subject to utilization review.	-	-	-
G8450	Beta-Blocker Therapy Prescribed	Non Covered: Procedure/service not covered by BCBSOK. Not		1	
	···· ··· · ··· · ···	subject to utilization review.	-	-	_
G8451	Beta-Blocker Therapy For Lvef <=40% Not Prescribed For	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Reasons Documented By The Clinician (E.G. Low Blood	subject to utilization review.	-	-	-
	Pressure Fluid Overload Asthma Patients Recently Treated	· · · · · · · · · · · · · · · · · · ·			
	With An Intravenous Positive Inotropic Agent Allergy				
	Intolerance Other Medical Reasons Patient Declined Other				
	Patient Reasons)				
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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Angiotensin Receptor Blocker	subject to utilization review.			
G8474	Angiotensin Converting Enzyme (Ace) Inhibitor Or	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed	subject to utilization review.			
	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)				
G8475	Angiotensin Converting Enzyme (Ace) Inhibitor Or	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Angiotensin Receptor Blocker (Arb) Therapy Not Prescribed	subject to utilization review.			
	Reason Not Given				
G8476	Most Recent Blood Pressure Has A Systolic Measurement Of	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	< 140 Mmhg And A Diastolic Measurement Of < 90 Mmhg	subject to utilization review.			
G8477	Most Recent Blood Pressure Has A Systolic Measurement Of	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	>=140 Mmhg And/Or A Diastolic Measurement Of >=90	subject to utilization review.			
	Mmhg				
G8478	Blood Pressure Measurement Not Performed Or	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	_
	Documented Reason Not Given	subject to utilization review.			
G8482	Influenza Immunization Administered Or Previously	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
00.100	Received	subject to utilization review.			
G8483		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Documented By Clinician (E.G. Patient Allergy Or Other	subject to utilization review.			
	Medical Reasons Patient Declined Or Other Patient Reasons				
	Vaccine Not Available Or Other System Reasons)				
G8484	Influenza Immunization Was Not Administered Reason Not	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Given	subject to utilization review.			

G9012	Other Specified Case Management Service Not Elsewhere	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Classified	defined or classified, and may be subject to benefit and/or			
		clinical review.			
G9050		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Staging At The Time Of Cancer Diagnosis Or Recurrence (For	subject to utilization review.			
	Use In A Medicare-Approved Demonstration Project)				
G9051	Oncology; Primary Focus Of Visit; Treatment Decision-	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Making After Disease Is Staged Or Restaged Discussion Of	subject to utilization review.			
	Treatment Options Supervising/Coordinating Active Cancer				
	Directed Therapy Or Managing Consequences Of Cancer				
	Directed Therapy (For Use In A Medicare-Approved				
	Demonstration Project)				
G9052	Oncology; Primary Focus Of Visit; Surveillance For Disease	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Recurrence For Patient Who Has Completed Definitive	subject to utilization review.			
	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)				
G9053		Non Covered: Procedure/service not covered by BCBSOK. Not	_		_
	Patient With Evidence Of Cancer For Whom No Cancer	subject to utilization review.			
	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)				
G9054	Oncology; Primary Focus Of Visit; Supervising Coordinating	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Or Managing Care Of Patient With Terminal Cancer Or For	subject to utilization review.			
	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)				
G9055	Oncology; Primary Focus Of Visit; Other Unspecified Service	Non Covered: Procedure/service not covered by the Plan. Not	_	_	_
	Not Otherwise Listed (For Use In A Medicare-Approved	subject to utilization review.			
	Demonstration Project)	Unlisted or Undefined			
G9056	Oncology; Practice Guidelines; Management Adheres To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Guidelines (For Use In A Medicare-Approved Demonstration	subject to utilization review.			
	Project)				
G9057	Oncology; Practice Guidelines; Management Differs From	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	_
	Guidelines As A Result Of Patient Enrollment In An	subject to utilization review.			
	Institutional Review Board Approved Clinical Trial (For Use In				
	A Medicare-Approved Demonstration Project)				
G9058	Oncology; Practice Guidelines; Management Differs From	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Guidelines Because The Treating Physician Disagrees With	subject to utilization review.			
	Guideline Recommendations (For Use In A Medicare-				
	Approved Demonstration Project)				

G9059	Oncology; Practice Guidelines; Management Differs From	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Guidelines Because The Patient After Being Offered	subject to utilization review.			
	Treatment Consistent With Guidelines Has Opted For				
	Alternative Treatment Or Management Including No				
	Treatment (For Use In A Medicare-Approved Demonstration				
	Proiect)				
G9060	Oncology; Practice Guidelines; Management Differs From	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Guidelines For Reason(S) Associated With Patient Comorbid	subject to utilization review.			
	Illness Or Performance Status Not Factored Into Guidelines				
	(For Use In A Medicare-Approved Demonstration Project)				
G9061	Oncology; Practice Guidelines; Patient'S Condition Not	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Addressed By Available Guidelines (For Use In A Medicare-	subject to utilization review.			
	Approved Demonstration Project)				
G9062	Oncology; Practice Guidelines; Management Differs From	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Guidelines For Other Reason(S) Not Listed (For Use In A	subject to utilization review.			
	Medicare-Approved Demonstration Project)				
G9063	Oncology; Disease Status; Limited To Non-Small Cell Lung	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer; Extent Of Disease Initially Established As Stage I	subject to utilization review.			
	(Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of				
	Disease Progression Recurrence Or Metastases (For Use In				
	A Medicare-Approved Demonstration Project)				
G9064	Oncology; Disease Status; Limited To Non-Small Cell Lung	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancer; Extent Of Disease Initially Established As Stage li	subject to utilization review.			
	(Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of	,			
	Disease Progression Recurrence Or Metastases (For Use In				
	A Medicare-Approved Demonstration Project)				
G9065	Oncology; Disease Status; Limited To Non-Small Cell Lung	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancer; Extent Of Disease Initially Established As Stage Iii A	subject to utilization review.			
	(Prior To Neo-Adjuvant Therapy If Any) With No Evidence Of	,			
	Disease Progression Recurrence Or Metastases (For Use In				
	A Medicare-Approved Demonstration Project)				
G9066	Oncology; Disease Status; Limited To Non-Small Cell Lung	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer; Stage lii B- Iv At Diagnosis Metastatic Locally	subject to utilization review.			
	Recurrent Or Progressive (For Use In A Medicare-Approved				
	Demonstration Project)				
G9067	Oncology; Disease Status; Limited To Non-Small Cell Lung	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer; Extent Of Disease Unknown Staging In Progress Or	subject to utilization review.			
	Not Listed (For Use In A Medicare-Approved Demonstration				
	Project)				
G9068	Oncology; Disease Status; Limited To Small Cell And	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Combined Small Cell/Non-Small Cell; Extent Of Disease	subject to utilization review.			
	Initially Established As Limited With No Evidence Of Disease				
	Progression Recurrence Or Metastases (For Use In A				
	Medicare-Approved Demonstration Project)				

G9069	Oncology: Discosso Status: Small Coll Lung Concor, Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
G9009			-	-	-
	Small Cell And Combined Small Cell/Non-Small Cell;	subject to utilization review.			
	Extensive Stage At Diagnosis Metastatic Locally Recurrent				
	Or Progressive (For Use In A Medicare-Approved				
G9070	Demonstration Project) Opcology: Disease Status: Small Cell Lung Cancer, Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
05070	Small Cell And Combined Small Cell/Non-Small; Extent Of	subject to utilization review.	-	-	-
	Disease Unknown Staging In Progress Or Not Listed (For	subject to utilization review.			
	Use In A Medicare-Approved Demonstration Project)				
G9071	Oncology; Disease Status; Invasive Female Breast Cancer	Non Covered: Procedure/service not covered by BCBSOK. Not			
05071	(Does Not Include Ductal Carcinoma In Situ);	subject to utilization review.	-	-	-
	Adenocarcinoma As Predominant Cell Type; Stage I Or Stage				
	lia-lib; 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)				
	(101 Ose in A Medicale-Approved Demonstration Project)				
G9072	Oncology; Disease Status; Invasive Female Breast Cancer	Non Covered: Procedure/service not covered by BCBSOK. Not		_	_
	(Does Not Include Ductal Carcinoma In Situ);	subject to utilization review.			
	Adenocarcinoma As Predominant Cell Type; Stage I Or				
	Stage lia-lib; 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)				
G9073	Oncology; Disease Status; Invasive Female Breast Cancer	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	(Does Not Include Ductal Carcinoma In Situ);	subject to utilization review.			
	Adenocarcinoma As Predominant Cell Type; Stage liia-liib;				
	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)				
60074		No. Consideration (as the set of the DCDCOV, Not			
G9074	Oncology; Disease Status; Invasive Female Breast Cancer	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	(Does Not Include Ductal Carcinoma In Situ);	subject to utilization review.			
	Adenocarcinoma As Predominant Cell Type; Stage liia-liib;				
	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)				
G9075	Oncology; Disease Status; Invasive Female Breast Cancer	Non Covered: Procedure/service not covered by BCBSOK. Not			
	(Does Not Include Ductal Carcinoma In Situ);	subject to utilization review.	_	_	
	Adenocarcinoma As Predominant Cell Type; M1 At Diagnosis				
	Metastatic Locally Recurrent Or Progressive (For Use In A				
	Medicare-Approved Demonstration Project)				

9077	Oncelegy Disease Status Prostate Concern Limited T	Non Covered, Breedure (convict and even day DCDCOV) Not			
1077	Oncology; Disease Status; Prostate Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Adenocarcinoma As Predominant Cell Type; T1-T2C And	subject to utilization review.			
	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)				
9078	Oncology; Disease Status; Prostate Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Adenocarcinoma As Predominant Cell Type; T2 Or T3A	subject to utilization review.			
	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)				
9079	Oncology; Disease Status; Prostate Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	
	Adenocarcinoma As Predominant Cell Type; T3B-T4 Any N;	subject to utilization review.			
	Any T N1 At Diagnosis With No Evidence Of Disease				
	Progression Recurrence Or Metastases (For Use In A				
	Medicare-Approved Demonstration Project)				
9080	Oncology; Disease Status; Prostate Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	
	Adenocarcinoma; After Initial Treatment With Rising Psa Or	subject to utilization review.			
	Failure Of Psa Decline (For Use In A Medicare-Approved				
	Demonstration Project)				
9083	Oncology; Disease Status; Prostate Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	
	Adenocarcinoma; Extent Of Disease Unknown Staging In	subject to utilization review.			
	Progress Or Not Listed (For Use In A Medicare-Approved				
	Demonstration Project)				
9084	Oncology; Disease Status; Colon Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.			
	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)				
9085	Oncology; Disease Status; Colon Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.			
	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)				
9086	Oncology; Disease Status; Colon Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.			
	Of Disease Initially Established As T1-4 N1-2 M0 With No				
	-				
	(in ose in A weater Approved benotstration Hoject)				
	Of Disease Initially Established As 11-4 N1-2 MU With No Evidence Of Disease Progression Recurrence Or Metastases (For Use In A Medicare-Approved Demonstration Project)				

C0007					
G9087		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Cancer Adenocarcinoma As Predominant Cell Type; M1 At	subject to utilization review.			
	Diagnosis Metastatic Locally Recurrent Or Progressive With				
	Current Clinical Radiologic Or Biochemical Evidence Of				
	Disease (For Use In A Medicare-Approved Demonstration				
	Project)				
G9088	Oncology; Disease Status; Colon Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer Adenocarcinoma As Predominant Cell Type; M1 At	subject to utilization review.			
	Diagnosis Metastatic Locally Recurrent Or Progressive				
	Without Current Clinical Radiologic Or Biochemical				
	Evidence Of Disease (For Use In A Medicare-Approved				
	Demonstration Project)				
G9089	Oncology; Disease Status; Colon Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.			
	Of Disease Unknown Staging In Progress Or Not Listed (For				
	Use In A Medicare-Approved Demonstration Project)				
G9090	Oncology; Disease Status; Rectal Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.	-	_	-
	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)				
	Medicale Approved Demonstration Projecty				
G9091	Oncology; Disease Status; Rectal Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.	-	-	-
	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				
	с , , , , , , , , , , , , , , , , , , ,				
	Medicare-Approved Demonstration Project)				
G9092	Oncology; Disease Status; Rectal Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not			
05052	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.	-	-	-
	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)				
G9093	Oncology; Disease Status; Rectal Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.	-	-	-
	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)				

G9094	Oncology; Disease Status; Rectal Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer Adenocarcinoma As Predominant Cell Type; M1 At	subject to utilization review.			
	Diagnosis Metastatic Locally Recurrent Or Progressive (For				
	Use In A Medicare-Approved Demonstration Project)				
G9095	Oncology; Disease Status; Rectal Cancer Limited To Invasive	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Cancer Adenocarcinoma As Predominant Cell Type; Extent	subject to utilization review.			
	Of Disease Unknown Staging In Progress Or Not Listed (For				
	Use In A Medicare-Approved Demonstration Project)				
G9096	Oncology; Disease Status; Esophageal Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Adenocarcinoma Or Squamous Cell Carcinoma As	subject to utilization review.			
	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-				
00007	Approved Demonstration Project)				
G9097	Oncology; Disease Status; Esophageal Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Adenocarcinoma Or Squamous Cell Carcinoma As	subject to utilization review.			
	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)				
G9098	Oncology; Disease Status; Esophageal Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Adenocarcinoma Or Squamous Cell Carcinoma As	subject to utilization review.	-	-	-
	Predominant Cell Type; M1 At Diagnosis Metastatic Locally				
	Recurrent Or Progressive (For Use In A Medicare-Approved				
	Demonstration Project)				
G9099	Oncology; Disease Status; Esophageal Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Adenocarcinoma Or Squamous Cell Carcinoma As	subject to utilization review.			
	Predominant Cell Type; Extent Of Disease Unknown Staging				
	In Progress Or Not Listed (For Use In A Medicare-Approved				
	Demonstration Project)				
G9100	Oncology; Disease Status; Gastric Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Adenocarcinoma As Predominant Cell Type; Post R0	subject to utilization review.			
	Resection (With Or Without Neoadjuvant Therapy) With No				
	Evidence Of Disease Recurrence Progression Or Metastases				
	(For Use In A Medicare-Approved Demonstration Project)				
G9101	Oncology; Disease Status; Gastric Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	_
	Adenocarcinoma As Predominant Cell Type; Post R1 Or R2	subject to utilization review.			
	Resection (With Or Without Neoadjuvant Therapy) With No				
	Evidence Of Disease Progression Or Metastases (For Use In				
	A Medicare-Approved Demonstration Project)				

G9102	Oncology; Disease Status; Gastric Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
05102	Adenocarcinoma As Predominant Cell Type; Clinical Or	subject to utilization review.	-	-	-
	Pathologic M0 Unresectable With No Evidence Of Disease	Subject to utilization review.			
	Progression Or Metastases (For Use In A Medicare-				
	Approved Demonstration Project)				
	Approved Demonstration (Toject)				
G9103	Oncology; Disease Status; Gastric Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Adenocarcinoma As Predominant Cell Type; Clinical Or	subject to utilization review.			
	Pathologic M1 At Diagnosis Metastatic Locally Recurrent				
	Or Progressive (For Use In A Medicare-Approved				
	Demonstration Project)				
G9104	Oncology; Disease Status; Gastric Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Adenocarcinoma As Predominant Cell Type; Extent Of	subject to utilization review.			
	Disease Unknown Staging In Progress Or Not Listed (For				
	Use In A Medicare-Approved Demonstration Project)				
G9105	Oncology; Disease Status; Pancreatic Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Adenocarcinoma As Predominant Cell Type; Post R0	subject to utilization review.			
	Resection Without Evidence Of Disease Progression				
	Recurrence Or Metastases (For Use In A Medicare-				
	Approved Demonstration Project)				
G9106	Oncology; Disease Status; Pancreatic Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Adenocarcinoma; Post R1 Or R2 Resection With No Evidence	subject to utilization review.			
	Of Disease Progression Or Metastases (For Use In A				
	Medicare-Approved Demonstration Project)				
G9107	Oncology; Disease Status; Pancreatic Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Adenocarcinoma; Unresectable At Diagnosis M1 At	subject to utilization review.			
	Diagnosis Metastatic Locally Recurrent Or Progressive (For				
	Use In A Medicare-Approved Demonstration Project)				
G9108	Oncology; Disease Status; Pancreatic Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Adenocarcinoma; Extent Of Disease Unknown Staging In	subject to utilization review.			
	Progress Or Not Listed (For Use In A Medicare-Approved				
G9109	Demonstration Project)	Non Covered: Procedure/service not covered by BCBSOK. Not			
99109			-	-	-
	Cancers Of Oral Cavity Pharynx And Larynx With Squamous	subject to utilization review.			
	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)				

G9110	Oncology: Disease Status: Head And Neck Cancer, Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
05110		subject to utilization review.	-	-	-
	Cell As Predominant Cell Type; Extent Of Disease Initially	subject to utilization review.			
	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)				
G9111		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Cancers Of Oral Cavity Pharynx And Larynx With Squamous	subject to utilization review.	-	-	-
	Cell As Predominant Cell Type; M1 At Diagnosis Metastatic				
	Locally Recurrent Or Progressive (For Use In A Medicare-				
	Approved Demonstration Project)				
G9112		Non Covered: Procedure/service not covered by BCBSOK. Not			
00111	Cancers Of Oral Cavity Pharynx And Larynx With Squamous	subject to utilization review.	-	-	-
	Cell As Predominant Cell Type; Extent Of Disease Unknown				
	Staging In Progress Or Not Listed (For Use In A Medicare-				
	Approved Demonstration Project)				
G9113	Oncology; Disease Status; Ovarian Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Epithelial Cancer; Pathologic Stage Ia-B (Grade 1) Without	subject to utilization review.	-	-	-
	Evidence Of Disease Progression Recurrence Or Metastases				
	(For Use In A Medicare-Approved Demonstration Project)				
G9114	Oncology; Disease Status; Ovarian Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Epithelial Cancer; Pathologic Stage Ia-B (Grade 2-3); Or Stage	subject to utilization review.			
	Ic (All Grades); Or Stage Ii; Without Evidence Of Disease				
	Progression Recurrence Or Metastases (For Use In A				
	Medicare-Approved Demonstration Project)				
G9115	Oncology; Disease Status; Ovarian Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Epithelial Cancer; Pathologic Stage lii-Iv; Without Evidence	subject to utilization review.			
	Of Progression Recurrence Or Metastases (For Use In A				
	Medicare-Approved Demonstration Project)				
G9116	Oncology; Disease Status; Ovarian Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	Epithelial Cancer; Evidence Of Disease Progression Or	subject to utilization review.			
	Recurrence And/Or Platinum Resistance (For Use In A				
	Medicare-Approved Demonstration Project)				
G9117	Oncology; Disease Status; Ovarian Cancer Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Epithelial Cancer; Extent Of Disease Unknown Staging In	subject to utilization review.			
	Progress Or Not Listed (For Use In A Medicare-Approved				
	Demonstration Project)				
G9123	Oncology; Disease Status; Chronic Myelogenous Leukemia	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	Limited To Philadelphia Chromosome Positive And/Or Bcr-	subject to utilization review.			
	Abl Positive; Chronic Phase Not In Hematologic Cytogenetic				
	Or Molecular Remission (For Use In A Medicare-Approved				
	Demonstration Project)				

G9124	Oncology; Disease Status; Chronic Myelogenous Leukemia	Non Covered: Procedure/service not covered by BCBSOK. Not			
09124			-	-	-
	Limited To Philadelphia Chromosome Positive And/Or Bcr-	subject to utilization review.			
	Abl Positive; Accelerated Phase Not In Hematologic				
	Cytogenetic Or Molecular Remission (For Use In A Medicare-				
G9125	Approved Demonstration Project) Oncology; Disease Status; Chronic Myelogenous Leukemia	Non Covered: Procedure/service not covered by BCBSOK. Not			
09125	Limited To Philadelphia Chromosome Positive And/Or Bcr-	subject to utilization review.	-	-	-
		-			
	Abl Positive; Blast Phase Not In Hematologic Cytogenetic Or				
	Molecular Remission (For Use In A Medicare-Approved				
G9126	Demonstration Project) Oncology; Disease Status; Chronic Myelogenous Leukemia	Non Covered: Procedure/service not covered by BCBSOK. Not			
05120	Limited To Philadelphia Chromosome Positive And/Or Bcr-	subject to utilization review.	-	-	-
	Abl Positive; In Hematologic Cytogenetic Or Molecular	subject to utilization review.			
	Remission (For Use In A Medicare-Approved Demonstration				
G9128	Project) Oncology; Disease Status; Limited To Multiple Myeloma	Non Covered: Procedure/service not covered by BCBSOK. Not			
03120	Systemic Disease; Smoldering Stage I (For Use In A	subject to utilization review.	-	-	-
	Medicare-Approved Demonstration Project)	subject to utilization review.			
G9129	Oncology; Disease Status; Limited To Multiple Myeloma	Non Covered: Procedure/service not covered by BCBSOK. Not			
05125		subject to utilization review.	-	-	-
	Approved Demonstration Project)	subject to utilization review.			
G9130	Oncology; Disease Status; Limited To Multiple Myeloma	Non Covered: Procedure/service not covered by BCBSOK. Not			
05150	Systemic Disease; Extent Of Disease Unknown Staging In	subject to utilization review.	-	-	-
	Progress Or Not Listed (For Use In A Medicare-Approved	Subject to utilization review.			
	Demonstration Project)				
G9140	Frontier Extended Stay Clinic Demonstration; For A Patient	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Stay In A Clinic Approved For The Cms Demonstration	subject to utilization review.	-	-	-
	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				
G9147	Outpatient Intravenous Insulin Treatment (Oivit) Either	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		_
	Pulsatile Or Continuous By Any Means Guided By The	to utilization review. Please see the Clinical Payment and			
	Results Of Measurements For:Respiratory Quotient; And/Or	Coding Policy titled: Non-Reimbursable Experimental,			
	Urine Urea Nitrogen (Uun); And/Or Arterial Venous Or	Investigational and/or Unproven Services (EIU).			
	Capillary Glucose; And/Or Potassium Concentration				
G9886	Behavioral Counseling For Diabetes Prevention In-Person	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Group 60 Minutes	subject to utilization review.			01/01/2024
G9887	Behavioral Counseling For Diabetes Prevention Distance	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	Learning 60 Minutes	subject to utilization review.			01/01/2024

G9888	Maintenance 5% WI From Baseline Weight In Months 7-12	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
		subject to utilization review.			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		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			
112011		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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Minutes	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Diem	subject to utilization review.			
H2037	Developmental Delay Prevention Activities Dependent Child	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Of Client Per 15 Minutes	subject to utilization review.			

