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Introduction and Guidelines for Benefits Interpretation

This section includes a set of guidelines for HMO benefit interpretation (Scope of Benefits).

Each HMO member receives a HMO Certificate of Health Care Benefits upon enrollment with the HMO. Certificates vary with in accordance with benefits plans purchased by the member's employer or by the member directly (direct-pay, or DIRPY).

To be eligible for the benefits of the policy, the services must be provided or ordered by the Primary Care Physician (PCP) or Woman's Principal health Care Provider (WPHCP).

Many portions of the Certificate are standard for all HMOI and BlueAdvantage enrollees, but benefits do vary from one benefit plan to another. Please refer to the Benefit Matrix. It has accurate details for each benefit plan regarding copayments, rehabilitation benefits, DME benefits and mental health and chemical dependency benefits.

The IPA is responsible for providing or arranging for all covered Physician Services, IPA-approved Inpatient and Outpatient Hospital Services, Ancillary Services and non-hospital-based Emergency Services within the scope of benefits of the various Benefit plans.

All inpatient hospital admissions, (except those which occur out of area or begin as an emergency), Skilled Nursing Facility days and Home Health visits must be approved by the IPA to be covered by the HMO.

An HMO Contracted Provider should provide services. Under special circumstances, the IPA can request an exception to this from the HMO Customer Assistance Unit before the service is rendered.

Only those services provided for under the Certificate are covered. When the IPA physician recommends non-covered services, the member's financial responsibility must be explained to him/her. The explanation should be documented.

This section is intended to provide a quick reference of covered and non-covered services. It includes frequently asked benefit issues and issues that have been misinterpreted in the past. However, it is not possible to include everything. The IPA may contact the Customer Assistance Unit Staff at **(312) 653-6600** for more help with benefits interpretation.

Abortion (Elective)

Benefit: Coverage for elective pregnancy termination (Abortion) is limited to two (2) occurrences during the member's lifetime. No limits apply to medically necessary abortions. The IPA physician must refer the member for the procedure. In the case of IPAs that do not retain the responsibility for abortion referrals the HMO must refer for the procedure.

Non-surgical abortions (RU 486) are a covered medical benefit if the employer group's policy provides coverage of elective abortions. The abortion pill is not available through pharmacies and is only distributed to physicians who have signed the FDA Prescriber's Agreement Form. (Information can be found on the FDA Web site: www.fda.gov).

Paid by: **Professional Charges (including drug charges for RU 486):** **IPA** (if referred by IPA)
HMO (if referred by HMO)

Facility fee: **HMO**

Coverage and IPA variations:

Certain employer groups do not provide any coverage for abortion in their HMO contract. **Eligibility for benefit should be predetermined in all cases.**

Medical Service Agreements with IPAs vary in assignment of responsibility for abortion referrals. If the IPA does not retain the responsibility for abortion referrals, members should be directed to call (312) 653-6600 for a referral for abortion.

Acupuncture

Benefit: If the PCP determines medical necessity, acupuncture is in benefit.

Interpretation: Acupuncture is the practice of piercing specific sites with needles. Acupuncture has been utilized for a variety of clinical conditions, including:

- Induction of surgical anesthesia
- Relief of pain
- Alleviation of withdrawal symptoms of substance abuse
- Treatment of various non-painful disorders

Paid by: IPA (if referred by the PCP)
Member (if not referred by the PCP)

Allergy Testing/Desensitization

Benefit: Allergy testing and allergy immunotherapy (desensitization injections) are covered in full.

Interpretation: Allergy testing and immunotherapy are covered if the IPA physician refers the member for the service. The IPA must provide testing supplies and antigens.

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that these services improve clinical outcomes:

- Rebeck Skin Window Test
- Leukocyte Histamine Release Test
- Urine auto injections
- Passive Transfer of PX (Prausnitz-Kustner Test)
- Provocative Food and Chemical Test
- Cytotoxic Food Testing
- Intradermal and subcutaneous provocative and neutralization therapy

Non-medical hypoallergenic items such as mattresses, mattress casings, pillows and pillow casings, clothing or special foods are excluded, as they are not primarily medical in nature. Comfort or convenience items commonly used for other than medical purposes such as air conditioners, humidifiers and air filters are not covered.