J0129	Injection Abatacept 10 Mg (Code May Be Used For	MP Criteria: Procedure/service reviewed to ensure each service		
	Medicare When Drug Administered Under The Direct	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	_
	Supervision Of A Physician Not For Use When Drug Is Self	submitting a Recommended Clinical Review (Predetermination)		
	Administered)	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 4/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review		4/1/2024
		(Predetermination) to avoid post-service review.		
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 _	5/31/2024	Retire effective
		meets BCBSOK Medical Policy criteria. BCBSOK recommends		5/31/2024
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
		Prior Authorization may be required per contract agreement.		
J0215	Injection Alefacept 0.5 Mg	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
		meets BCBSOK 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 1/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review		01/01/2024
		(Predetermination) to avoid post-service review.		

J0218	Injection Olipudase Alfa-Rpcp 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service			
30210		meets BCBSOK Medical Policy criteria. BCBSOK recommends	· _	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
J0219	Intention Anglehoppidese Alfe Newt 4 Ma	Policy criteria.			
J0219	Injection Avalglucosidase Alfa-Ngpt 4 Mg	MP Criteria: Procedure/service reviewed to ensure each service	² –	-	-
		meets BCBSOK 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	² –	_	-
		meets BCBSOK 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.			
J0224	Injection Lumasiran 0.5 Mg	Prior Authorization may be required per contract agreement. MP Criteria: Procedure/service reviewed to ensure each service			
JUZZ4	Injection Lumasitan 0.5 Mg		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
10005		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	5/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			5/1/2024
		(Predetermination) to avoid post-service review.			

J0256	Injection Alpha 1 Proteinase Inhibitor (Human) Not	Unlisted or Undefined: Procedure/service not otherwise			
	Otherwise Specified 10 Mg	defined or classified, and may be subject to benefit and/or			
		clinical review.			
J0270	Injection Alprostadil 1. 25 Mcg (Code May Be Used For	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Medicare When Drug Administered Under The Direct	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Supervision Of A Physician Not For Use When Drug Is Self	submitting a Recommended Clinical Review (Predetermination)			
	Administered)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
J0275	Alprostadil Urethral Suppository (Code May Be Used For	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Medicare When Drug Administered Under The Direct	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Supervision Of A Physician Not For Use When Drug Is Self	submitting a Recommended Clinical Review (Predetermination)			
	Administered)	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	3/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			03/01/2024
		(Predetermination) to avoid post-service review.			
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.			

	MP Criteria: Procedure/service reviewed to ensure each service	-	•	-
	meets bebook medical rolley chteria. Bebook 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. MP Criteria: Procedure/service reviewed to ensure each service			
		-	·	-
		-	·	-
	Policy criteria.			
	Prior Authorization may be required per contract agreement.			
n 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.			
n Rimabotulinumtoxinb 100 Units	MP Criteria: Procedure/service reviewed to ensure each service _	1/3	31/2024	Retire effective
	meets BCBSOK Medical Policy criteria. BCBSOK recommends			01/31/2024
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
	Policy criteria.			
	MP Criteria: Procedure/service reviewed to ensure each service	1/3	31/2024	Retire effective
	meets BCBSOK Medical Policy criteria. BCBSOK recommends			01/31/2024
	submitting a Recommended Clinical Review (Predetermination)			
	request if it is unclear if the service meets BCBSOK Medical			
n Daxibotulinumtoxina-Lanm 1 Unit		2024		Add effective
		–		4/1/2024
	(Predetermination) to avoid post-service review.			
	· · · · · · · · · · · · · · · · · · ·	-	ľ	-
	Policy criteria.			
	n Onabotulinumtoxina 1 Unit n Abobotulinumtoxina 5 Units n Rimabotulinumtoxinb 100 Units n Incobotulinumtoxin A 1 Unit n Daxibotulinumtoxina-Lanm 1 Unit n Edetate Calcium Disodium Up To 1000 Mg	meets BCBSOK 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. MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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. MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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. MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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. MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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. MP Criteria: Procedure/service reviewed dagainst Medical Policy riteria. Submit for Recommended Clinical Review (Predetermination) to avoid post-service review.	meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical Policy criteria. n Onabotulinumtoxina 1 Unit MP Criteria: Procedure/Service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Medical Policy criteria: Procedure/Service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Medical Policy criteria: Procedure/Service reviewed to ensure each service Prior Authorization may be required per contract agreement. – n Abobotulinumtoxina 5 Units Prior Authorization may be required per contract agreement. – n Abobotulinumtoxina 5 Units MP Criteria: Procedure/Service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK Medical Policy criteria: – – n Rimabotulinumtoxinb 100 Units MP Criteria: Procedure/Service reviewed to ensure each service Prior Authorization may be required per contract agreement. – 1/2 n Rimabotulinumtoxinb 100 Units MP Criteria: Procedure/Service reviewed to ensure each service Prior Authorization may be required per contract agreement. – 1/2 n Incobotulinumtoxin A 1 Unit MP Criteria: Procedure/Service reviewed to ensure each service Prior Authorization may be required per contract agreement. 1/2 n Incobotulinumtoxin A 1 Unit MP Criteria: Procedure/Service reviewed to ensure each service Prior Authorization may be required per contract agreement. 1/2 <td>n Onabotulinumtoxina 1 Unit MP Criteria: Procedure/Service reviewed to ensure each service</td>	n Onabotulinumtoxina 1 Unit MP Criteria: Procedure/Service reviewed to ensure each service

J0717	Injection Certolizumab Pegol 1 Mg (Code May Be Used For	MP Criteria: Procedure/service reviewed to ensure each service		
	Medicare When Drug Administered Under The Direct	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_
	Supervision Of A Physician Not For Use When Drug Is Self	submitting a Recommended Clinical Review (Predetermination)		
	Administered)	request if it is unclear if the service meets BCBSOK Medical		
		Policy criteria.		
		Prior Authorization may be required per contract agreement.		
0739	Injection, cabotegravir, 1mg, fda approved prescription, onl	y MP Criteria: Procedure/service reviewed against Medical Policy	3/14/2024	Retire effective
	for use as hiv pre-exposure prophylaxis (not for use as	Criteria. Submit for Recommended Clinical Review	-, , -	03/14/2024
	treatment for hiv)	(Predetermination) to avoid post-service review.		
0741	Injection Cabotegravir And Rilpivirine 2Mg/3Mg	MP Criteria: Procedure/service reviewed against Medical Policy	6/30/2024	Retire effective
		Criteria. Submit for Recommended Clinical Review		06/30/2024
		(Predetermination) to avoid post-service review.		
0775	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.		
0791	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.		
10881	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.		
0895	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.		
1071	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.		
1203	Injection Cipaglucosidase Alfa-Atga 5 Mg	MP Criteria: Procedure/service reviewed against Medical Policy 4/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review		4/1/2024
		(Predetermination) to avoid post-service review.		

J1301	Injection Edaravone 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service			
51501		meets BCBSOK Medical Policy criteria. BCBSOK recommends		-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
11202	Injection Sutimlimab-Jome 10 Mg	Prior Authorization may be required per contract agreement.			
J1302	injection Sutimimab-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 1/2	1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
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.			
J1323	Injection Elranatamab-Bcmm 1 Mg	Prior Authorization may be required per contract agreement. MP Criteria: Procedure/service reviewed against Medical Policy 4/:	1/2024		Add effective
11323			1/2024	-	
		Criteria. Submit for Recommended Clinical Review			4/1/2024
14225	Injustice Engrandenel O.E.Ma	(Predetermination) to avoid post-service review.			
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		MP Criteria: Procedure/service reviewed to ensure each service _		 -	-
	Dose	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Containing Nominal 2 X 10^13 Vector Genomes	Criteria. Submit for Recommended Clinical Review		-	01/01/2024
		(Predetermination) to avoid post-service review.			
J1413	Injection Delandistrogene Moxeparvovec-Rokl Per	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Therapeutic Dose	Criteria. Submit for Recommended Clinical Review		-	01/01/2024
		(Predetermination) to avoid post-service review.			
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	_		
1		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
1		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.			

4500					
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.	Unlisted Procedure; May require Prior Authorization per	_		
	Powder) Not Otherwise Specified 500 Mg	contract agreement.			
	, , , , , , , , , , , , , , , , , , , ,	U U U U U U U U U U U U U U U U U U U			
J1576	Injection Immune Globulin (Panzyga) Intravenous Non-	MP Criteria: Procedure/service reviewed to ensure each service			
	Lyophilized (E.G. Liquid) 500 Mg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	-,op	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	Unlisted Procedure; May require Prior Authorization per			
11000	(E.G. Liquid) Not Otherwise Specified 500 Mg		-	-	_
	(E.G. Liquid) Not Otherwise specified 500 Mg	contract agreement.			
J1620	Injection Gonadorelin Hydrochloride Per 100 Mcg	MP Criteria: Procedure/service reviewed to ensure each service			
11020	injection donadorenn nydrochionde Per 100 Wieg		_	-	-
		meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Specified 10 Mg	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.			
		r nor Authorization may be required per contract agreement.			

J1747	Injection Spesolimab-Sbzo 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service			
517 17		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Pump) Per 50 Units	meets BCBSOK 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.	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Insulin Pump) Per 50 Units	meets BCBSOK 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	3/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			03/01/2024
		(Predetermination) to avoid post-service review.			
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			
14.054		Policy criteria.			<u> </u>
J1951	Injection Leuprolide Acetate For Depot Suspension	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	(Fensolvi) 0.25 Mg	meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service			
	7.5 Mg	meets BCBSOK 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		6/30/2024	Retire effective
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			06/30/2024
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
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			
52020		meets BCBSOK 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 4/	/15/2024		Add effective
52027		Criteria. Submit for Recommended Clinical Review	10/2021	-	4/15/2024
		(Predetermination) to avoid post-service review.			17 137 202 1
J2329	Injection Ublituximab-Xiiy 1Mg	MP Criteria: Procedure/service reviewed to ensure each service			
52525	injection oblicational any ring	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy 3/	/1/2024		Add effective
12000	Injection 1 Mg	Criteria. Submit for Recommended Clinical Review	1,2021	-	03/01/2024
	injection 1 Mg	(Predetermination) to avoid post-service review.			03/01/2024
J2354	Injection Octreatide Non-Depat Form For Subcutaneous Or	MP Criteria: Procedure/service reviewed against Medical Policy 3/	/1/2024		Add effective
12007	Intravenous Injection 25 Mcg	Criteria. Submit for Recommended Clinical Review	1,2027	-	03/01/2024
	initiavenous injection 25 wieg	(Predetermination) to avoid post-service review.			03/01/2024
J2356	Injection Tezepelumab-Ekko 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service			
12000		meets BCBSOK 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			
JZ440	injection rapavenne nei op 10 00 mg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
J2502	Injection Pasireotide Long Acting 1 Mg	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
12202	Injection Pasireotide Long Acting I Mg		-	-	-
		meets BCBSOK 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	1/1/2024	-	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			
J2777	Injection Faricimab-Svoa 0.1 Mg	MP Criteria: Procedure/service reviewed to ensure each service	² –	-	_
		meets BCBSOK 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	<u>-</u>	_	_
		meets BCBSOK 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)	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	0.1 Mg	meets BCBSOK 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	4/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			4/1/2024
		(Predetermination) to avoid post-service review.			
J2787	Riboflavin 5'-Phosphate Ophthalmic Solution Up To 3 Ml	MP Criteria: Procedure/service reviewed to ensure each service	<u> </u>		
		meets BCBSOK 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	3/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review		Ī	03/01/2024
		(Predetermination) to avoid post-service review.			
J3032	Injection Eptinezumab-Jjmr 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service	2		
		meets BCBSOK 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.			
		Phor Authonzation may be required ber contract agreement.			

J3055	Injection Talquetamab-Tgvs 0.25 Mg	MP Criteria: Procedure/service reviewed against Medical Policy 4/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review	-	4/1/2024
		(Predetermination) to avoid post-service review.		, , -
J3111	Injection Romosozumab-Aggg 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy 3/1/2024		Add effective
		Criteria. Submit for Recommended Clinical Review	-	03/01/2024
		(Predetermination) to avoid post-service review.		
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 lu	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			
15500		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
J3396	Injection Vortenerfin 0.1 Mg	Prior Authorization may be required per contract agreement. MP Criteria: Procedure/service reviewed to ensure each service			
12220	Injection Verteporfin 0.1 Mg		-	-	-
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Genomes	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Up To 5X10^15 Vector Genomes	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	_	Add effective
	Containing Nominal 5 X 10^9 Pfu/MI Vector Genomes Per	Criteria. Submit for Recommended Clinical Review			01/01/2024
	0.1 MI	(Predetermination) to avoid post-service review.			
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			
J, 1, 1	injection fundit formogen concentrate (fibryga) 1 Wg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy			
37 105	1 I.U. Vwf:Rco	Criteria. Submit for Recommended Clinical Review	-	-	-
	11.0. Willico	(Predetermination) to avoid post-service review.			
J7192	Factor Viii (Antihemophilic Factor Recombinant) Per I.U.	Unlisted or Undefined: Procedure/service not otherwise			
37 192	Not Otherwise Specified	defined or classified, and may be subject to benefit and/or	-	-	-
	Not otherwise specified	clinical review.			
J7195	Injection Factor Ix (Antihemophilic Factor Recombinant)	Unlisted or Undefined: Procedure/service not otherwise			
37 199	Per lu Not Otherwise Specified	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%	MP Criteria: Procedure/service reviewed to ensure each service			
	Single Unit Dosage Form (354 Mg)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	16.8% 1 Gram	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	(Retisert) 0.01 Mg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Iluvien) 0.01 Mg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	10 Mg	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Micrograms	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	Administered Through	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Administered Through Dme Concentrated Form 0.5 Mg	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Administered Through Dme Unit Dose 1 Mg	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
1764.0		Investigational and/or Unproven Services (EIU).			
J7610	Albuterol Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Administered Through Dme Concentrated Form 1 Mg	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
17615	Loughuteral Inhalation Colution Compounded Draduct	Investigational and/or Unproven Services (EIU).			
J7615	Levalbuterol Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Administered Through Dme Unit Dose 0.5 Mg	to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental,			
J7622	Performations and Inhalation Solution, Compounded Product	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
37022		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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
			-	-	-
		· ·			
	Administered Through Dme Unit Dose Form Per Milligram	to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).			

J7627	Rudesenide Inhabition Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
1/02/	Budesonide Inhalation Solution Compounded Product		-	-	-
	Administered Through Dme Unit Dose Form Up To 0.5 Mg	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
J7628	Bitolterol Mesylate Inhalation Solution Compounded	Investigational and/or Unproven Services (EIU).			
1/028		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Product Administered Through Dme Concentrated Form	to utilization review. Please see the Clinical Payment and			
	Per Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
17620	Distance Marches to be t	Investigational and/or Unproven Services (EIU).			
J7629	Bitolterol Mesylate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Product Administered Through Dme Unit Dose Form Per	to utilization review. Please see the Clinical Payment and			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
17.000		Investigational and/or Unproven Services (EIU).			
J7632	Cromolyn Sodium Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Product Administered Through	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	Administered Through Dme Concentrated Form Per 0.25	to utilization review. Please see the Clinical Payment and			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7635	Atropine Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Administered Through Dme Concentrated Form Per	to utilization review. Please see the Clinical Payment and			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7636	Atropine Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	_
	Administered Through Dme Unit Dose Form Per Milligram	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Administered Through Dme Concentrated Form Per	to utilization review. Please see the Clinical Payment and			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7638	Dexamethasone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Administered Through Dme Unit Dose Form Per Milligram	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	_
	Administered Through Dme Unit Dose Form 12 Micrograms	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Administered Through Dme Unit Dose Per Milligram	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			

J7642	Chronymolate Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
J704Z	Glycopyrrolate Inhalation Solution Compounded Product Administered Through Dme Concentrated Form Per	to utilization review. Please see the Clinical Payment and	-	-	-
		· ·			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
J7643	Glycopyrrolate Inhalation Solution Compounded Product	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
11042			-	-	-
	Administered Through Dme Unit Dose Form Per Milligram	to utilization review. Please see the Clinical Payment and			
1		Coding Policy titled: Non-Reimbursable Experimental,			
J7645	Invatronium Bromida Inhalation Solution Compounded	Investigational and/or Unproven Services (EIU).			
17045	Ipratropium Bromide Inhalation Solution Compounded Product Administered Through Dme Unit Dose Form Per	EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and	-	-	-
	Ū.	· ·			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
J7647	Isoetharine Hcl Inhalation Solution Compounded Product	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
17047			-	-	-
	Administered Through Dme Concentrated Form Per	to utilization review. Please see the Clinical Payment and			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
J7650	Isoetharine Hcl Inhalation Solution Compounded Product	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
17030	Administered Through Dme Unit Dose Form Per Milligram	to utilization review. Please see the Clinical Payment and	-	-	-
	Administered Inrough Dme Unit Dose Form Per Milligram	· ·			
		Coding Policy titled: Non-Reimbursable Experimental,			
J7657	Isoprotoronal Hel Inhalation Solution, Compounded Product	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
1,021			-	-	-
	Administered Through Dme Concentrated Form Per	to utilization review. Please see the Clinical Payment and			
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
17660	Isoproterenal Hcl. Inhalation Solution, Compounded Product	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
37000	Administered Through Dme Unit Dose Form Per Milligram	to utilization review. Please see the Clinical Payment and	-	-	-
	Automistered fillough Dine Onit Dose Forth Pel Minigram	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7667	Metaproterenol Sulfate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
57007	Product Concentrated Form Per 10 Milligrams	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
,,,,,,	Product Administered Through Dme Unit Dose Form Per	to utilization review. Please see the Clinical Payment and	-	-	-
	10 Milligrams	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7676	Pentamidine Isethionate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
37070	Product Administered	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
37000	Product Administered Through Dme Concentrated Form	to utilization review. Please see the Clinical Payment and	-	-	-
	0				
	Per Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
μ		Investigational and/or Unproven Services (EIU).			

J7681	Terbutaline Sulfate Inhalation Solution Compounded	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Product Administered Through Dme Unit Dose Form Per	to utilization review. Please see the Clinical Payment and	-	-	-
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7683	Triamcinolone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Administered Through Dme Concentrated Form Per	to utilization review. Please see the Clinical Payment and	-	-	-
	Milligram	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
J7684	Triamcinolone Inhalation Solution Compounded Product	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Administered Through Dme Unit Dose Form Per Milligram	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	Administered Through Dme Unit Dose Form Per 300	to utilization review. Please see the Clinical Payment and	_	_	-
	Milligrams	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	Unlisted or Undefined: Procedure/service not otherwise			
	Through Dme	defined or classified, and may be subject to benefit and/or	_	_	_
	č	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	Unlisted or Undefined: Procedure/service not otherwise			
	Specified	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	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Units	defined or classified, and may be subject to benefit and/or			
		clinical review.			
J9029	Intravesical Instillation Nadofaragene Firadenovec-Vncg Per	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Therapeutic Dose	meets BCBSOK 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	4/1/2024	_	Add effective
		subject to utilization review.			4/1/2024

J9056	Injection Bendamustine Hydrochloride (Vivimusta) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service			
	,, j,	meets BCBSOK 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	4/1/2024		Add effective
		subject to utilization review.		-	4/1/2024
J9058	Injection Bendamustine Hydrochloride (Apotex) 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service	2		
		meets BCBSOK 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.			
<mark>J9063</mark>	Injection Mirvetuximab Soravtansine-Gynx 1 Mg	MP Criteria: Procedure/service reviewed to ensure each service	2		
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
	Therapeutically Equivalent To J9264 1 Mg	Criteria. Submit for Recommended Clinical Review			01/01/2024 Retire
		(Predetermination) to avoid post-service review.			effective 06/30/2024
J9259	Injection Paclitaxel Protein-Bound Particles (American	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Regent) Not Therapeutically Equivalent To J9264 1 Mg	meets BCBSOK 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	1/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			

J9313	Injection Moxetumomab Pasudotox-Tdfk 0.01 Mg	Non Covered: Procedure/service not covered by BCBSOK. Not 4/1/2024	4 –	Add effective
		subject to utilization review.		4/1/2024
J9321	Injection Epcoritamab-Bysp 0.16 Mg	MP Criteria: Procedure/service reviewed against Medical Policy 1/1/2024	4 –	Add effective
		Criteria. Submit for Recommended Clinical Review		01/01/2024
		(Predetermination) to avoid post-service review.		
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 1/1/2024	4 _	Add effective
		Criteria. Submit for Recommended Clinical Review		01/01/2024
		(Predetermination) to avoid post-service review.		
J9334	Injection Efgartigimod Alfa 2 Mg And Hyaluronidase-Qvfc	MP Criteria: Procedure/service reviewed against Medical Policy 1/1/202	4 _	Add effective
		Criteria. Submit for Recommended Clinical Review		01/01/2024
		(Predetermination) to avoid post-service review.		
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 4/1/2024	4	Add effective
		Criteria. Submit for Recommended Clinical Review		4/1/2024
		(Predetermination) to avoid post-service review.		
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		
32301		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		· · · · · · · · · · · · · · · · · · ·		
		submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical		
J9600	Injection Porfimer Sodium 75 Mg	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
19000	Injection Porninei Soulum 75 Mg	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
J9999	Not Otherwise Classified Antineoplastic Drugs	Policy criteria. Unlisted Procedure; May require Prior Authorization per		
19999	Not Otherwise classified Antineoplastic Drugs	contract agreement.	-	-
K0002	Standard Hemi (Low Seat) Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service		
K0002	Standard Herni (Low Seat) Wheelchair	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
1				
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
коооз	Lightweight Wheelchair	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
10005		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
К0004	High Strength Lightweight Wheelchair	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
KUUU4	High Strength Lightweight Wheelchair	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
K0005	Ultralightweight Wheelchair	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
K0005	Oltraightweight wheelchan		-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
К0006	Hoovy Duty Whoolchair	Policy criteria.		
NUUUD	Heavy Duty Wheelchair	MP Criteria: Procedure/service reviewed to ensure each service	-	-
1		meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
K0007	Extra Lloove Duty Wheelsheir	Policy criteria.		
КООО7	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.		
К0008	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.		

-
-
-
-
-
-
-
-
-
-
[
-
-
-
-
<u> </u>
-
-
-
-

К0108	Wheelchair Component Or Accessory Not Otherwise	MP Criteria: Procedure/service reviewed to ensure each service			
10100	Specified	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	specified	· ·			
		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			
K0455		clinical review.			
K0455	Infusion Pump Used For Uninterrupted Parenteral	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Administration Of Medication (E. G. Epoprostenol Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Treprostinol)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
к0669	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.			
К0743	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.			
К0744	Absorptive Wound Dressing For Use With Suction Pump	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Home Model Portable Pad Size 16 Square Inches Or Less	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Home Model Portable Pad Size More Than 16 Square	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Inches But Less Than Or Equal To 48 Square Inches	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		-	
К0746	Absorptive Wound Dressing For Use With Suction Pump	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Home Model Portable Pad Size Greater Than 48 Square	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Inches	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
к0800		MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Capacity Up To And Including 300 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		I	
NUOUI	Weight Capacity 301 To 450 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	weight capacity 301 10 450 Pounds				
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0802	Device Operated Makiela, Creve 1 Mary Heavy Duty Detient	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
K0802	Power Operated Vehicle Group 1 Very Heavy Duty Patient		-	-	-
	Weight Capacity 451 To 600 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Capacity Up To And Including 300 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0807	Power Operated Vehicle Group 2 Heavy Duty Patient	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Weight Capacity 301 To 450 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
к0808	Power Operated Vehicle Group 2 Very Heavy Duty Patient	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Weight Capacity 451 To 600 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Seat And Back Patient Weight Capacity Up To And Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	300 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Chair Patient Weight Capacity Up To And Including 300	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	 	–
	Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		ו טונץ נוונכוומ.	P	ļ	ļ

K0815	Dower Wheelchair Group 1 Standard Sling (Salid Seat And	MP Criteria: Procedure/service reviewed to ensure each service			
10012	Power Wheelchair Group 1 Standard Sling/Solid Seat And		-	-	-
	Back Patient Weight Capacity Up To And Including 300	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0816	Dower Wheelsheir Group 1 Standard Cantains Chair	Policy criteria.			
K0816	Power Wheelchair Group 1 Standard Captains Chair	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Patient Weight Capactiy Up To And Including 300 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
10000		Policy criteria.			
К0820	Power Wheelchair Group 2 Standard Portable Sling/Solid	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Chair Patient Weight Capacity Up To And Including 300	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0822	Power Wheelchair Group 2 Standard Sling/Solid Seat/Back	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Patient Weight Capacity Up To And Including 300 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Patient Weight Capacity Up To And Including 300 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Seat/Back Patient Weight Capacity 301 To 450 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Patient Weight Capacity 301 To 450 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	_
	Seat/Back Patient Weight Capacity 451 To 600 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Patient Weight Capacity 451 To 600 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Seat/Back Patient Weight Capacity 601 Pounds Or More	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Chair Patient Weight Capacity 601 Pounds Or More	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Sling/Solid Seat/Back Patient Weight Capacity Up To And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including 300 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	300 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Sling/Solid Seat/Back Patient Weight Capacity Up To And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including 300 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0027		Policy criteria.			
K0837	Power Wheelchair Group 2 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Option Sling/Solid Seat/Back Patient Weight Capacity 301	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	To 450 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0838	Dower Wheelshair Group 2 Heavy Duty Cingle Dower	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
NU030	Power Wheelchair Group 2 Heavy Duty Single Power		-	-	-
	Option Captains Chair Patient Weight Capacity 301 To 450	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

K0839	Dower Wheelshair, Group 2 Very Heavy Duty Single Dower	MP Criteria: Procedure/service reviewed to ensure each service		F	
10839	, , , , ,		-	-	-
	Option Sling/Solid Seat/Back Patient Weight Capacity 451	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	To 600 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
к0840	Power Wheelchair Group 2 Extra Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Option Sling/Solid Seat/Back Patient Weight Capacity 601	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds Or More	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Option Sling/Solid Seat/Back Patient Weight Capacity Up To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Including 300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0842	Power Wheelchair Group 2 Standard Multiple Power	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Option Captains Chair Patient Weight Capacity Up To And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including 300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0843	Power Wheelchair Group 2 Heavy Duty Multiple Power	MP Criteria: Procedure/service reviewed to ensure each service			
	Option Sling/Solid Seat/Back Patient Weight Capacity 301	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	To 450 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0848	Power Wheelchair Group 3 Standard Sling/Solid Seat/Back	MP Criteria: Procedure/service reviewed to ensure each service		_	
	Patient Weight Capacity Up To And Including 300 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0849	Power Wheelchair Group 3 Standard Captains Chair	MP Criteria: Procedure/service reviewed to ensure each service			
	Patient Weight Capacity Up To And Including 300 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0850	Power Wheelchair Group 3 Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed to ensure each service		1	
	Seat/Back Patient Weight Capacity 301 To 450 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	sea, such and the greedputty set to 450 founds	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	MP Criteria: Procedure/service reviewed to ensure each service			
NOOJ1	Patient Weight Capacity 301 To 450 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	i attent weight capacity Sof 10 450 Founds	-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

K0852	Power Wheelchair Group 3 Very Heavy Duty Sling/Solid	MP Criteria: Procedure/service reviewed to ensure each service			
NU032			-	-	-
	Seat/Back Patient Weight Capacity 451 To 600 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0853	Power Wheelchair Group 3 Very Heavy Duty Captains Chair	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
KU033			-	-	-
	Patient Weight Capacity 451 To 600 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0854	Power Wheelchair Group 3 Extra Heavy Duty Sling/Solid	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
KU854	. , , , .		-	-	-
	Seat/Back Patient Weight Capacity 601 Pounds Or More	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
KOREE	Dawar Whaalahair Group 2 Fitte House Dute Casteins	Policy criteria.			
K0855	Power Wheelchair Group 3 Extra Heavy Duty Captains	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Chair Patient Weight Capacity 601 Pounds Or More	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0056		Policy criteria.			
К0856	Power Wheelchair Group 3 Standard Single Power Option	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Sling/Solid Seat/Back Patient Weight Capacity Up To And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including 300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0057	Device Wildestates Crewer 2 Stee dead Single Device Oction	Policy criteria.			
K0857	Power Wheelchair Group 3 Standard Single Power Option	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0858	Device Wheelsheir Crewe 2 Harve Duty Single Device	Policy criteria.			
KU858	Power Wheelchair Group 3 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Option Sling/Solid Seat/Back Patient Weight Capacity 301	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	To 450 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K0850	Device Wheelsheir Crewe 2 Harve Duty Single Device	Policy criteria.			
К0859	Power Wheelchair Group 3 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Option Captains Chair Patient Weight Capacity 301 To 450	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K08C0	Device Wildesteletein Convert 2014 - User - Data Circle D	Policy criteria.			
K0860	Power Wheelchair Group 3 Very Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Option Sling/Solid Seat/Back Patient Weight Capacity 451	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	To 600 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service		1	
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	And Including 300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
	And melduling 500 Founds	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
K0862	Power Wheelchair Group 3 Heavy Duty Multiple Power	MP Criteria: Procedure/service reviewed to ensure each service			
	Option Sling/Solid Seat/Back Patient Weight Capacity 301	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	To 450 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Power Option Sling/Solid Seat/Back Patient Weight	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Capacity 451 To 600 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Power Option Sling/Solid Seat/Back Patient Weight	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Capacity 601 Pounds Or More	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Patient Weight Capacity Up To And Including 300 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
к0869	Power Wheelchair Group 4 Standard Captains Chair	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Patient Weight Capacity Up To And Including 300 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Seat/Back Patient Weight Capacity 301 To 450 Pounds	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Seat/Back Patient Weight Capacity 451 To 600 Pounds	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
V0077	Dowor Whoolebair Group & Standard Cingle Dowor Orthog	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		}	
К0877			-	-	-
	Sling/Solid Seat/Back Patient Weight Capacity Up To And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including 300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

К0878	Power Wheelchair Group 4 Standard Single Power Option	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	300 Pounds	submitting a Recommended Clinical Review (Predetermination)			
	Soo Founds	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0879	Power Wheelchair Group 4 Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service			
10075	Option Sling/Solid Seat/Back Patient Weight Capacity 301	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	To 450 Pounds	submitting a Recommended Clinical Review (Predetermination)			
	10 450 1 00103	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
K0880	Power Wheelchair Group 4 Very Heavy Duty Single Power	MP Criteria: Procedure/service reviewed to ensure each service			
	Option Sling/Solid Seat/Back Patient Weight 451 To 600	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Pounds	submitting a Recommended Clinical Review (Predetermination)			
	i ounus	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
K0884	Power Wheelchair Group 4 Standard Multiple Power	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	And Including 300 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	300 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Option Sling/Solid Seat/Back Patient Weight Capacity 301	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	To 450 Pounds	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К0890	Power Wheelchair Group 5 Pediatric Single Power Option	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Sling/Solid Seat/Back Patient Weight Capacity Up To And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including 125 Pounds	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Option Sling/Solid Seat/Back Patient Weight Capacity Up To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Including 125 Pounds	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.			

К0899	Power Mobile Device; No Dme Pdac	MP Criteria: Procedure/service reviewed to ensure each service			
KU099	Fower Mobile Device, No Diffe Fuac	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
K1004	Low Frequency Ultrasonic Diathermy Treatment Device For	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
K1004	Home Use		-	-	-
	Home Use	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
K1007	Bilateral Hip Knee Ankle Foot Device Powered Includes	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject		-	
K1007			-	-	-
	Pelvic Component Single Or Double Upright(S) Knee Joints	to utilization review. Please see the Clinical Payment and			
	Any Type With Or Without Ankle Joints Any Type Includes	Coding Policy titled: Non-Reimbursable Experimental,			
	All Components And Accessories Motors Microprocessors Sensors	Investigational and/or Unproven Services (EIU).			
K1027	Oral Device/Appliance Used To Reduce Upper Airway	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Collapsibility Without Fixed Mechanical Hinge Custom	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Fabricated Includes Fitting And Adjustment	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	With Implanted Cardiac Contractility Modulation Generator	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Replacement Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
К1034	Provision Of Covid-19 Test Nonprescription Self-	Non Covered: Procedure/service not covered by the Plan. Not	_	_	_
	Administered And Self-Collected Use Fda Approved	subject to utilization review.			
	Authorized Or Cleared One Test Count				
K1035	Molecular Diagnostic Test Reader Nonprescription Self-	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Administered And Self-Collected Use Fda Approved	subject to utilization review.			
	Authorized Or Cleared				
K1036	Supplies And Accessories (E.G. Transducer) For Low	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Frequency Ultrasonic Diathermy Treatment Device Per	to utilization review. Please see the Clinical Payment and			
	Month	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
K1037	Docking Station For Use With Oral Device/Appliance Used To	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effective
	Reduce Upper Airway Collapsibility	Criteria. Submit for Recommended Clinical Review			4/1/2024
		(Predetermination) to avoid post-service review.			
L0120	Cervical Flexible Non-Adjustable Prefabricated Off-The-	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Shelf (Foam Collar)	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	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024		Add effectuce
	Rigid Circumferential Frame With Anterior And Posterior	Criteria. Submit for Recommended Clinical Review			04/01/2024
	Rigid Pads Custom Fabricated	(Predetermination) to avoid post-service review.			

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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Ligament Custom Fabricated	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Adjustable Flexion And Extension Joint (Unicentric Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Polycentric) Medial-Lateral And Rotation Control With Or	submitting a Recommended Clinical Review (Predetermination)			
	Without Varus/Valgus Adjustment Custom Fabricated	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L1846	Knee Orthosis Double Upright Thigh And Calf With	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Adjustable Flexion And Extension Joint (Unicentric Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Polycentric) Medial-Lateral And Rotation Control With Or	submitting a Recommended Clinical Review (Predetermination)			
	Without Varus/Valgus Adjustment Custom Fabricated	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L1860	Knee Orthosis Modification Of Supracondylar Prosthetic	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Socket Custom-Fabricated (Sk)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Upright Stance Control Automatic Lock And Swing Phase	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Release Any Type Activation Includes Ankle Joint Any Type	submitting a Recommended Clinical Review (Predetermination)			
	Custom Fabricated	request if it is unclear if the service meets BCBSOK Medical			
12000	Les and Establish Calibration Net Others for Constitute	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			
L3001	Fast Incort Domourble Melded To Dationt Medal Spanse	clinical review.			
13001	Foot Insert Removable Molded To Patient Model Spenco	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
L3002	Each Foot Insert Removable Molded To Patient Model	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
13002	Plastazote Or Equal Each	subject to utilization review.	-	-	-
L3003	Foot Insert Removable Molded To Patient Model Silicone	Non Covered: Procedure/service not covered by BCBSOK. Not			
15005	Gel Each	subject to utilization review.	-	-	-
L3010	Foot Insert Removable Molded To Patient Model	Non Covered: Procedure/service not covered by BCBSOK. Not			
25010	Longitudinal Arch Support Each	subject to utilization review.	-	-	-
L3020	Foot Insert Removable Molded To Patient Model	Non Covered: Procedure/service not covered by BCBSOK. Not			
13020			-	-	-
	Longitudinal/ Metatarsal Support Each	subject to utilization review.			

10000					
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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Orthosis High Strength Lightweight Material All Hybrid	subject to utilization review.			
	Lamination/Prepreg Composite Each				
L3040	Foot Arch Support Removable Premolded Longitudinal	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Each	subject to utilization review.			
L3050	Foot Arch Support Removable Premolded Metatarsal	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Each	subject to utilization review.			
L3060	Foot Arch Support Removable Premolded Longitudinal/	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Metatarsal Each	subject to utilization review.			
L3070	Foot Arch Support Non-Removable Attached To Shoe	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Longitudinal Each	subject to utilization review.			
L3080	Foot Arch Support Non-Removable Attached To Shoe	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Metatarsal Each	subject to utilization review.			
L3090	Foot Arch Support Non-Removable Attached To Shoe	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Longitudinal/Metatarsal Each	subject to utilization review.			
L3100	Hallus-Valgus Night Dynamic Splint Prefabricated Off-The-	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Shelf	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Off-The-Shelf Each	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Infant	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	-	-
	Junior	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.			