Nutritional items such as infant formula, weight-loss supplements and over-the-counter food substitutes are not in benefit.

Paid by: Physician charges: **IPA**
Testing supplies: **IPA**
Antigens: **IPA**

Ambulance Services

Benefit: Ground ambulance service is covered under emergency conditions and also under non-emergency conditions that are specified below.
Air ambulance services are not covered.

Interpretation: Benefits for **emergency** ambulance transportation are available when:

- Such transportation is ordered by the primary care physician; or
- Such transportation is rendered in a severe emergency; or
- Such transportation is rendered outside the IPA's treatment area (beyond 30 miles from IPA) **and** is in connection with an emergency; or
- A physician, public safety official or other emergency medical personnel have determined a need for immediate medical transport.

Under **non-emergency** conditions, ambulance service is covered if, in the following situations, the PCP and IPA have given prior approval:

- transfer of a member from one hospital to the IPA's affiliated hospital or any other facility where specialized care is available;
- transfer to a skilled nursing facility;
- transfer to home when a homebound member will be receiving home health care services.

Transportation from home to a doctor's office, hospital, or another facility for outpatient services is **not** covered.

Transfer of a hospitalized member to off-site facilities for diagnostic or therapeutic services related to the inpatient stay must be arranged and paid for by the hospital.

Inquiries to the HMO may be made for coverage on an exception basis for air or ground ambulance services.

Medi-cars are **not** in benefit.

The IPA may use the ambulance company of its choice.

Paid by: Physician Charges: **N/A**
Facility Charges: **N/A**
Ambulance Charges: **HMO**

Ambulatory Blood Pressure Monitoring

Benefit: Semi-automatic and manual blood pressure monitoring equipment that is available over the counter for periodic self measurement of blood pressure is not in benefit. Twenty-Four (24) hour non-invasive continuous ambulatory blood pressure monitors are in benefit if determined to be medically necessary by the PCP/WPHCP.

a. Interpretation: Twenty-four hour non-invasive continuous ambulatory blood pressure Monitors (24 hour sphygmomanometer) are portable devices that record blood pressure while the member is involved in daily activities.

Available scientific evidence does not support widespread or routine use of automated ambulatory blood pressure monitoring. They may however be considered medically necessary for the rare member who, after routine follow-up, is suspected of having continuing labile blood pressure, who cannot be adequately monitored in the office setting or by periodic self blood pressure determinations, and who is otherwise incapable of following instructions to the degree needed to obtain periodic blood pressure determinations.

Member self-measurement of blood pressure using manual equipment (i.e., training the member to use a stethoscope and sphygmomanometer) or a semi-automatic unit (a portable device that requires a member's action to initiate the measurement of the blood pressure, but does not require a stethoscope) is the usual approach and should be encouraged in most circumstances.

Paid by: Physician charges: **IPA**
Monitor/ equipment **HMO**
charges:

Coverage variation: Benefit Plan DIRPY- Equipment charges excluded.

Amniocentesis

Benefit: Amniocentesis is covered in full when performed by or on referral of an IPA physician.

Interpretation: Benefits are available for amniocentesis when performed as a means of attempting to determine if the fetus is afflicted with, or at high risk for, a specific hereditary disorder or developmental defect. The IPA physician is not obliged to perform or refer for amniocentesis when there is no clinical indication for it, i.e. for fetal gender determination.

Paid by: Physician Charges: **IPA**
Inpatient Facility Charges: **HMO**
Outpatient Facility Charges: **IPA**

Apnea Monitors

Benefit: Apnea monitors are a covered benefit for members up to 12-months of age who:

- Have had a clinically significant episode of apnea
- Have a history of a sibling with SID

Interpretation: Clinically significant apnea in infants is defined as a condition in which:

- (a) breathing stops for 20 seconds or longer; or
- (b) breathing stops for less than 20 seconds when associated with bradycardia (slowing of heartbeat) or cyanosis (bluish discoloration of the skin).