12210	Orthogoadia Fasturan Ladica Shaa Dauth Inlaw Fash	New Coursed, Depending / set in set on set of DCDCOK, Net			
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	Non Covered: Procedure/service not covered by BCBSOK. Not			
19217	Each	subject to utilization review.	-	-	-
L3219	Orthopedic Footwear Mens Shoe Oxford Each	Non Covered: Procedure/service not covered by BCBSOK. Not			
15215		subject to utilization review.	-	-	-
L3221	Orthopedic Footwear Mens Shoe Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not			
19221	orthopedic rootwear mensione Deptirinay Lach	subject to utilization review.	-	-	-
L3222	Orthopedic Footwear Mens Shoe Hightop Depth Inlay	Non Covered: Procedure/service not covered by BCBSOK. Not			
LJZZZ	Each	subject to utilization review.	-	-	-
L3224	Orthopedic Footwear Woman'S Shoe Oxford Used As An	Non Covered: Procedure/service not covered by BCBSOK. Not			
15224	Integral Part Of A Brace (Orthosis)	subject to utilization review.	-	-	-
L3225	Orthopedic Footwear Man'S Shoe Oxford Used As An	Non Covered: Procedure/service not covered by BCBSOK. Not			
13225		· · ·	-	-	-
L3230	Integral Part Of A Brace (Orthosis)	subject to utilization review.			
L3230	Orthopedic Footwear Custom Shoe Depth Inlay Each	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
12250	Outback d'a Factoria Castary Maldad Chara David able	subject to utilization review.			
L3250	Orthopedic Footwear Custom Molded Shoe Removable	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
10054	Inner Mold Prosthetic Shoe Each	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		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Custom Fabricated Each	subject to utilization review.			
L3253	Foot Molded Shoe Plastazote (Or Similar) Custom Fitted	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Each	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			
	Ŭ	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	(Leather With Eyelets)	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Soft Counter	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Plate Existing	subject to utilization review.	-	–	-
L3610		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Plate New	subject to utilization review.	-	-	_
L3620	Transfer Of An Orthosis From One Shoe To Another Solid	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Stirrup Existing	subject to utilization review.	-	-	_
L3630	Transfer Of An Orthosis From One Shoe To Another Solid	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Stirrup New	subject to utilization review.	-	-	-
L3640		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Browne Splint (Riveton) Both Shoes	subject to utilization review.	-	-	_
L3649	Orthopedic Shoe Modification Addition Or Transfer Not	Non Covered: Procedure/service not covered by the Plan. Not			
	Otherwise Specified	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	MP Criteria: Procedure/service reviewed to ensure each service			
10010	Knee Hydracadence System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
1.5011	Knee - Knee Disarticulation 4 Bar Linkage With Friction	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Swing Phase Control	submitting a Recommended Clinical Review (Predetermination)			
	Swilly Flidse Colluloi	, , , , , , , , , , , , , , , , , , ,			
		request if it is unclear if the service meets BCBSOK Medical			
L5613	Addition To Lower Extremity Endeckeletal System Above	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		 	
12012	Addition To Lower Extremity Endoskeletal System Above		-	-	-
	Knee-Knee Disarticulation 4 Bar Linkage With Hydraulic	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Swing Phase Control	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

L5614	Addition To Lower Extremity Exoskeletal System Above	MP Criteria: Procedure/service reviewed to ensure each service			
20011	Knee-Knee Disarticulation 4 Bar Linkage With Pneumatic	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Swing Phase Control	submitting a Recommended Clinical Review (Predetermination)			
	Swing Phase Control	request if it is unclear if the service meets BCBSOK Medical			
L5615	Addition Endoskeletal Knee-Shin System 4 Bar Linkage Or	Policy criteria. MP Criteria: Procedure/service reviewed against Medical Policy 1	/1/2024		Add effective
15015	Multiaxial Fluid Swing And Stance Phase Control	Criteria. Submit for Recommended Clinical Review	./ 1/ 2024	-	01/01/2024
	Multiaxial Fluid Swillg And Stance Phase Control				01/01/2024
L5616	Addition To Lower Extremity Endoskeletal System Above	(Predetermination) to avoid post-service review. MP Criteria: Procedure/service reviewed to ensure each service			
13010	Knee Universal Multiplex System Friction Swing Phase	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Control	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
L5620	Addition To Lower Extremity Test Socket Below Knee	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			-
13020	Addition to Lower Extremity Test Socket Below Kilee		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
15004	Addition Tells and File soft. Test Cost of Alexandratic	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	MP Criteria: Procedure/service reviewed to ensure each service _	-	-	_
	Disarticulation Acrylic Socket	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
20010	Socket	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	JOUREL	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			
20012	Addition to cover extremity Above thee cediter booker	meets BCBSOK 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			
10011		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Socket External Frame	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Equal Cushion Socket	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Equal Cushion Socket	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Socket External Frame	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Knee Or Knee Disarticulation Socket	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
23070	Supracondylar Suspension ('Pts' Or Similar)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Single Axis Pair	meets BCBSOK 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		MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Lock	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
L5711	Additions Exoskeletal Knee-Shin System Single Axis Manual	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13/11	Lock Ultra-Light Material	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
23712	Swing And Stance Phase Control (Safety Knee)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Variable Friction Swing Phase Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			1
13/10	Mechanical Stance Phase Lock	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		· ·			
L5718	Addition Exoskeletal Knee-Shin System Polycentric	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13718	Friction Swing And Stance Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Friction swing And Stance Phase control	· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
L5722	Addition Exoskeletal Knee-Shin System Single Axis	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
13722	Pneumatic Swing Friction Stance Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Filedifiatic Swillg Fliction Statice Flase Colition	· ·			
		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	MP Criteria: Procedure/service reviewed to ensure each service			
13724	Swing Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Swing Phase control	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	MP Criteria: Procedure/service reviewed to ensure each service			
23720	External Joints Fluid Swing Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	External Joints Hald Swing Hase control	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	MP Criteria: Procedure/service reviewed to ensure each service			
20720	Swing And Stance Phase Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Pneumatic/Hydra Pneumatic Swing Phase Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Material (Titanium Carbon Fiber Or Equal)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	Ē	_
	· · · · · · · · · · · · · · · · · · ·	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	MP Criteria: Procedure/service reviewed to ensure each service			_
	Material (Titanium Carbon Fiber Or Equal)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	Ē	_
		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	MP Criteria: Procedure/service reviewed to ensure each service		Γ	
	Material (Titanium Carbon Fiber Or Equal)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Manual Lock	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			_
	Manual Lock Ultra-Light Material	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Friction Swing And Stance Phase Control (Safety Knee)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Hydraulic Swing Phase Control Mechanical Stance Phase	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Lock	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	MP Criteria: Procedure/service reviewed to ensure each service	-	 _	-
	Mechanical Stance Phase Lock	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Friction Swing And Stance Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
. 5000		Policy criteria.			
L5822	Addition Endoskeletal Knee-Shin System Single Axis	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Pneumatic Swing Friction Stance Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
15024	Addition Endeskolstel Knos Chin Custom Circle A. S. S. St.	Policy criteria.			
L5824	Addition Endoskeletal Knee-Shin System Single Axis Fluid	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Swing Phase Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.	ļ	ļ	ļ

L5826	Addition Endoskeletal Knee-Shin System Single Axis	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	Frame	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Swing And Stance Phase Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Pneumatic/ Swing Phase Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Multiaxial Pneumatic Swing Phase Control	meets BCBSOK 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	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effectuce
	Pneumatic Swing And Stance Phase Control	Criteria. Submit for Recommended Clinical Review			04/01/2024
		(Predetermination) to avoid post-service review.			
L5848		MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Extension Dampening Feature With Or Without	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Adjustability	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L5856		MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Shin System Microprocessor Control Feature Swing And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Stance Phase Includes Electronic Sensor(S) Any Type	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L5857		MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Shin System Microprocessor Control Feature Swing Phase	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Only Includes Electronic Sensor(S) Any Type	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L5858		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Only Includes Electronic Sensor(S) Any Type	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-	MP Criteria: Procedure/service reviewed to ensure each service			
	Shin System Powered And Programmable Flexion/Extension		-	-	_
	Assist Control Includes Any Type Motor(S)	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	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		Add effective
	Disarticulation Above Knee Hip Disarticulation Positional	Criteria. Submit for Recommended Clinical Review			01/01/2024
	Rotation Unit Any Type	(Predetermination) to avoid post-service review.			
L5961	Addition Endoskeletal System Polycentric Hip Joint	MP Criteria: Procedure/service reviewed to ensure each service	· _		
	Pneumatic Or Hydraulic Control Rotation Control With Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Without Flexion And/Or Extension Control	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	MP Criteria: Procedure/service reviewed to ensure each service	· _	_	_
	Protective Outer Surface Covering System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	·		
	Protective Outer Surface Covering System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Protective Outer Surface Covering System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	2	_	_
	Swing Phase Active Dorsiflexion Feature	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	<u> </u>	_	_
	Assist Includes Any Type Motor(S)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	2		_
	Foot	meets BCBSOK 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 _	-	-
1		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Feature Dorsiflexion And/Or Plantar Flexion Control	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
	Includes Power Source	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		MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Carbon Copy li Or Equal)	meets BCBSOK 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		
15070		Policy criteria.		
L5979	All Lower Extremity Prosthesis Multi-Axial Ankle Dynamic	MP Criteria: Procedure/service reviewed to ensure each service _	-	-
	Response Foot One Piece System	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
L5980	All Lower Extremity Prostheses Flex Foot System	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
13980	All Lowel Extremity Prostneses Flex Foot System		—	-
		meets BCBSOK 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		
25561	All Lower Extremity Prostneses Thex-Walk System of Equal	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		
23302	Unit	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
1		Policy criteria.		
		Pulley citteria.	ļ	ļ.

L5984	All Endoskeletal Lower Extremity Prosthesis Axial Rotation	MP Criteria: Procedure/service reviewed to ensure each service			
23304	Unit With Or Without Adjustability	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	onic with of without Adjustability	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	MP Criteria: Procedure/service reviewed to ensure each service			
23303	Prosthetic Pylon	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
23300	('Mcp' Or Equal)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
20007	Vertical Loading Pylon	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
	External Prosthetic Connector	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	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Prosthesis External Power Self-Suspended Inner Socket	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	With Removable Forearm Section Electrodes And Cables	submitting a Recommended Clinical Review (Predetermination)			
	Two Batteries Charger Myoelectric Control Of Terminal	request if it is unclear if the service meets BCBSOK Medical			
	Device Excludes Terminal Device(S)	Policy criteria.			
L6611	Addition To Upper Extremity Prosthesis External Powered	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Additional Switch Any Type	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Wrist With Or Without Friction For Use With External	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Powered Terminal Device	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Motor(S) Initial Issue Or Replacement	meets BCBSOK 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	

L6880	Electric Hand Switch Or Myolelectric Controlled	MP Criteria: Procedure/service reviewed to ensure each service		T	
20000	Independently Articulating Digits Any Grasp Pattern Or	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Combination Of Grasp Patterns Includes Motor(S)	submitting a Recommended Clinical Review (Predetermination)			
	combination of Grasp Patterns includes Motor(5)	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6882	Microprocessor Control Feature Addition To Upper Limb	MP Criteria: Procedure/service reviewed to ensure each service			
20002	Prosthetic Terminal Device	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
20020	Socket Removable Forearm Shell Otto Bock Or Equal	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Switch Cables Two Batteries And One Charger Switch	submitting a Recommended Clinical Review (Predetermination)			
	Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6925	Wrist Disarticulation External Power Self-Suspended Inner	MP Criteria: Procedure/service reviewed to ensure each service			
	Socket Removable Forearm Shell Otto Bock Or Equal	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Electrodes Cables Two Batteries And One Charger	submitting a Recommended Clinical Review (Predetermination)			
	Myoelectronic Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6930	Below Elbow External Power Self-Suspended Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service			
		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Two Batteries And One Charger Switch Control Of Terminal	submitting a Recommended Clinical Review (Predetermination)			
	Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6935	Below Elbow External Power Self-Suspended Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service			
	Removable Forearm Shell Otto Bock Or Equal Electrodes	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	Cables Two Batteries And One Charger Myoelectronic	submitting a Recommended Clinical Review (Predetermination)			
	Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6940	Elbow Disarticulation External Power Molded Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Removable Humeral Shell Outside Locking Hinges Forearm	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Otto Bock Or Equal Switch Cables Two Batteries And One	submitting a Recommended Clinical Review (Predetermination)			
	Charger Switch Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6945	Elbow Disarticulation External Power Molded Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Removable Humeral Shell Outside Locking Hinges Forearm	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Otto Bock Or Equal Electrodes Cables Two Batteries And	submitting a Recommended Clinical Review (Predetermination)			
	One Charger Myoelectronic Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
L6950	Above Elbow External Power Molded Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Removable Humeral Shell Internal Locking Elbow Forearm	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Otto Bock Or Equal Switch Cables Two Batteries And One	submitting a Recommended Clinical Review (Predetermination)			
	Charger Switch Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

L6955	Above Elbow External Power Molded Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service			
20000	Removable Humeral Shell Internal Locking Elbow Forearm	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Otto Bock Or Equal Electrodes Cables Two Batteries And	submitting a Recommended Clinical Review (Predetermination)			
	One Charger Myoelectronic Control Of Terminal Device	request if it is unclear if the service meets BCBSOK Medical			
	one charger mybelectionic control of reminal bevice	Policy criteria.			
L6960	Shoulder Disarticulation External Power Molded Inner	MP Criteria: Procedure/service reviewed to ensure each service			
	Socket Removable Shoulder Shell Shoulder Bulkhead	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Humeral Section Mechanical Elbow Forearm Otto Bock Or	submitting a Recommended Clinical Review (Predetermination)			
	Equal Switch Cables Two Batteries And One Charger Switch	Ū , , , , , , , , , , , , , , , , , , ,			
	Control Of Terminal Device	Policy criteria.			
L6965	Shoulder Disarticulation External Power Molded Inner	MP Criteria: Procedure/service reviewed to ensure each service			
	Socket Removable Shoulder Shell Shoulder Bulkhead	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Humeral Section Mechanical Elbow Forearm Otto Bock Or	submitting a Recommended Clinical Review (Predetermination)			
	Equal Electrodes Cables Two Batteries And One Charger	request if it is unclear if the service meets BCBSOK Medical			
	Myoelectronic Control Of Terminal Device	Policy criteria.			
L6970		MP Criteria: Procedure/service reviewed to ensure each service			
	Removable Shoulder Shell Shoulder Bulkhead Humeral	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_		
	Section Mechanical Elbow Forearm Otto Bock Or Equal	submitting a Recommended Clinical Review (Predetermination)			
	Switch Cables Two Batteries And One Charger Switch	request if it is unclear if the service meets BCBSOK Medical			
	Control Of Terminal Device	Policy criteria.			
L6975	Interscapular-Thoracic External Power Molded Inner Socket	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Removable Shoulder Shell Shoulder Bulkhead Humeral	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Section Mechanical Elbow Forearm Otto Bock Or Equal	submitting a Recommended Clinical Review (Predetermination)			
	Electrodes Cables Two Batteries And One Charger	request if it is unclear if the service meets BCBSOK Medical			
	Myoelectronic Control Of Terminal Device	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.			

17045	Flootric Hook Switch Or Mucoloctric Ontrolled Dedictric	MD Criteria: Dreadure leaning reviewed to answer and		I	
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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Elbow And Terminal Device	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Elbow And Terminal Device	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Switch Controlled	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Controlled	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Myoelectronically Controlled	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Myoelectronically Controlled	meets BCBSOK 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	\		
L/300	Six Voit Battery Each		-	-	-
		meets BCBSOK 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	2 _	-	-
		meets BCBSOK 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	2_	_	_
		meets BCBSOK 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	5 _	_	_
		meets BCBSOK 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	2		_
		meets BCBSOK 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	2		
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	<u>.</u>		
2,302	Replacement Only Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	· -	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
19020	Project Procthosic Not Otherwise Specified	Policy criteria. Unlisted or Undefined: Procedure/service not otherwise			
L8039	Breast Prosthesis Not Otherwise Specified		-	-	-
		defined or classified, and may be subject to benefit and/or			
		clinical review.			

L8048	Unspecified Maxillofacial Prosthesis By Report Provided By	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	A Non-Physician	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.	EIU: Procedure/service not reimbursed by the Plan. Not subject	5/15/2024	-	Add effective
	5 MI Syringe Includes Shipping And Necessary Supplies	to pre-service review. Check EIU policy, which is one of our			05/15/2024
		Clinical Payment and Coding Policy (CPCP).			
L8604	Injectable Bulking Agent Dextranomer/Hyaluronic Acid	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Copolymer Implant Urinary Tract 1 MI Includes Shipping	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And Necessary Supplies	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Copolymer Implant Anal Canal 1 MI Includes Shipping And				
	Necessary Supplies	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
L8606	Injectable Bulking Agent Synthetic Implant Urinary Tract 1	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	MI Syringe Includes Shipping And Necessary Supplies	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	MI Includes Shipping And Necessary Supplies	meets BCBSOK 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		EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Use With The Argus Ii Retinal Prosthesis System	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
10000		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			
10610		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			
10070		Policy criteria.			
L8678	Electrical Stimulator Supplies (External) For Use With	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Implantable Neurostimulator Per Month	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			

10070	Incelestable Neurotinulates Dulas Consults : A T	MD Criteria. Dressed une last instantiation de la sus inst			1
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			
10000		Policy criteria.		l	
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			
10004		Policy criteria.			
L8681	Patient Programmer (External) For Use With Implantable	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Programmable Neurostimulator Pulse Generator	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Replacement Only	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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Implantable Neurostimulator Radiofrequency Receiver	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Rechargeable Includes Extension	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Non-Rechargeable Includes Extension	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Rechargeable Includes Extension	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Non-Rechargeable Includes Extension	meets BCBSOK 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 Becharging System For Pattery (Internal) For Lice	MD Critaria: Procedure/convice reviewed to onsure each convice			1
LOUDY	External Recharging System For Battery (Internal) For Use	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	With Implantable Neurostimulator Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
10004		Policy criteria.			
L8694	Auditory Osseointegrated Device Transducer/Actuator	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Replacement Only Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
10005		Policy criteria.			
L8695	External Recharging System For Battery (External) For Use	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	With Implantable Neurostimulator Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
19609	Miccollangous Component Surath Or Assessment Fredha	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
L8698	Miscellaneous Component Supply Or Accessory For Use		-	-	-
	With Total Artificial Heart System	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
19600	Dreath stic Incoloret Net Otherwise Creatified	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			
L8701	Powered Upper Extremity Range Of Motion Assist Device	clinical review. MP Criteria: Procedure/service reviewed to ensure each service			
10/01	Elbow Wrist Hand With Single Or Double Upright(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Includes Microprocessor Sensors All Components And	submitting a Recommended Clinical Review (Predetermination)			
	Accessories Custom Fabricated				
	Accessories Custom Fabricated	request if it is unclear if the service meets BCBSOK Medical			
L8702	Powered Upper Extremity Range Of Motion Assist Device	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
10702	Elbow Wrist Hand Finger Single Or Double Upright(S)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Includes Microprocessor Sensors All Components And	submitting a Recommended Clinical Review (Predetermination)			
	Accessories Custom Fabricated	request if it is unclear if the service meets BCBSOK Medical			
	Accessories Custom Fabricated	Policy criteria.			
M0001	Advancing Cancer Care Mips Value Pathways	Non Covered: Procedure/service not covered by BCBSOK. Not			
WIOODI	Auvancing cancer care imps value r attiways	subject to utilization review.	-	-	-
M0002	Optimal Care For Kidney Health Mips Value Pathways	Non Covered: Procedure/service not covered by BCBSOK. Not			
1010002	Optimal care for Kidney health wips value fathways	subject to utilization review.	-	-	-
M0003	Optimal Care For Patients With Episodic Neurological	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Conditions Mips Value Pathways	subject to utilization review.	-	-	-
M0004	Supportive Care For Neurodegenerative Conditions Mips	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Value Pathways	subject to utilization review.	-	-	-
M0005	Value In Primary Care Mips Value Pathway	Non Covered: Procedure/service not covered by BCBSOK. Not			
	salde in thinking care thips value tuttivay	subject to utilization review.	-	-	-
M0075	Cellular Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not			
1110075	Contract Therapy	subject to utilization review.	-	-	-
		Subject to utilization review.			

M0076	Prolotherapy	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
10076	Рюбонетару	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			
10100	Intragastile Hypotherma Using Gastile Heezing		-	-	-
M0240	Introveneus Influcion Or Subsutaneous Injection Cosiriuimah	subject to utilization review. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
10240			-	-	-
	And Imdevimab Includes Infusion Or Injection And Post	to utilization review. Please see the Clinical Payment and			
	Administration Monitoring Subsequent Repeat Doses	Coding Policy titled: Non-Reimbursable Experimental,			
M0241		Investigational and/or Unproven Services (EIU).			
10241	-	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	And Imdevimab Includes Infusion Or Injection And Post	to utilization review. Please see the Clinical Payment and			
	Administration Monitoring In The Home Or Residence This	Coding Policy titled: Non-Reimbursable Experimental,			
	Includes A Beneficiary'S Home That Has Been Made Provider	Investigational and/or Unproven Services (EIU).			
	Based To The Hospital During The Covid-19 Public Health				
	Emergency Subsequent Repeat Doses				
M0243	Intravenous Infusion Or Subcutaneous Injection, Casirivinab	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
1010245	And Imdevimab Includes Infusion Or Injection And Post	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
	Administration Monitoring				
M0244	Introvenous Infusion Or Subsutaneous Injection, Casirivimab	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
10244	And Imdevimab Includes Infusion Or Injection And Post	to utilization review. Please see the Clinical Payment and	-	-	-
	-				
	Administration Monitoring In The Home Or Residence; This	Coding Policy titled: Non-Reimbursable Experimental,			
	Includes A Beneficiary'S Home That Has Been Made Provider	investigational and/or Unproven Services (EIU).			
	Based To The Hospital During The Covid-19 Public Health				
M0245	Emergency Intravenous Infusion Bamlanivimab And Etesevimab	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
10245	Includes Infusion And Post Administration Monitoring	to utilization review. Please see the Clinical Payment and	-	-	-
	includes infusion And Fost Administration Monitoring	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
M0246	Intravenous Infusion Bamlanivimab And Etesevimab	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
10240	Includes Infusion And Post Administration Monitoring In The		-	-	-
	Home Or Residence; This Includes A Beneficiary'S Home	Coding Policy titled: Non-Reimbursable Experimental,			
	That Has Been Made Provider Based To The Hospital During	Investigational and/or Unproven Services (EIU).			
M0300	The Covid 19 Public Health Emergency Iv Chelation Therapy (Chemical Endarterectomy)	MP Criteria: Procedure/service reviewed to ensure each service			
10000		meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
M1150	Left Ventricular Ejection Fraction (Lvef) Less Than Or Equal	Policy criteria. Non Covered: Procedure/service not covered by BCBSOK. Not			
WIII JU	To 40% Or Documentation Of Moderately Or Severely	subject to utilization review.	-	-	-
	Depressed Left Ventricular Systolic Function				
M1151	Patients With A History Of Heart Transplant Or With A Left	Non Covered: Procedure/service not covered by BCBSOK. Not			
IVITTOT			-	-	-
	Ventricular Assist Device (Lvad)	subject to utilization review.			

N411E2	Detients With A Listers Of Least Transplant On With A Laft	New Coursed, Dressedure (see its set sourced by DCDCOK, Net			
M1152	Patients With A History Of Heart Transplant Or With A Left	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Ventricular Assist Device (Lvad)	subject to utilization review.			
M1153	Patient With Diagnosis Of Osteoporosis On Date Of	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
= .	Encounter	subject to utilization review.			
M1154	Hospice Services Provided To Patient Any Time During The	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Measurement Period	subject to utilization review.			
M1155	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Any Time During Or Before The Measurement Period	subject to utilization review.			
M1159	Hospice Services Provided To Patient Any Time During The	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Measurement Period	subject to utilization review.			
M1160	Patient Had Anaphylaxis Due To The Meningococcal Vaccine	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Any Time On Or Before The Patient'S 13Th Birthday	subject to utilization review.			
	, , , , , , , , , , , , , , , , , , , ,				
M1161	Patient Had Anaphylaxis Due To The Tetanus Diphtheria Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Pertussis Vaccine Any Time On Or Before The Patient'S 13Th		-	-	-
	Birthday				
M1162	Patient Had Encephalitis Due To The Tetanus Diphtheria Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
1011102	Pertussis Vaccine Any Time On Or Before The Patient'S 13Th		-	-	-
	Birthday	subject to utilization review.			
M1163		Non Covered: Procedure/service not covered by BCBSOK. Not			
1011105			-	-	-
N444C4	On Or Before The Patient'S 13Th Birthday	subject to utilization review.			
M1164	Patients With Dementia Any Time During The Patient'S	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	History Through The End Of The Measurement Period	subject to utilization review.			
M1165	Patients Who Use Hospice Services Any Time During The	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Measurement Period	subject to utilization review.			
M1166	Pathology Report For Tissue Specimens Produced From	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Wide Local Excisions Or Re-Excisions	subject to utilization review.			
M1167	In Hospice Or Using Hospice Services During The	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	Measurement Period	subject to utilization review.			
M1168	Patient Received An Influenza Vaccine On Or Between July 1	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Of The Year Prior To The Measurement Period And June 30	subject to utilization review.			
	Of The Measurement Period				
M1169	Documentation Of Medical Reason(S) For Not Administering	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Influenza Vaccine (E.G. Prior Anaphylaxis Due To The	subject to utilization review.			
	Influenza Vaccine)				
M1170	Patient Did Not Receive An Influenza Vaccine On Or	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Between July 1 Of The Year Prior To The Measurement	subject to utilization review.			
	Period And June 30 Of The Measurement Period				
M1171	Patient Received At Least One Td Vaccine Or One Tdap	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Vaccine Between Nine Years Prior To The Encounter And	subject to utilization review.		_	
	The End Of The Measurement Period				
M1172		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Td Or Tdap Vaccine (E.G. Prior Anaphylaxis Due To The Td	subject to utilization review.	-	-	-
	Or Tdap Vaccine Or History Of Encephalopathy Within Seven				
	Days After A Previous Dose Of A Td-Containing Vaccine)				

M1173	Patient Did Not Receive At Least One Td Vaccine Or One	Non Covered: Procedure/service not covered by BCBSOK. Not			
IVI1173		,	-	-	-
	Tdap Vaccine Between Nine Years Prior To The Encounter	subject to utilization review.			
	And The End Of The Measurement Period				
M1174	Patient Received At Least Two Doses Of The Herpes Zoster	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Recombinant Vaccine (At Least 28 Days Apart) Anytime On	subject to utilization review.			
	Or After The Patient'S 50Th Birthday Before Or During The				
	Measurement Period				
M1175	Documentation Of Medical Reason(S) For Not Administering	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	-
	Zoster Vaccine (E.G. Prior Anaphylaxis Due To The Zoster	subject to utilization review.			
	Vaccine)				
M1176	Patient Did Not Receive At Least Two Doses Of The Herpes	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Zoster Recombinant Vaccine (At Least 28 Days Apart)	subject to utilization review.			
	Anytime On Or After The Patient'S 50Th Birthday Before Or				
	During The Measurement Period				
M1177	Patient Received Any Pneumococcal Conjugate Or	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Polysaccharide Vaccine On Or After Their 60Th Birthday And	subject to utilization review.			
	Before The End Of The Measurement Period				
M1178		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Pneumococcal Vaccine (E.G. Prior Anaphylaxis Due To The	subject to utilization review.	-	–	-
	Pneumococcal Vaccine)				
M1179	Patient Did Not Receive Any Pneumococcal Conjugate Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Polysaccharide Vaccine On Or After Their 60Th Birthday And	· · ·	-	-	-
	Before Or During Measurement Period				
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	Non Covered: Procedure/service not covered by BCBSOK. Not			
-	Bowel Disease (Ibd) (E.G. Ulcerative Colitis Crohn'S Disease)		-	-	-
M1183	Documentation Of Immune Checkpoint Inhibitor Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Held And Corticosteroids Or Immunosuppressants	subject to utilization review.	-	-	-
	Prescribed Or Administered	subject to utilization review.			
M1184		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Administering Corticosteroid Or Immunosuppressant	subject to utilization review.	-	-	-
	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)				
M1185	Documentation Of Immune Checkpoint Inhibitor Therapy	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Not Held And/Or Corticosteroids Or Immunosuppressants	subject to utilization review.			
	Prescribed Or Administered Was Not Performed Reason Not				
	Given				
M1186	Patients Who Have An Order For Or Are Receiving Hospice	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Or Palliative Care	subject to utilization review.			

N41107	Detients With A Discretic Of Full Observation (Full)	New Coursed, Dreading (service set to service because the Dependent of			
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		Non Covered: Procedure/service not covered by BCBSOK. Not	_	-	-
	Stage 5	subject to utilization review.			
M1189	Documentation Of A Kidney Health Evaluation Defined By An	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Estimated Glomerular Filtration Rate (Egfr) And Urine	subject to utilization review.			
	Albumin-Creatinine Ratio (Uacr) Performed				
M1190	Documentation Of A Kidney Health Evaluation Was Not	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Performed Or Defined By An Estimated Glomerular Filtration	subject to utilization review.			
	Rate (Egfr) And Urine Albumin-Creatinine Ratio (Uacr)				
M1191	Hospice Services Provided To Patient Any Time During The	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	
	Measurement Period	subject to utilization review.			
M1192	Patients With An Existing Diagnosis Of Squamous Cell	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Carcinoma Of The Esophagus	subject to utilization review.			
M1193	Surgical Pathology Reports That Contain Impression Or	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	
	Conclusion Of Or Recommendation For Testing Of Mmr By	subject to utilization review.			
	Immunohistochemistry Msi By Dna-Based Testing Status Or				
	Both				
M1194	Documentation Of Medical Reason(S) Surgical Pathology	Non Covered: Procedure/service not covered by BCBSOK. Not	_		_
	Reports Did Not Contain Impression Or Conclusion Of Or	subject to utilization review.			
	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)				
M1195	Surgical Pathology Reports That Do Not Contain Impression	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Or Conclusion Of Or Recommendation For Testing Of Mmr	subject to utilization review.	-	–	_
	By Immunohistochemistry Msi By Dna-Based Testing Status				
	Or Both Reason Not Given				
M1196	Initial (Index Visit) Numeric Rating Scale (Nrs) Visual Rating	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Scale (Vrs) Or Itchyquant Assessment Score Of Greater Than				
	Or Equal To 4				
M1197	Itch Severity Assessment Score Is Reduced By 3 Or More	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Points From The Initial (Index) Assessment Score To The	subject to utilization review.			
	Follow-Up Visit Score				
M1198	Itch Severity Assessment Score Was Not Reduced By At	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Least 3 Points From Initial (Index) Score To The Follow-Up	subject to utilization review.			
	Visit Score Or Assessment Was Not Completed During The				
	Follow-Up Encounter				
M1199		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Patients Receiving Rrt				
		subject to utilization review.	-	-	
M1200	Ace Inhibitor (Ace-I) Or Arb Therapy Prescribed During The				

M1201	Documentation Of Medical Reason(S) For Not Prescribing	Non Covered: Procedure/service not covered by BCBSOK. Not			
111201	Ace Inhibitor (Ace-I) Or Arb Therapy During The	subject to utilization review.	-	-	-
	Measurement Period (E.G. Pregnancy History Of	Subject to utilization review.			
	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)				
M1202		Non Covered: Procedure/service not covered by BCBSOK. Not			
111202	Inhibitor Or Arb Therapy During The Measurement Period	subject to utilization review.	-	-	-
	(E.G. Patient Declined Other Patient Reasons)				
M1203	Ace Inhibitor Or Arb Therapy Not Prescribed During The	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Measurement Period Reason Not Given	subject to utilization review.	-	-	-
M1204	Initial (Index Visit) Numeric Rating Scale (Nrs) Visual Rating	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Scale (Vrs) Or Itchyquant Assessment Score Of Greater Than		-	-	-
	Or Equal To 4				
M1205	Itch Severity Assessment Score Is Reduced By 3 Or More	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Points From The Initial (Index) Assessment Score To The	subject to utilization review.	-	-	-
	Follow-Up Visit Score				
M1206	Itch Severity Assessment Score Was Not Reduced By At	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Least 3 Points From Initial (Index) Score To The Follow-Up	subject to utilization review.	-	-	-
	Visit Score Or Assessment Was Not Completed During The				
	Follow-Up Encounter				
M1207	Patient Is Screened For Food Insecurity Housing Instability	Non Covered: Procedure/service not covered by BCBSOK. Not			
-	Transportation Needs Utility Difficulties And Interpersonal	subject to utilization review.	-	-	-
	Safety	· · · · · · · · · · · · · · · · · · ·			
M1208	Patient Is Not Screened For Food Insecurity Housing	Non Covered: Procedure/service not covered by BCBSOK. Not			_
	Instability Transportation Needs Utility Difficulties And	subject to utilization review.			
	Interpersonal Safety				
M1209	At Least Two Orders For High-Risk Medications From The	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Same Drug Class (Table 4) Without Appropriate Diagnoses	subject to utilization review.			
M1210	At Least Two Orders For High-Risk Medications From The	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Same Drug Class (Table 4) Not Ordered	subject to utilization review.			
M1211	Most Recent Hemoglobin A1C Level > 9.0%	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
		subject to utilization review.			01/01/2024
M1212	Hemoglobin A1C Level Is Missing Or Was Not Performed	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	During The Measurement Period (12 Months)	subject to utilization review.			01/01/2024
M1213	No History Of Spirometry Results With Confirmed Airflow	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Obstruction (Fev1/Fvc < 70%) And Present Spirometry Is >=	subject to utilization review.			01/01/2024
	70%				
M1214	Spirometry Results With Confirmed Airflow Obstruction	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	(Fev1/Fvc < 70%) Documented And Reviewed	subject to utilization review.			01/01/2024
M1215	Documentation Of Medical Reason(S) For Not Documenting	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	And Reviewing Spirometry Results (E.G. Patients With	subject to utilization review.			01/01/2024
	Dementia Or Tracheostomy)				

M1216		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		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		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	lop 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	1/1/2024	_ Add effective 01/01/2024
M1229	Patient Who Has A Reactive Hcv Antibody Test And Has A	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	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
111230	Have A Follow Up Hcv Viral Test Or Patient Has A Reactive	subject to utilization review.	1/1/2024	-	01/01/2024
	Hcv Antibody Test And Has A Follow Up Hcv Viral Test That	subject to utilization review.			01/01/2024
	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				
M1231	Patient Receives Hcv Antibody Test With Nonreactive Result	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
		subject to utilization review.			01/01/2024
M1232	Patient Receives Hcv Antibody Test With Reactive Result	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
		subject to utilization review.			01/01/2024
M1233	Patient Does Not Receive Hcv Antibody Test Or Patient Does	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Receive Hcv Antibody Test But Results Not Documented	subject to utilization review.			01/01/2024
	Reason Not Given				
M1234	Patient Has A Reactive Hcv Antibody Test And Has A Follow	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Up Hcv Viral Test That Does Not Detect Hcv Viremia	subject to utilization review.			01/01/2024
M1235	Documentation Or Patient Report Of Hcv Antibody Test Or	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Hcv Rna Test Which Occurred Prior To The Performance	subject to utilization review.			01/01/2024
	Period				
M1236	Baseline Mrs > 2	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
		subject to utilization review.			01/01/2024
M1237	Patient Reason For Not Screening For Food Insecurity	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Housing Instability Transportation Needs Utility Difficulties	subject to utilization review.			01/01/2024
	And Interpersonal Safety (E.G. Patient Declined Or Other				
	Patient Reasons)				
M1238	Documentation That Administration Of Second Recombinant	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Zoster Vaccine Could Not Occur During The Performance	subject to utilization review.			01/01/2024
	Period Due To The Recommended 2-6 Month Interval				
	Between Doses (I.E First Dose Received After October 31)				
M1239	Patient Did Not Respond To The Question Of Patient Felt	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
1011239	·		1/1/2024	-	
M1240	Heard And Understood By This Provider And Team Patient Did Not Respond To The Question Of Patient Felt	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		01/01/2024 Add effective
1011240			1/1/2024	-	01/01/2024
	This Provider And Team Put My Best Interests First When	subject to utilization review.			01/01/2024
N 44 2 44	Making Recommendations About My Care	New Conserved Descendence (see the second day DCDCOV), New	1/1/2024		A did offereiter
M1241	Patient Did Not Respond To The Question Of Patient Felt	· · · ·	1/1/2024	-	Add effective
	This Provider And Team Saw Me As A Person Not Just	subject to utilization review.			01/01/2024
N41242	Someone With A Medical Problem	New Coursed, Decedure (consistent of the DODGOV, At the	1/1/2024		
M1242	Patient Did Not Respond To The Question Of Patient Felt	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	This Provider And Team Understood What Is Important To	subject to utilization review.			01/01/2024
	Me In My Life		4 /4 /2023		
M1243	Patient Provided A Response Other Than Completely True		1/1/2024	-	Add effective
	For The Question Of Patient Felt Heard And Understood By	subject to utilization review.			01/01/2024
	This Provider And Team				

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

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

M1274	Patients Who Were Admitted To A Skilled Nursing Facility	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	(Snf) During The Month Of Evaluation Were Excluded From	subject to utilization review.		_	01/01/2024
	That Month				
M1275	Patients Determined To Be In Hospice Were Excluded From	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Month Of Evaluation And The Remainder Of Reporting	subject to utilization review.			01/01/2024
	Period				
M1276	Bmi Documented Outside Normal Parameters No Follow-Up	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Plan Documented No Reason Given	subject to utilization review.			01/01/2024
M1277	Colorectal Cancer Screening Results Documented And	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Reviewed	subject to utilization review.			01/01/2024
M1278	Elevated Or Hypertensive Blood Pressure Reading	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Documented And The Indicated Follow-Up Is Documented	subject to utilization review.			01/01/2024
M1279	Elevated Or Hypertensive Blood Pressure Reading	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Documented Indicated Follow-Up Not Documented Reason	subject to utilization review.			01/01/2024
	Not Given				
M1280	Women Who Had A Bilateral Mastectomy Or Who Have A	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	History Of A Bilateral Mastectomy Or For Whom There Is	subject to utilization review.			01/01/2024
	Evidence Of A Right And A Left Unilateral Mastectomy				
M1281	Blood Pressure Reading Not Documented Reason Not Given		1/1/2024	_	Add effective
		subject to utilization review.			01/01/2024
M1282	Patient Screened For Tobacco Use And Identified As A	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Tobacco Non-User	subject to utilization review.			01/01/2024
M1283	Patient Screened For Tobacco Use And Identified As A	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Tobacco User	subject to utilization review.			01/01/2024
M1284		· · ·	1/1/2024	_	Add effective
	(Snp) Or Residing In Long Term Care With Pos Code 32 33	subject to utilization review.			01/01/2024
	34 54 Or 56 For More Than 90 Consecutive Days During				
	The Measurement Period				
M1285	Screening Diagnostic Film Digital Or Digital Breast	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	Tomosynthesis (3D) Mammography Results Were Not	subject to utilization review.			01/01/2024
	Documented And Reviewed Reason Not Otherwise				
14200	Specified	New Constant Description (see the second data DCDCOV, Net	1/1/2024		Add effective
M1286	Bmi Is Documented As Being Outside Of Normal Parameters	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	
	Follow-Up Plan Is Not Completed For Documented Medical	subject to utilization review.			01/01/2024
M1287	Reason Rmills Documented Relew Normal Parameters And A Follow	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
1011207	Up Plan Is Documented	subject to utilization review.	1/1/2024	-	01/01/2024
M1288			1/1/2024		Add effective
	Follow-Up For High Blood Pressure	subject to utilization review.	-, -, -, -, -, -, -, -, -, -, -, -, -, -	-	01/01/2024
M1289		Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Cessation Intervention During The Measurement Period Or	subject to utilization review.	-, -, 202 1	-	01/01/2024
	In The Six Months Prior To The Measurement Period				
	(Counseling And/Or Pharmacotherapy)				
M1290		Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
		subject to utilization review.	, _,	-	01/01/2024

M1291	Patients 66 Years Of Age And Older With At Least One	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Claim/Encounter For Frailty During The Measurement	subject to utilization review.	-, -,	-	01/01/2024
	Period And A Dispensed Medication For Dementia During				,,
	The Measurement Period Or The Year Prior To The				
	Measurement Period				
M1292	Patients 66 Years Of Age And Older With At Least One	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Claim/Encounter For Frailty During The Measurement	subject to utilization review.		_	01/01/2024
	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				
M1293		Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Up Plan Is Documented	subject to utilization review.		_	01/01/2024
M1294	Normal Blood Pressure Reading Documented Follow-Up Not	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Required	subject to utilization review.			01/01/2024
M1295	Patients With A Diagnosis Or Past History Of Total	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Colectomy Or Colorectal Cancer	subject to utilization review.			01/01/2024
M1296	Bmi Is Documented Within Normal Parameters And No		1/1/2024	_	Add effective
	Follow-Up Plan Is Required	subject to utilization review.			01/01/2024
M1297	Bmi Not Documented Due To Medical Reason Or Patient	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Refusal Of Height Or Weight Measurement	subject to utilization review.			01/01/2024
M1298	Documentation Of Patient Pregnancy Anytime During The	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Measurement Period Prior To And Including The Current	subject to utilization review.			01/01/2024
	Encounter				
M1299	Influenza Immunization Administered Or Previously	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Received	subject to utilization review.			01/01/2024
M1300	Influenza Immunization Was Not Administered For Reasons	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Documented By Clinician (E.G. Patient Allergy Or Other	subject to utilization review.			01/01/2024
	Medical Reasons Patient Declined Or Other Patient Reasons				
	Vaccine Not Available Or Other System Reasons)				
M1301	Patient Identified As A Tobacco User Received Tobacco	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	Cessation Intervention During The Measurement Period Or	subject to utilization review.			01/01/2024
	In The Six Months Prior To The Measurement Period				
	(Counseling And/Or Pharmacotherapy)		1/1/2024		
M1302	Screening Diagnostic Film Digital Or Digital Breast	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	Tomosynthesis (3D) Mammography Results Documented	subject to utilization review.			01/01/2024
11202	And Reviewed	New Coursed, Decoding (see is set to see the DODGOV, at the	1/1/2024		
M1303	Hospice Services Provided To Patient Any Time During The		1/1/2024	-	Add effective
11204	Measurement Period	subject to utilization review.	1/1/2024		01/01/2024
M1304	Patient Did Not Receive Any Pneumococcal Conjugate Or		1/1/2024	-	Add effective
	Polysaccharide Vaccine On Or After Their 19Th Birthday And	subject to utilization review.			01/01/2024
	Before The End Of The Measurement Period				

M1305	Patient Received Any Pneumococcal Conjugate Or	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Polysaccharide Vaccine On Or After Their 19Th Birthday And			_	01/01/2024
	Before The End Of The Measurement Period				
M1306	Patient Had Anaphylaxis Due To The Pneumococcal Vaccine	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Any Time During Or Before The Measurement Period	subject to utilization review.			01/01/2024
M1307	Documentation Stating The Patient Has Received Or Is	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Currently Receiving Palliative Or Hospice Care	subject to utilization review.			01/01/2024
M1308			1/1/2024	_	Add effective
	Given	subject to utilization review.			01/01/2024
M1309		Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	The Measurement Period	subject to utilization review.			01/01/2024
M1310	Patient Screened For Tobacco Use And Received Tobacco	. ,	1/1/2024	-	Add effective
	Cessation Intervention During The Measurement Period Or	subject to utilization review.			01/01/2024
	In The Six Months Prior To The Measurement Period				
	(Counseling Pharmacotherapy Or Both) If Identified As A				
M1311	Tobacco User Anaphylaxis Due To The Vaccine On Or Before The Date Of	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
IVITOTI	The Encounter	subject to utilization review.	1/1/2024	-	01/01/2024
M1312	Patient Not Screened For Tobacco Use	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
1011312	Tatient Not Screened For Tobacco Ose	subject to utilization review.	1/1/2024	-	01/01/2024
M1313	Tobacco Screening Not Performed Or Tobacco Cessation		1/1/2024		Add effective
111515	Intervention Not Provided During The Measurement Period	subject to utilization review.	1, 1, 202 1	-	01/01/2024
	Or In The Six Months Prior To The Measurement Period				01/01/2021
M1314	Bmi Not Documented And No Reason Is Given	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
		subject to utilization review.		_	01/01/2024
M1315	Colorectal Cancer Screening Results Were Not Documented	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	And Reviewed; Reason Not Otherwise Specified	subject to utilization review.			01/01/2024
M1316	Current Tobacco Non-User	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
		subject to utilization review.			01/01/2024
M1317	Patients Who Are Counseled On Connection With A Csp And	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	_	Add effective
	Explicitly Opt Out	subject to utilization review.			01/01/2024
M1318		· · · · · ·	1/1/2024	_	Add effective
	For At Least One Of Their Screened Positive Hrsns Within 60	subject to utilization review.			01/01/2024
	Days After Screening Or Documentation That There Was No				
	Contact With A Csp				
M1319	Patients Who Had Documented Contact With A Csp For At	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024	-	Add effective
	Least One Of Their Screened Positive Hrsns Within 60 Days	subject to utilization review.			01/01/2024
14220	After Screening		4/4/2024		A -1 -1 - 551 -
M1320	Patients Who Screened Positive For At Least 1 Of The 5		1/1/2024	-	Add effective
N41221	Hrsns	subject to utilization review.	1/1/2024		01/01/2024
M1321		· · · · · ·	1/1/2024	-	Add effective
	Date Of Injection For Follow Up Or Who Did Not Have A	subject to utilization review.			01/01/2024
	Documented lop Or No Plan Of Care Documented If The lop				
	Was >25 Mm Hg				

M1322	Patients Seen Within 7 Weeks Following The Date Of	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Injection And Are Screened For Elevated Intraocular	subject to utilization review.		_	01/01/2024
	Pressure (lop) With Tonometry With Documented lop =<25				
	Mm Hg For Injected Eye				
M1323	Patients Seen Within 7 Weeks Following The Date Of	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Injection And Are Screened For Elevated Intraocular	subject to utilization review.		_	01/01/2024
	Pressure (lop) With Tonometry With Documented lop >25				
	Mm Hg And A Plan Of Care Was Documented				
M1324	Patients Who Had An Intravitreal Or Periocular	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Corticosteroid Injection (E.G. Triamcinolone Preservative-	subject to utilization review.	, , -	-	01/01/2024
	Free Triamcinolone Dexamethasone Dexamethasone	····,·····			
	Intravitreal Implant Or Fluocinolone Intravitreal Implant)				
M1325	Patients Who Were Not Seen For Reasons Documented By	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Clinician For Patient Or Medical Reasons (E.G. Inadequate	subject to utilization review.	-, -, -0- 1	-	01/01/2024
	Time For Follow-Up Patients Who Received A Prior				01/01/2024
	Intravitreal Or Periocular Steroid Injection Within The Last				
	Six (6) Months And Had A Subsequent lop Evaluation With				
	lop <25Mm Hg Within Seven (7) Weeks Of Treatment)				
M1326	Patients With A Diagnosis Of Hypotony	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
11520		subject to utilization review.	1, 1, 202 1	-	01/01/2024
M1327	Patients Who Were Not Appropriately Evaluated During The	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
11527	Initial Exam And/Or Who Were Not Re-Evaluated Within 8	subject to utilization review.	1/1/2024	-	01/01/2024
	Weeks				01/01/2024
M1328	Patients With A Diagnosis Of Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	c c	subject to utilization review.		_	01/01/2024
M1329	Patients With A Post-Operative Encounter Of The Eye With	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	The Acute Pvd Within 2 Weeks Before The Initial Encounter	subject to utilization review.	, , -	-	01/01/2024
	Or 8 Weeks After Initial Acute Pvd Encounter				
M1330	Documentation Of Patient Reason(S) For Not Having A	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Follow Up Exam (E.G. Inadequate Time For Follow Up)	subject to utilization review.	, , -	-	01/01/2024
M1331	Patients Who Were Appropriately Evaluated During The	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Initial Exam And Were Re-Evaluated No Later Than 8 Weeks		-, -,	-	01/01/2024
	From Initial Exam				01/01/2021
M1332	Patients Who Were Not Appropriately Evaluated During The	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
	Initial Exam And/Or Who Were Not Re-Evaluated Within 2	subject to utilization review.	-, -,	-	01/01/2024
	Weeks				01/01/2021
M1333	Acute Vitreous Hemorrhage	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
		subject to utilization review.	-, -,	-	01/01/2024
V1334	Patients With A Post-Operative Encounter Of The Eye With		1/1/2024		Add effective
	The Acute Pvd Within 2 Weeks Before The Initial Encounter	subject to utilization review.	-, -, 202 .	-	01/01/2024
	Or 2 Weeks After Initial Acute Pvd Encounter				
M1335	Documentation Of Patient Reason(S) For Not Having A	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
112000	Follow Up Exam (E.G. Inadeguate Time For Follow Up)	subject to utilization review.	1, 1, 2024	-	01/01/2024
M1336	Patients Who Were Appropriately Evaluated During The	Non Covered: Procedure/service not covered by BCBSOK. Not	1/1/2024		Add effective
11330			1/1/2024	-	01/01/2024
	miliai Exam Anu Were Re-Evaluated NO Later man 2 Weeks	subject to utilization review.			01/01/2024

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

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

P2031	Hair Analysis (Excluding Arsenic)	MP Criteria: Procedure/service reviewed to ensure each service			
P2031	Hall Analysis (Excluding Arsenic)		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
00000	Distaist Disk Discuss Fack Linit	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,			
P0000	Diand Company of Draduct Nat Otherwise Classified	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			
00025	Cardialuma arrantu	clinical review.			
Q0035	Cardiokymography	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
00114	Form Toot	subject to utilization review.			
Q0114	Fern Test	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
00115	Deat Califal Disect Qualitative Examinations Of Verinal Or	subject to utilization review.			
Q0115	Post-Coital Direct Qualitative Examinations Of Vaginal Or	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
Q0240	Cervical Mucous	subject to utilization review. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q0240	Injection Casirivimab And Imdevimab 600 Mg		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
Q0243	Injection Casirivimab And Imdevimab 2400 Mg	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q0243	injection casinvinab And indevinab 2400 Mg		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
Q0244	Injection Casirivimab And Imdevimab 1200 Mg	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q0244	injection casinvinab And indevinab 1200 Mg		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
Q0245	Injection Bamlanivimab And Etesevimab 2100 Mg	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q0245	injection barnanivinab And Etesevinab 2100 Mg	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
Q0477	Power Module Patient Cable For Use With Electric Or	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
Q0477	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
	Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
Q0478	Power Adapter For Use With Electric Or Electric/Pneumatic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
QU+70	Ventricular Assist Device Vehicle Type	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	ventricular Assist Device Venicle Type	-			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.	ļ	<u>I</u>	ļ

Q0479	Power Module For Use With Electric Or Electric/Pneumatic	MP Criteria: Procedure/service reviewed to ensure each service			
0475	Ventricular Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Ventricular Assist Device Replacement Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
0,0400	Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Replacement Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
0,0401	Ventricular Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Ventricular Assist Device Replacement Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
Q0+02	Electric/Pneumatic Combination Ventricular Assist Device	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Replacement Only	submitting a Recommended Clinical Review (Predetermination)			
	heplacement only	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
Q0483	Monitor/Display Module For Use With Electric Ventricular	MP Criteria: Procedure/service reviewed to ensure each service			
0,0400	Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Assist Device Replacement only	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	MP Criteria: Procedure/service reviewed to ensure each service			
L	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Only	submitting a Recommended Clinical Review (Predetermination)			
	omy	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
Q0485	Monitor Control Cable For Use With Electric Ventricular	MP Criteria: Procedure/service reviewed to ensure each service			
	Assist Device Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Ventricular Assist Device Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	Ĺ	
	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-		_
	Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
Q0400			-	-	-
	Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
00400		Policy criteria.			
Q0489	Power Pack Base For Use With Electric/Pneumatic	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Ventricular Assist Device Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Assist Device Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Ventricular Assist Device Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Ventricular Assist Device Replacement Only	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	_
	Only	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	MP Criteria: Procedure/service reviewed to ensure each service		1	
	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Only	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	MP Criteria: Procedure/service reviewed to ensure each service		1	
Q0750	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		ļ	

Q0497	Battery Clips For Use With Electric Or Electric/Pneumatic	MP Criteria: Procedure/service reviewed to ensure each service			
0437	Ventricular Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Ventricular Assist Device Replacement Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
Q0498	Holster For Use With Electric Or Electric/Pneumatic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
Q0498	Ventricular Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Ventricular Assist Device Replacement Only	· ·			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
Q0499	Belt/Vest/Bag For Use To Carry External Peripheral	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
Q0499	Components Of Any Type Ventricular Assist Device	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
		· ·			
	Replacement Only	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
Q0500	Filters For Use With Electric Or Electric/Pneumatic	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
0000	Ventricular Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Ventricular Assist Device Replacement Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
00001	Ventricular Assist Device Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Ventricular Assist Device Replacement Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
Q0502	Replacement Only	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	hepidement only	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Replacement Only Each	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Replacement Only Vehicle Type	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Electric/Pneumatic Ventricular Assist Device Replacement	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	F	-
	Only	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Ventricular Assist Device	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		_	_
	Implanted Ventricular Assist Device	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Implanted Ventricular Assist Device For Which Payment Was	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Not Made Under Medicare Part A	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	Non Covered: Procedure/service not covered by BCBSOK. Not	1/2/2024	_	Add effective
	Fda Approved Prescription Drug Per 30-Days	subject to utilization review.			01/02/2024
Q0517	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis	Non Covered: Procedure/service not covered by BCBSOK. Not	1/2/2024	-	Add effective
	Fda Approved Prescription Drug Per 60-Days	subject to utilization review.			01/02/2024
Q0518	Pharmacy Supplying Fee For Hiv Pre-Exposure Prophylaxis	. ,	1/2/2024	-	Add effective
	Fda Approved Prescription Drug Per 90-Days	subject to utilization review.			01/02/2024
Q2026	Injection Radiesse 0.1 MI	MP Criteria: Procedure/service reviewed to ensure each service	—	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
0.0000		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			
02020	Left and March March Mark Others in Case 19	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-	MP Criteria: Procedure/service reviewed to ensure each service	_		
	Cd19 Car Positive Viable T Cells Including Leukapheresis And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Dose Preparation Procedures Per Therapeutic Dose	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	Unlisted Procedure; May require Prior Authorization per	_		
	Otherwise Specified 10Mg	contract agreement.			
Q2052	Services Supplies And Accessories Used In The Home For	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	The Administration Of Intravenous Immune Globulin (Ivig)	subject to utilization review.			
Q2053	Brexucabtagene Autoleucel Up To 200 Million Autologous	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Anti-Cd19 Car Positive Viable T Cells Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Leukapheresis And Dose Preparation Procedures Per	submitting a Recommended Clinical Review (Predetermination)			
	Therapeutic Dose	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Anti-Cd19 Car-Positive Viable T Cells Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Leukapheresis And Dose Preparation Procedures Per	submitting a Recommended Clinical Review (Predetermination)			
	Therapeutic Dose	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Maturation Antigen (Bcma) Directed Car-Positive T Cells	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including Leukapheresis And Dose Preparation Procedures	submitting a Recommended Clinical Review (Predetermination)			
	Per Therapeutic Dose	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-	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Cell Maturation Antigen (Bcma) Directed Car-Positive T Cells	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Including Leukapheresis And Dose Preparation Procedures	submitting a Recommended Clinical Review (Predetermination)			
	Per Therapeutic Dose	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		Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Strapping Fasteners Padding And Other Supplies)	defined or classified, and may be subject to benefit and/or			
		clinical review.			
Q4082	Drug Or Biological Not Otherwise Classified Part B Drug	Non Covered: Procedure/service not covered by the Plan. Not	-	-	-
	Competitive Acquisition Program (Cap)	subject to utilization review.			
		Unlisted or Undefined			

Q4100	Skin Substitute Not Otherwise Specified	MP Criteria: Procedure/service reviewed to ensure each service			
Q1100	Skir Substitute Not Otherwise Specified	meets BCBSOK 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			
Q4101	Apligraf Per Square Centimeter	clinical review. MP Criteria: Procedure/service reviewed to ensure each service			
Q4101	Apligrar Per Square Centimeter		-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
0.4400		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.		L	
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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	_	-
	Centimeter	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Omnigraft Dermal Regeneration Matrix Per Square	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Centimeter	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	_	F	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
		Pulicy criteria.			

Q4110	Primatrix Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q4110		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			
Q+111	Ganimagrait i er square centimeter	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			
Q4112		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			
Q4115	Granjacket Apress injectable icc	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			
QTIIT		meets BCBSOK 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			
QTIIS		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	2		
		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	2		
-,	Square Centimeter	meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	 ⁻	-
	- 1	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical	′		
		Policy criteria.			
		i oncy criteria.	1	1	

Q4123	Alloskin Rt Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q+125	Alloskin kt. Per square centimeter	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			
Q4124	Casis Offra TheLayer Wound Mathx Fel Square Centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
Q4125	Arthroflex Per Square Centimeter	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q412J	Artinoliex Tel Square Centimeter	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q+120	Square Centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
	Square centimeter	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			
Q1127		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			
4.110		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Square Centimeter	meets BCBSOK 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			
Q4150	Ez-Derni Per Square Centimeter		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
Q4137	Amnioexcel Amnioexcel Plus Or Biodexcel Per Square	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q4157	Centimeter		-	-	-
	Centimeter	to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
Q4138	Biodfence Dryflex Per Square Centimeter	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q4138	Biodience Drynex Per Square Centimeter		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
Q4139	Amniomatrix Or Biodmatrix Injectable 1 Cc	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q4139	Amniomatrix Or Biodmatrix Injectable 1 Cc		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
0.44.40		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	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
4.2.10	Centimeter	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	-	Γ	_
		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			
Q 1200		meets BCBSOK 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,			
0.4467		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,			
04168	Areniahand 1 Ma	Investigational and/or Unproven Services (EIU). MP Criteria: Procedure/service reviewed to ensure each service			
Q4168	Amnioband 1 Mg	· · · · · · · · · · · · · · · · · · ·	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
04160	Artagent Wound Der Gruppe Continutor	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	Cuanus Por Square Continetor	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q4170	Cygnus Per Square Centimeter		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
04474		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,			
0.4470		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			
Q4102	Transcyte Per Square Centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
04102	Currievett Des Causes Castinates	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			
Q 1102		to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			

Q4193	Call E Dave Des Courties des	FILL Dress dure (see instructure day DCDCOV, National State			
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,			
04404		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,			
0.4405		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	Yuran Dar Sauara Continator	FULL Procedure (convice not reimburged by PCPSOK Net subject			
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,			
0.4005		Investigational and/or Unproven Services (EIU).			
Q4205	Membrane Graft Or Membrane Wrap Per Square	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Centimeter	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	Artecent Court Der Course Continenter	FULL Descedure /see instanting burned by DCDCOK Net subject			
Q4210	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,			
0.4047		Investigational and/or Unproven Services (EIU).			
Q4217	Woundfix Biowound Woundfix Plus Biowound Plus	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	-	-	-
	Woundfix Xplus Or Biowound Xplus Per Square Centimeter	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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_		
	Square Centimeter	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 TI 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			
Q1225	cogenex Anniolie Memorane i el square centimeter	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			
Q+230	Cogenex Flowable Annion Per 0.5 CC	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
Q4231	Courtless D. Don Co	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,			
0.4222		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,			
0.4222		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	Delverte For Terrisel Use Only Der 0.5 Co	FULL Descending for the net with used by DCDCOK. Not exhibit			
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	_	3/31/2024	Retire effective
		to utilization review. Please see the Clinical Payment and			03/31/2024
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
Q4245	Amniotext Per Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
Q4246	Coretext Or Protext Per Cc	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
Q4247	Amniotext Patch Per 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	_
	Centimeter	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).			

a					
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 DI 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q+233	Centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
	Centimeter	Coding Policy titled: Non-Reimbursable Experimental,			
Q4260	Signature Apatch Per Square Centimeter	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
Q4200	Signature Apaterr Per Square Centimeter		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
04261		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 TI 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			
Q.120 .		meets BCBSOK Medical Policy criteria. BCBSOK recommends	_ 	-	-
		submitting a Recommended Clinical Review (Predetermination)	l		
		request if it is unclear if the service meets BCBSOK Medical	l		
		Policy criteria.	l		
Q4265	Neostim TI 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 DI 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 SI 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	_	_
1		to utilization review. Please see the Clinical Payment and		
1		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	_	_
1		to utilization review. Please see the Clinical Payment and		
1		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		
1		Coding Policy titled: Non-Reimbursable Experimental,		
		Investigational and/or Unproven Services (EIU).		
	Injection Human Fibrinogen Concentrate Not Otherwise	MP Criteria: Procedure/service reviewed to ensure each service	6/30/2024	Retire Effective
	Specified 1 Mg	meets BCBSOK Medical Policy criteria. BCBSOK recommends		6/30/2024
		submitting a Recommended Clinical Review (Predetermination)		
J7178		request if it is unclear if the service meets BCBSOK Medical		
Q4279	Vendaje Ac Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy 1/1/202	6/30/2024	Add effective
1		Criteria. Submit for Recommended Clinical Review		01/01/2024
1		(Predetermination) to avoid post-service review.		Retire effective
				06/30/2024
Q4280	Xcell Amnio Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_
1		to utilization review. Please see the Clinical Payment and		
1		Coding Policy titled: Non-Reimbursable Experimental,		
		Investigational and/or Unproven Services (EIU).		
Q4281	Barrera SI Or Barrera DI Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject		
		to utilization review. Please see the Clinical Payment and	_	-
		to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental,	-	-
		Coding Policy titled: Non-Reimbursable Experimental,	-	-
Q4282	Cygnus Dual Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).		
Q4282	Cygnus Dual Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental,	-	-
Q4282	Cygnus Dual Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and	-	-
Q4282	Cygnus Dual Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental,	-	-
Q4282 Q4283	Cygnus Dual Per Square Centimeter Biovance Tri-Layer Or Biovance 3L Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and	-	-
		Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-
		Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and	-	-
		Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental,	-	-
	Biovance Tri-Layer Or Biovance 3L Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).	-	-
Q4283		Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject EIU: Procedure/service not reimbursed by BCBSOK. Not subject		- - - -
Q4283	Biovance Tri-Layer Or Biovance 3L Per Square Centimeter	Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject to utilization review. Please see the Clinical Payment and Coding Policy titled: Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU).		-

Q4285	Nudyn Dl Or Nudyn Dl Mesh Per Square Centimeter	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
04203	Nudyn bror Nudyn brwesi'r er square centineter	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			
Q+200	Nudyn 5i o'r Nudyn 5iw 'r er Square centimeter	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
Q4279	Mandaia An Day Causan Continuator	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024		Add effective
Q4279	Vendaje Ac Per Square Centimeter		//1/2024	-	
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
0.4207		Clinical Payment and Coding Policy (CPCP).	4/4/2024	c /20 /2024	A did offered to a
Q4287	Dermabind DI Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
			- / . /		06/30/2024
Q4287	Dermabind DI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	-	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).		- / /	
Q4288	Dermabind Ch Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4288	Dermabind Ch Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4289	Revoshield + Amniotic Barrier Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4289	Revoshield + Amniotic Barrier Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4290	Membrane Wrap-Hydro Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4290	Membrane Wrap-Hydro Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4291	Lamellas Xt Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4291	Lamellas Xt Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024		Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			- , - , -

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 DI 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 DI 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).		-	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	7/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4299	Amnicore Pro+ Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4299	Amnicore Pro+ Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4300	Acesso TI Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4300	Acesso TI Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	-	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4301	Activate Matrix Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
					06/30/2024
Q4301	Activate Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4302	Complete Aca Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
			- / . /		06/30/2024
Q4302	Complete Aca Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	-	Add effective
		to pre-service review. Check EIU policy, which is one of our			07/01/2024
0.4202	Constitute As Des Construction	Clinical Payment and Coding Policy (CPCP).	4 /4 /2024	c /20 /2024	
Q4303	Complete Aa Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024	6/30/2024	Add effective
		Criteria. Submit for Recommended Clinical Review			01/01/2024
		(Predetermination) to avoid post-service review.			Retire effective
Q4304	Grafix Plus Per Square Centimeter	MP Criteria: Procedure/service reviewed against Medical Policy	1/1/2024		06/30/2024 Add effective
Q4304	Grafix Plus Per Square Centimeter	Criteria. Submit for Recommended Clinical Review	1/1/2024	-	
					01/01/2024
Q4305	American Amnion Ac Tri-Layer Per Square Centimeter	(Predetermination) to avoid post-service review. EIU: Procedure/service not reimbursed by the Plan. Not subject	4/1/2024		Add effective
Q4303	American Annion AC m-Layer Per Square Centimeter		4/1/2024	-	
		to pre-service review. Check EIU policy, which is one of our			04/01/2024
Q4306	American Amnion Ac Per Square Centimeter	Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject	1/1/2024		Add effective
Q 4 300		to pre-service review. Check EIU policy, which is one of our	+/1/2024	-	
		1 1 1/			04/01/2024
Q4307	Amorican Ampion Por Square Continutor	Clinical Payment and Coding Policy (CPCP). EIU: Procedure/service not reimbursed by the Plan. Not subject	4/1/2024		Add effective
Q4507	American Amnion Per Square Centimeter		4/1/2024	-	
		to pre-service review. Check EIU policy, which is one of our			04/01/2024
		Clinical Payment and Coding Policy (CPCP).			

Q4308	Sanopellis Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	4/1/2024		Add effective
		to pre-service review. Check EIU policy, which is one of our			04/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4309	Via Matrix Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	4/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			04/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q4310	Procenta Per 100 Mg	EIU: Procedure/service not reimbursed by the Plan. Not subject	4/1/2024	_	Add effective
		to pre-service review. Check EIU policy, which is one of our			04/01/2024
		Clinical Payment and Coding Policy (CPCP).			
Q5009	Hospice Or Home Health Care Provided In Place Not	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Otherwise Specified (Nos)	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-	MP Criteria: Procedure/service reviewed against Medical Policy	_	_	_
	Esrd Use) 1000 Units	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	4/1/2024	_	Add effective
		Criteria. Submit for Recommended Clinical Review			8/1/2024
		(Predetermination) to avoid post-service review.			

Q5134	Injection Natalizumab-Sztn (Tyruko) Biosimilar 1 Mg	MP Criteria: Procedure/service reviewed against Medical Policy 4/1/2	2024	Add effective
		Criteria. Submit for Recommended Clinical Review		4/1/2024
		(Predetermination) to avoid post-service review.		
Q9004	Department Of Veterans Affairs Whole Health Partner	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_
	Services	subject to utilization review.		
Q9982	Flutemetamol F18 Diagnostic Per Study Dose Up To 5	MP Criteria: Procedure/service reviewed to ensure each service _	_	_
	Millicuries	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-
	Millicuries	meets BCBSOK Medical Policy criteria. BCBSOK recommends		
		submitting a Recommended Clinical Review (Predetermination)		
		request if it is unclear if the service meets BCBSOK Medical		
S0013	Esketamine Nasal Spray 1 Mg	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		
50015	Esteratione Masarspray Time	meets BCBSOK 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 lu	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 lu	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.		
	Testosterone Pellet 75Mg	Prior Authorization may be required per contract agreement. MP Criteria: Procedure/service reviewed to ensure each service		
50105		meets BCBSOK 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-	Non Covered: Procedure/service not covered by BCBSOK. Not			
00207	Voluntary) Non-Transport	subject to utilization review.	-	-	_
S0209	Wheelchair Van Mileage Per Mile	MP Criteria: Procedure/service reviewed to ensure each service			
	ő	meets BCBSOK 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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	End Of Life Care Planning And Decisions With Patient	subject to utilization review.			
	And/Or Surrogate (List Separately In Addition To Code For				
	Appropriate Evaluation And Management Service)				
S0315	Disease Management Program; Initial Assessment And	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Initiation Of The Program	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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Management Program Member For Monitoring Purposes;	subject to utilization review.			
	Per Month				
S0390	Routine Foot Care; Removal And/Or Trimming Of Corns	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Calluses And/Or Nails And Preventive Maintenance In	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Specific Medical Conditions (E. G. Diabetes) Per Visit	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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Lens	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	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Separately	defined or classified, and may be subject to benefit and/or			
60506		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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Separately In Addition To Appropriate Evaluation And	subject to utilization review.	-	-	_
	Management Code)				
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	Unlisted or Undefined: Procedure/service not otherwise	-	-	-
	Basic Item)	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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Purchase (For Physician Interpretation Of Data Use Cpt	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Code)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
64024		Policy criteria.			
S1031		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Including Sensor Sensor Replacement And Download To	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Monitor (For Physician Interpretation Of Data Use Cpt Code)	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
S1034	Artificial Pancreas Device System (Eg Low Glucose Suspend	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		ł	
31054	[Lgs] Feature) Including Continuous Glucose Monitor Blood	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		-			
	Communicates With All Of The Devices	submitting a Recommended Clinical Review (Predetermination) request if it is unclear if the service meets BCBSOK Medical			
	communicates with All OF The Devices	Policy criteria.			
S1035	Sensor; Invasive (Eg Subcutaneous) Disposable For Use	MP Criteria: Procedure/service reviewed to ensure each service			
51055		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service		1	†
	Device System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Device System	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	Interface Material Custom Fabricated Includes Fitting And	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Adjustment(S)	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	(Propel)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	_	_
	Port By Injection Or Aspiration Of Saline	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Destruction Percutaneous Any Method Using Yttrium-90	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Microspheres	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			
624.02		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			
\$2107	Adoptivo Immunothoropy I. C. Development Of Sectific Asti	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service		ł	
S2107			-	-	-
	Tumor Reactivity (E. G. Tumor-Infiltrating Lymphocyte	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Therapy) Per Course Of Treatment	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.		1	

S2112	Arthroscopy Knee Surgical For Harvesting Of Cartilage	MP Criteria: Procedure/service reviewed to ensure each service			
	(Chondrocyte Cells)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Umbilical) Allogeneic Or Autologous Harvesting	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Transplantation And Related Complications; Including:	submitting a Recommended Clinical Review (Predetermination)			
	Pheresis And Cell Preparation/Storage; Marrow Ablative	request if it is unclear if the service meets BCBSOK Medical			
	Therapy; Drugs Supplies Hospitalization With Outpatient	Policy criteria.			
	Follow-Up; Medical/Surgical Diagnostic Emergency And				
	Rehabilitative Services; And The Number Of Days Of Pre-And				
<u></u>	Post-Transplant Care In The Global Definition				
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			
S2230	Implantation Of Magnetic Component Of Semi-Implantable	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
52230			-	-	-
	Hearing Device On Ossicles In Middle Ear	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
S2235	Implantation Of Auditory Brain Stem Implant	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
52233		meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
52500	Capsulorrhaphy	to utilization review. Please see the Clinical Payment and	-	-	-
	capsaiornaphy	Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
		investigational and/or onproven services (EIO).			

S2348	Decompression Procedure Percutaneous Of Nucleus	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Pulposus Of Intervertebral Disc Using Radiofrequency	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Energy Single Or Multiple Levels Lumbar	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Temporary Tracheal Occlusion Procedure Performed In	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Utero	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Performed In Utero	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Fetus Procedure Performed In Utero	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Procedure Performed In Utero	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Performed In Utero	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Performed In Utero	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Performed In Utero Not Otherwise Classified	meets BCBSOK 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.			1

S2411	Fetoscopic Laser Therapy For Treatment Of Twin-To-Twin	MP Criteria: Procedure/service reviewed to ensure each service			
J2711	Transfusion Syndrome	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
\$3650	Saliva Test Hormone Level; During Menopause	EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
55050	Saliva Test Hormone Level, During Menopause	to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
S3652	Colive Test Hermone Level, To Assess Draterm Labor Dick	Investigational and/or Unproven Services (EIU). EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
53052	Saliva Test Hormone Level; To Assess Preterm Labor Risk		-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
\$3655	Antionerum Antikadian Test (Immunchand)	Investigational and/or Unproven Services (EIU).			
53055	Antisperm Antibodies Test (Immunobead)	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
62722	Deep Optimization By Area Under The Curve (Aug) Applysic	subject to utilization review.			
S3722	Dose Optimization By Area Under The Curve (Auc) Analysis	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	For Infusional 5-Fluorouracil	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
62000		Policy criteria.			
\$3900	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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Resulting In Delivery)	subject to utilization review.			
S4011	In Vitro Fertilization; Including But Not Limited To	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Identification And Incubation Of Mature Oocytes	subject to utilization review.			
	Fertilization With Sperm Incubation Of Embryo(S) And				
	Subsequent Visualization For Determination Of				
	Development				
S4013	Complete Cycle Gamete Intrafallopian Transfer (Gift) Case	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Rate	subject to utilization review.			
S4014	Complete Cycle Zygote Intrafallopian Transfer (Zift) Case	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	_
	Rate	subject to utilization review.			
S4015	Complete In Vitro Fertilization Cycle Not Otherwise	Non Covered: Procedure/service not covered by the Plan. Not	-	-	_
	Specified Case Rate	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		Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Case Rate	subject to utilization review.			
S4018	Frozen Embryo Transfer Procedure Cancelled Before	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Transfer Case Rate	subject to utilization review.			
S4020	In Vitro Fertilization Procedure Cancelled Before Aspiration	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Case Rate	subject to utilization review.			

S4021	In Vitro Fertilization Procedure Cancelled After Aspiration	Non Covered: Procedure/service not covered by BCBSOK. Not			
34021	Case Rate	subject to utilization review.	-	-	-
S4022	Assisted Oocyte Fertilization Case Rate	Non Covered: Procedure/service not covered by BCBSOK. Not			
01022		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)	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Case Rate	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Visit	subject to utilization review.			
S4031	Sperm Procurement And Cryopreservation Services;	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Subsequent Visit	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Days	subject to utilization review.			
S4042	Management Of Ovulation Induction (Interpretation Of	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Diagnostic Tests And Studies Non-Face-To-Face Medical	subject to utilization review.			
	Management Of The Patient) Per Cycle				
S4988	Penile Contracture Device Manual Greater Than 3 Lbs	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effective
	Traction Force	Criteria. Submit for Recommended Clinical Review			4/1/2024
		(Predetermination) to avoid post-service review.			
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	-	-	-
65405		subject to utilization review.			
S5105	Day Care Services Center-Based; Services Not Included In	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Program Fee Per Diem	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	Harra Cara Training To Harra Cara Client Day Consist	New Coursed, Depending (see instanting and by DCDCOV). Net			
22103	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			
33110	Home Care Haining Faining, Per 15 Windutes	subject to utilization review.	-	-	-
S5111	Home Care Training Family; Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not			
33111	nome care maining ranniy, rei Session	subject to utilization review.	-	-	-
\$5115	Home Care Training Non-Family; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not			
55115	nome care maining Non-raininy, rer 13 minutes	subject to utilization review.	-	-	-
S5116	Home Care Training Non-Family; Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not			
33110	nome care maining non raininy, rer session	subject to utilization review.	-	-	-
S5120	Chore Services; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not			
55120		subject to utilization review.	-	-	-
S5121	Chore Services; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not			
55121		subject to utilization review.	-	-	-
S5125	Attendant Care Services; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not			
55125	Attendant care services, i er 15 windtes	subject to utilization review.	-	-	-
S5126	Attendant Care Services; Per Diem	Non Covered: Procedure/service not covered by BCBSOK. Not			
33120	Attendant Care Services, Fer Dieni	subject to utilization review.	-	-	-
S5130	Homomokor Sorvice, Nosi Dor 15 Minutor	Non Covered: Procedure/service not covered by the Plan. Not		-	
35130	Homemaker Service Nos; Per 15 Minutes		-	-	-
		subject to utilization review.			
65121	Llansanalian Camira New Der Diam	Unlisted or Undefined Non Covered: Procedure/service not covered by the Plan. Not			
S5131	Homemaker Service Nos; Per Diem		-	-	-
		subject to utilization review.			
05405		Unlisted or Undefined			
\$5135	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.			
\$5150	Unskilled Respite Care Not Hospice; Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
		subject to utilization review.			
\$5151	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	(Excludes Installation And Testing)	subject to utilization review.			
S5162	Emergency Response System; Purchase Only	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
		subject to utilization review.			

S5165	Lleves Medifications, Des Comica	New Coursed, Dressedure (see the set on used by DCDCOK, Net			
55105	Home Modifications; Per Service	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
05470		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	Unlisted or Undefined: Procedure/service not otherwise	_	_	_
	Otherwise Classified; Includes Administrative Services	defined or classified, and may be subject to benefit and/or			
	Professional Pharmacy Services Care Coordination And All	clinical review.			
	Necessary Supplies And Equipment (Drugs And Nursing				
	Visits Coded Separately) Per Diem				
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	MP Criteria: Procedure/service reviewed to ensure each service			
50000	Breast) Unilateral Including Supply Of Radiopharmaceutical	· · ·	-	-	-
	breasty officieral melduling supply of hadiopharmaceutical	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
		1 ·			
S8130	Interferential Current Stimulator 2 Channel	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
30130			-	-	-
		to utilization review. Please see the Clinical Payment and			
		Coding Policy titled: Non-Reimbursable Experimental,			
60404		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	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Device	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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	15 Minutes Of Personal One-On-One Contact With The	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Patient	submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
600.40	French de Autoralitere en Der Constan	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	MP Criteria: Procedure/service reviewed to ensure each service			
50540	Attendance) To One Or More Areas; Low-Level Laser; Each	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	15 Minutes	submitting a Recommended Clinical Review (Predetermination)			
	15 Windles	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
S8990	Physical Or Manipulative Therapy Performed For	MP Criteria: Procedure/service reviewed to ensure each service			
	Maintenance Rather Than Restoration	meets BCBSOK 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	EIU: Procedure/service not reimbursed by BCBSOK. Not subject	_	_	-
	Services	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	MP Criteria: Procedure/service reviewed against Medical Policy	4/1/2024	_	Add effectuce
	For Pelvic Floor Muscle Rehabilitation Device	Criteria. Submit for Recommended Clinical Review			04/01/2024
60055		(Predetermination) to avoid post-service review.			
S9055	Procuren Or Other Growth Factor Preparation To Promote	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Wound Healing	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
		request if it is unclear if the service meets BCBSOK Medical			
\$9056	Coma Stimulation Per Diem	Policy criteria. EIU: Procedure/service not reimbursed by BCBSOK. Not subject			
55050		to utilization review. Please see the Clinical Payment and	-	-	-
		Coding Policy titled: Non-Reimbursable Experimental,			
		Investigational and/or Unproven Services (EIU).			
\$9090	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			
55117		meets BCBSOK 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			
55125	hespite care in the nome rel blem	subject to utilization review.	-	-	-
S9128	Speech Therapy In The Home Per Diem	MP Criteria: Procedure/service reviewed to ensure each service			
55120	opecent merupy in the nome tel bien	meets BCBSOK 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			
00120		meets BCBSOK 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			
00101		meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service			
	(Pump Not Included)	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	(, amp not molded)	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	MP Criteria: Procedure/service reviewed to ensure each service			
	Professional Pharmacy Services Care Coordination And All	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
	Necessary Supplies And Equipment (Drugs And Nursing	submitting a Recommended Clinical Review (Predetermination)			
	Services Coded Separately) Per Diem	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
S9340	Home Therapy; Enteral Nutrition; Administrative Services	MP Criteria: Procedure/service reviewed to ensure each service			
	Professional Pharmacy Services Care Coordination And All	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	_
	Necessary Supplies And Equipment (Enteral Formula And	submitting a Recommended Clinical Review (Predetermination)			
	Nursing Visits Coded Separately) Per Diem	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
S9341	Home Therapy; Enteral Nutrition Via Gravity; Administrative	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	Services Professional Pharmacy Services Care Coordination	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And All Necessary Supplies And Equipment (Enteral Formula	submitting a Recommended Clinical Review (Predetermination)			
	And Nursing Visits Coded Separately) Per Diem	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
S9342	Home Therapy; Enteral Nutrition Via Pump; Administrative	MP Criteria: Procedure/service reviewed to ensure each service	_	_	
	Services Professional Pharmacy Services Care Coordination	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
		submitting a Recommended Clinical Review (Predetermination)			
	And Nursing Visits Coded Separately) Per Diem	request if it is unclear if the service meets BCBSOK Medical			
	G	Policy criteria.			

500.40					
S9343	Home Therapy; Enteral Nutrition Via Bolus; Administrative	MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
	Services Professional Pharmacy Services Care Coordination	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And All Necessary Supplies And Equipment (Enteral Formula	submitting a Recommended Clinical Review (Predetermination)			
	And Nursing Visits Coded Separately) Per Diem	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
S9355	Home Infusion Therapy Chelation Therapy; Administrative	MP Criteria: Procedure/service reviewed to ensure each service	-	_	-
	Services Professional Pharmacy Services Care Coordination	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	And All Necessary Supplies And Equipment (Drugs And	submitting a Recommended Clinical Review (Predetermination)			
	Nursing Visits Coded Separately) Per Diem	request if it is unclear if the service meets BCBSOK Medical			
		Policy criteria.			
\$9364	Home Infusion Therapy Total Parenteral Nutrition (Tpn);	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Administrative Services Professional Pharmacy Services	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Care Coordination And All Necessary Supplies And	submitting a Recommended Clinical Review (Predetermination)			
	Equipment Including Standard Tpn Formula (Lipids Specialty	request if it is unclear if the service meets BCBSOK Medical			
	Amino Acid Formulas Drugs Other Than In Standard	Policy criteria.			
	Formula And Nursing Visits Coded Separately) Per Diem (Do				
	Not Use With Home Infusion Codes S9365-S9368 Using Daily				
	Volume Scales)				
S9366	Home Infusion Therapy Total Parenteral Nutrition (Tpn);	MP Criteria: Procedure/service reviewed to ensure each service	_		_
	More Than One Liter But No More Than Two Liters Per Day	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Administrative Services Professional Pharmacy Services	submitting a Recommended Clinical Review (Predetermination)			
	Care Coordination And All Necessary Supplies And	request if it is unclear if the service meets BCBSOK Medical			
	Equipment Including Standard Tpn Formula (Lipids Specialty				
	Amino Acid Formulas Drugs Other Than In Standard				
	Formula And Nursing Visits Coded Separately) Per Diem				
	Tormula And Warsing Visits Coded Separately) Ter Diem				
S9367	Home Infusion Therapy Total Parenteral Nutrition (Tpn);	MP Criteria: Procedure/service reviewed to ensure each service			
	More Than Two Liters But No More Than Three Liters Per	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	_	-
		submitting a Recommended Clinical Review (Predetermination)			
	Care Coordination And All Necessary Supplies And	request if it is unclear if the service meets BCBSOK Medical			
	Equipment Including Standard Tpn Formula (Lipids Specialty				
	Amino Acid Formulas Drugs Other Than In Standard	rolley entend.			
	Formula And Nursing Visits Coded Separately) Per Diem				
	Formula And Nursing visits Coded Separately) Fer Diem				
S9368	Home Infusion Therapy Total Parenteral Nutrition (Tpn);	MP Criteria: Procedure/service reviewed to ensure each service			
	More Than Three Liters Per Day Administrative Services	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-	-	-
	Professional Pharmacy Services Care Coordination And All	submitting a Recommended Clinical Review (Predetermination)			
	Necessary Supplies And Equipment Including Standard Tpn	request if it is unclear if the service meets BCBSOK Medical			
	Formula (Lipids Specialty Amino Acid Formulas Drugs Other	Policy criteria.			
	Than In Standard Formula And Nursing Visits Coded				
S9379	Separately) Per Diem Home Infusion Therapy Infusion Therapy Not Otherwise	Unlisted or Undefined: Procedure/service not otherwise			
575/9			-	-	-
	Classified; Administrative Services Professional Pharmacy	defined or classified, and may be subject to benefit and/or			
	Services Care Coordination And All Necessary Supplies And	clinical review.			
	Equipment (Drugs And Nursing Visits Coded Separately) Per				
	Diem				

S9381	Delivery Or Service To High Risk Areas Requiring Escort Or	Non Covered: Procedure/service not covered by BCBSOK. Not			
39301	Extra Protection Per Visit	subject to utilization review.	_	-	-
S9401	Anticoagulation Clinic Inclusive Of All Services Except	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Laboratory Tests Per Session	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Metabolism	subject to utilization review.			
\$9435	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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Provider Per Session	subject to utilization review.			
\$9437	Childbirth Refresher Classes Non-Physician Provider Per	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	_
	Session	subject to utilization review.			
\$9438	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	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
60.4.4	Provider Per Session	subject to utilization review.			
S9441	Asthma Education Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
60.440		subject to utilization review.			
S9442	Birthing Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
60444		subject to utilization review.			
S9444	Parenting Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
C0445	Detient Education Net Otherwise Classified New Division	subject to utilization review.			
S9445	Patient Education Not Otherwise Classified Non-Physician	Non Covered: Procedure/service not covered by the Plan. Not	-	-	-
	Provider Individual Per Session	subject to utilization review.			
S9446	Patient Education Not Otherwise Classified Non-Physician	Unlisted or Undefined Non Covered: Procedure/service not covered by the Plan. Not			
35440			-	-	-
	Provider Group Per Session	subject to utilization review.			
S9447	Infant Safety (Including Cpr) Classes Non-Physician Provider	Unlisted or Undefined Non Covered: Procedure/service not covered by BCBSOK. Not			
55447		· · ·	-	-	-
S9449	Per Session Weight Management Classes Non-Physician Provider Per	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
55445	Session	subject to utilization review.	-	-	-
S9451	Exercise Classes Non-Physician Provider Per Session	Non Covered: Procedure/service not covered by BCBSOK. Not			
55451	Exercise classes from rigsicial Frovider Fer Session	subject to utilization review.	-	-	-
		subject to utilization review.			

S9454	Stress Management Classes Non-Physician Provider Per	Non Covered: Procedure/service not covered by BCBSOK. Not		I	
	Session	subject to utilization review.	-	-	_
S9472		MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Diem	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Per Diem	meets BCBSOK 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	-	-	-
60527		subject to utilization review.			
S9537		MP Criteria: Procedure/service reviewed to ensure each service	-	-	-
		meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Professional Pharmacy Services Care Coordination And All	submitting a Recommended Clinical Review (Predetermination)			
	Necessary Supplies And Equipment (Drugs And Nursing	request if it is unclear if the service meets BCBSOK Medical			
\$9542	Visits Coded Separately) Per Diem Home Injectable Therapy Not Otherwise Classified	Policy criteria. Unlisted or Undefined: Procedure/service not otherwise			
33342	Including Administrative Services Professional Pharmacy	defined or classified, and may be subject to benefit and/or	-	-	-
	Services Care Coordination And All Necessary Supplies And	clinical review.			
	Equipment (Drugs And Nursing Visits Coded Separately) Per				
	Diem				
S9558	Home Injectable Therapy; Growth Hormone Including	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Administrative Services Professional Pharmacy Services	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Care Coordination And All Necessary Supplies And	submitting a Recommended Clinical Review (Predetermination)			
	Equipment (Drugs And Nursing Visits Coded Separately) Per	request if it is unclear if the service meets BCBSOK Medical			
	Diem	Policy criteria.			
S9560	Home Injectable Therapy; Hormonal Therapy (E. G. ;	MP Criteria: Procedure/service reviewed to ensure each service	_	_	-
	Leuprolide Goserelin) Including Administrative Services	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Professional Pharmacy Services Care Coordination And All	submitting a Recommended Clinical Review (Predetermination)			
	Necessary Supplies And Equipment (Drugs And Nursing	request if it is unclear if the service meets BCBSOK Medical			
005.00	Visits Coded Separately) Per Diem	Policy criteria.			
S9562		MP Criteria: Procedure/service reviewed to ensure each service	_	-	-
	Antibody For Rsv Including Administrative Services	meets BCBSOK Medical Policy criteria. BCBSOK recommends			
	Professional Pharmacy Services Care Coordination And All	submitting a Recommended Clinical Review (Predetermination)			
	Necessary Supplies And Equipment (Drugs And Nursing	request if it is unclear if the service meets BCBSOK Medical			
S9810	Visits Coded Separately) Per Diem	Policy criteria. MP Criteria: Procedure/service reviewed to ensure each service			
55610		meets BCBSOK Medical Policy criteria. BCBSOK recommends	_	-	-
	Disease State Management Not Otherwise Classified Per	submitting a Recommended Clinical Review (Predetermination)			
	Hour (Do Not Use This Code With Any Per Diem Code)	request if it is unclear if the service meets BCBSOK Medical			
	Hour (Do Not Ose This code with Any Per Dieni Code)	Policy criteria.			
		,			
		Unlisted or Undefined: Procedure/service not otherwise			
		Unlisted or Undefined: Procedure/service not otherwise defined or classified, and may be subject to benefit and/or			

\$9900	Services By A Journal-Listed Christian Science Practitioner	Non Covered: Procedure/service not covered by BCBSOK. Not			
	For The Purpose Of Healing Per Diem	subject to utilization review.	-	_	-
\$9960	Ambulance Service Conventional Air Services	MP Criteria: Procedure/service reviewed to ensure each service			
	Nonemergency Transport One Way (Fixed Wing)	meets BCBSOK 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	MP Criteria: Procedure/service reviewed to ensure each service	_	_	_
	Nonemergency Transport One Way (Rotary Wing)	meets BCBSOK 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.	-	-	-
\$9982	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Service Not Medically Necessary)	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
	(List In Addition To Code(S) For Services(S))	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Transportation Costs (E. G. Fares For Taxicab Or Bus) For	subject to utilization review.			
	Clinical Trial Participant And One Caregiver/Companion				
S9994	Lodging Costs (E. G. Hotel Charges) For Clinical Trial	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Participant And One Caregiver/Companion	subject to utilization review.			
S9996	Meals For Clinical Trial Participant And One	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Caregiver/Companion	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	Non Covered: Procedure/service not covered by BCBSOK. Not			
11000	Counseling	subject to utilization review.	-	-	-
T1009	Child Sitting Services For Children Of The Individual	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Receiving Alcohol And/Or Substance Abuse Services	subject to utilization review.	-	-	-
T1010	Meals For Individuals Receiving Alcohol And/Or Substance	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Abuse Services (When Meals Not Included In The Program)	subject to utilization review.	-	-	-
T1012	Alcohol And/Or Substance Abuse Services Skills	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Development	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Bill Separately	subject to utilization review.			
T1018	School-Based Individualized Education Program (lep)	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Services Bundled	subject to utilization review.			
T1019	Personal Care Services Per 15 Minutes Not For An Inpatient	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Or Resident Of A Hospital Nursing Facility Icf/Mr Or Imd	subject to utilization review.			
	Part Of The Individualized Plan Of Treatment (Code May Not				
	Be Used To Identify Services Provided By Home Health Aide				
	Or Certified Nurse Assistant)				
T1029	Comprehensive Environmental Lead Investigation Not	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
T 1000	Including Laboratory Analysis Per Dwelling	subject to utilization review.			
T1032	Services Performed By A Doula Birth Worker Per 15 Minutes	Non Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
T1033	Carriers Derformed Du A Deule Dirth Marlier, Der Diere	subject to utilization review. Non Covered: Procedure/service not covered by BCBSOK. Not			
11033	Services Performed By A Doula Birth Worker Per Diem	subject to utilization review.	-	-	-
T1505	Electronic Medication Compliance Management Device	Unlisted or Undefined: Procedure/service not otherwise			
11505	Includes All Components And Accessories Not Otherwise	defined or classified, and may be subject to benefit and/or	-	-	-
	Classified	clinical review.			
T1999	Miscellaneous Therapeutic Items And Supplies Retail	Unlisted or Undefined: Procedure/service not otherwise			
	Purchases Not Otherwise Classified; Identify Product In	defined or classified, and may be subject to benefit and/or	-	-	-
	Remarks	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-	Non Covered: Procedure/service not covered by BCBSOK. Not	-	_	_
	Emergency Vehicle One-Half (1/2) Hour Increments	subject to utilization review.			

T2012	Habilitation Educational; Waiver Per Diem	Non Covered: Procedure/service not covered by the Plan. Not			
12012	Habilitation Educational, waiver Per Diem		-	-	-
		subject to utilization review.			
T2013	Uphilitation Educational Waivar Dar Hour	Unlisted or Undefined Non Covered: Procedure/service not covered by the Plan. Not			
12013	Habilitation Educational Waiver; Per Hour		-	-	-
		subject to utilization review.			
72044		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	Non Covered: Procedure/service not covered by the Plan. Not	_	_	_
	Minutes	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			
12020	specialized supply not otherwise specifical warver	subject to utilization review.	-	-	-
T2029	Specialized Medical Equipment Not Otherwise Specified	Non Covered: Procedure/service not covered by the Plan. Not			
12025	Waiver	subject to utilization review.	-	-	-
T2030	Assisted Living Waiver; Per Month	Unlisted or Undefined: Procedure/service not otherwise			
12030		defined or classified, and may be subject to benefit and/or	-	-	-
T2031	Accisted Living: Waiver Der Diem	clinical review. Unlisted or Undefined: Procedure/service not otherwise			
12031	Assisted Living; Waiver Per Diem		-	-	-
		defined or classified, and may be subject to benefit and/or			
		clinical review.			

T2032	Residential Care Not Otherwise Specified (Nos) Waiver; Per	Unlisted or Undefined: Procedure/service not otherwise			
12032	Month	defined or classified, and may be subject to benefit and/or	-	-	-
	Wonth	clinical review.			
T2033	Residential Care Not Otherwise Specified (Nos) Waiver; Per				
12033	Diem	defined or classified, and may be subject to benefit and/or	-	-	-
	Diem	clinical review.			
T2034	Crisis Intervention Waiver; Per Diem	Non Covered: Procedure/service not covered by the Plan. Not			
12054	Clisis intervention waiver, Per Diem		-	-	-
T2035	Litility Convisor To Cupport Modical Equipment And Accistive	subject to utilization review. Non Covered: Procedure/service not covered by the Plan. Not	1		
12035			-	-	-
T2036	Technology/Devices Waiver Therapeutic Camping Overnight Waiver; Each Session	subject to utilization review. Non Covered: Procedure/service not covered by the Plan. Not			
12030	Therapeutic camping Overnight Walver; Each Session		-	-	-
T2027	There exists Complete Day, Waiser, Fook Consist	subject to utilization review.			
T2037	Therapeutic Camping Day Waiver; Each Session	Non Covered: Procedure/service not covered by the Plan. Not	-	-	-
T 2020		subject to utilization review.			
T2038	Community Transition Waiver; Per Service	Non Covered: Procedure/service not covered by the Plan. Not	-	-	-
T 2020	Malatala Maniffrantiana Matana Dan Canatan	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	Non Covered: Procedure/service not covered by the Plan. Not	-	-	-
	Minutes	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 Covered: Procedure/service not covered by BCBSOK. Not	-	-	-
	Mile	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.	1		
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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Only	subject to utilization review.			
T4521	Adult Sized Disposable Incontinence Product Brief/Diaper	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Small Each	subject to utilization review.			
T4522	Adult Sized Disposable Incontinence Product Brief/Diaper	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Medium Each	subject to utilization review.			
T4523	Adult Sized Disposable Incontinence Product Brief/Diaper	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Large Each	subject to utilization review.			
T4524	Adult Sized Disposable Incontinence Product Brief/Diaper	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	-
	Extra Large Each	subject to utilization review.			
T4525	Adult Sized Disposable Incontinence Product Protective	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Underwear/Pull-On Small Size Each	subject to utilization review.			
T4526	Adult Sized Disposable Incontinence Product Protective	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Underwear/Pull-On Medium Size Each	subject to utilization review.			
T4527	Adult Sized Disposable Incontinence Product Protective	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Underwear/Pull-On Large Size Each	subject to utilization review.			
T4528	Adult Sized Disposable Incontinence Product Protective	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Underwear/Pull-On Extra Large Size Each	subject to utilization review.			

T4529	Pediatric Sized Disposable Incontinence Product	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Brief/Diaper Small/Medium Size Each	subject to utilization review.	-	-	-
T4530	Pediatric Sized Disposable Incontinence Product	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Brief/Diaper Large Size Each	subject to utilization review.	-	-	-
T4531		Non Covered: Procedure/service not covered by BCBSOK. Not			
	Underwear/Pull-On Small/Medium Size Each	subject to utilization review.	-	_	-
T4532	Pediatric Sized Disposable Incontinence Product Protective	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Underwear/Pull-On Large Size Each	subject to utilization review.	_		
T4533	Youth Sized Disposable Incontinence Product Brief/Diaper	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Each	subject to utilization review.	_		
T4534	Youth Sized Disposable Incontinence Product Protective	Non Covered: Procedure/service not covered by BCBSOK. Not	_		
	Underwear/Pull-On Each	subject to utilization review.	_		
T4535	Disposable Liner/Shield/Guard/Pad/Undergarment For	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Incontinence Each	subject to utilization review.			
T4536	Incontinence Product Protective Underwear/Pull-On	Non Covered: Procedure/service not covered by BCBSOK. Not			
	Reusable Any Size Each	subject to utilization review.			
T4537	Incontinence Product Protective Underpad Reusable Bed	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Size Each	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Size Each	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	Non Covered: Procedure/service not covered by BCBSOK. Not	_	_	_
	Brief/Diaper Above Extra Large Each	subject to utilization review.			
T5001	Positioning Seat For Persons With Special Orthopedic Needs	Non Covered: Procedure/service not covered by BCBSOK. Not	5/1/2024	_	Effective
		subject to utilization review.			5/1/2024
Т5999	Supply Not Otherwise Specified	Unlisted or Undefined: Procedure/service not otherwise	5/1/2024	_	Effective
		defined or classified, and may be subject to benefit and/or			5/1/2024
		clinical review.			
V2199	Not Otherwise Classified Single Vision Lens	Unlisted or Undefined: Procedure/service not otherwise	5/1/2024	-	Effective
		defined or classified, and may be subject to benefit and/or			5/1/2024
		clinical review.			

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.		-	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		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		MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK 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		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	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.	-	_	_

		to pre-service review. Check EIU policy, which is one of our Clinical Payment and Coding Policy (CPCP).			07/01/2024
4303	Complete Aa Per Square Centimeter	EIU: Procedure/service not reimbursed by the Plan. Not subject	7/1/2024	_	Add effective
0826T	Pacemaker System In Single-Cardiac Chamber	roncy enteria.			
		Policy criteria.		1	
	Values With Analysis Review And Report By A Physician Or	request if it is unclear if the service meets BCBSOK Medical			
	Of The Device And Select Optimal Permanent Programmed	submitting a Recommended Clinical Review (Predetermination)		1	5/15/2024
	Programming Device Evaluation (In Person) With Iterative	MP Criteria: Procedure/service reviewed to ensure each service meets BCBSOK Medical Policy criteria. BCBSOK recommends	5/15/2024	-	Effective 5/15/2024
)825T	Description Design Fredericker (In Description) (1971) (1971)	MD Citerte Describer (sector esta esta esta esta esta esta esta esta	E /4 E /2024		
00257	(Eg Interrogation Or Programming) When Performed			1	
	Femoral Venography Cavography) And Device Evaluation	Policy criteria.		1	
	Right Atrial Angiography And/Or Right Ventriculography	request if it is unclear if the service meets BCBSOK Medical		1	
	Imaging Guidance (Eg Fluoroscopy Venous Ultrasound	submitting a Recommended Clinical Review (Predetermination)		1	
	Single-Chamber Leadless Pacemaker Right Atrial Including	meets BCBSOK Medical Policy criteria. BCBSOK recommends			5/15/2024
	Transcatheter Removal And Replacement Of Permanent	MP Criteria: Procedure/service reviewed to ensure each service	5/15/2024	_	Effective
0824T	Venography Cavography) When Performed	Policy criteria.			
	Angiography And/Or Right Ventriculography Femoral	request if it is unclear if the service meets BCBSOK Medical		1	
	Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial	submitting a Recommended Clinical Review (Predetermination)			-,,
	Leadless Pacemaker Right Atrial Including Imaging	meets BCBSOK Medical Policy criteria. BCBSOK recommends	-, -, -	_	5/15/2024
	Transcatheter Removal Of Permanent Single-Chamber	MP Criteria: Procedure/service reviewed to ensure each service	5/15/2024		Effective
0823T	Interrogation Or Programming) When Performed	Policy criteria.			
		Policy criteria.			
	Angiography And/Or Right Ventriculography Femoral	request if it is unclear if the service meets BCBSOK Medical			
	Leadless Pacemaker Right Atrial Including Imaging Guidance (Eg Fluoroscopy Venous Ultrasound Right Atrial	meets BCBSOK Medical Policy criteria. BCBSOK recommends submitting a Recommended Clinical Review (Predetermination)			5/15/2024
	Transcatheter Insertion Of Permanent Single-Chamber	MP Criteria: Procedure/service reviewed to ensure each service	5/15/2024	-	Effective 5/15/2024

CPT copyright 2023 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

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.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSOK.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSOK to provide utilization management services for members with coverage through BCBSOK.

BCBSOK makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Availity or Carelon Medical Benefits Management. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Blue Cross and Blue Shield of Oklahoma, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association