Home apnea monitors generally monitor both respiratory and heart rate. An alarm will sound if there is respiratory cessation beyond a predetermined time limit (e.g. twenty seconds) or if the heart rate falls below a preset rate.

Parent or guardian training and instruction by a physician or nurse in use of monitor and appropriate response to warnings from the monitor are also eligible for benefit.

Non-covered services include:

- Installation of back-up electrical systems
- Housing alterations
- Nursing services when the only activity performed by the nurse is observing and responding to the monitor alarm.

Paid by: Equipment costs: **HMO**
Professional Charges: **IPA**

Coverage Variation: Benefit Plan DIRPY- excluded.

Assistant Surgeon

- Benefit:** Services of an assistant surgeon are in benefit. An Assistant Surgeon is a physician, dentist, podiatrist or other Allied Health Provider who actively assists the operating surgeon in the performance of a covered surgical service.
- Interpretation:** Benefits are provided if the surgery is in benefit and the complexity of the surgery requires technical assistance of a second provider.
- Paid by:** Physician charges: **IPA**

Autism and Other Pervasive Developmental Disorders (PDD) Inpatient and Outpatient

Benefit: Autism and PDD related services are in benefit when provided for the treatment of autism or other PDD. The extent of the inpatient and outpatient benefits available to any given member is defined by the members' benefit plan and state law.

Illinois Public Act (PA) 95 -1005 "Autism Spectrum Disorders" is effective December, 12, 2008, for new groups and upon renewal for existing groups. In addition, Pervasive Developmental Disorders are considered Serious Mental Illness (SMI) under Public Act (PA) 094-0906 and PA 094-0921.

Interpretation: A summary of the important points of PA 95-1005 follows in the Question and Answer document at the end of this Scope.

Paid by:	Inpatient Professional charges:	IPA
	Outpatient Professional charges (including ABA therapy)	IPA
	Inpatient Facility charges	HMO
	DME equipment charges (from a contracted provider)	HMO
	DME equipment charges (from a non-contracted provider)	IPA

Note: See related benefits interpretation on Mental Health Care (Inpatient) and Mental Health Care (Outpatient)

Autism and Other Pervasive Developmental Disorders (PDD) Inpatient and Outpatient (cont.)

PA 95-1005 Autism Spectrum Disorders

Q1. What is the law regarding Autism Spectrum Disorders?

A1. State Mandate PA 95-1005 requires coverage of up to \$36,000 for Autism Spectrum Disorders. The effective date of this new law is December 12, 2008; however, it applies to group policies as of the effective date or first renewal following that date. For example, if a client renews 07/01/09, the law applies to that client's members as of 07/01/09. The law mandates coverage for members up to age 21.

Q2. How is the \$36,000 defined?

A2. The law allows \$36,000 per benefit period in addition to benefits already in place, including ABA therapy. Example: If a contract has visit/dollar limits for ST, OT, PT or SMI, once the max is met additional benefits would be applied to the \$36,000 maximum.

Q3. How does this apply to the HMO?

A3. There are no visit limits when calculating the \$36,000. Services are applicable to shared risk grid. ABA therapy will fall into the \$36,000 bucket only. (not applied to any other SMI or rehab benefit. Referral procedure still applies.

Q4. Are there additional provisions in the law?

A4. Yes. Here are the additional provisions of the law:

- The \$36,000 is an annual max per patient per benefit period. (1/1 of each calendar year)
- We can't limit the number of visits.
- Other diagnosis codes should not accumulate to the \$36,000.
- Coverage is subject to co-pay, deductible & coinsurance as long as it's the same for any other service covered by the contract.
- Services are subject to medical necessity / maintenance, determination to be consistent with the manner used for other diseases or illnesses.
- Coverage includes Applied Behavior Analysis (ABA.), psychiatric care, psychological care, habilitative or rehabilitative care and therapeutic care.
- The law requires that ABA services be provided. This is performed by providers previously not covered but now are, and also includes Developmental Therapists, Licensed Social Workers and Social Workers.) or a "licensed physician or certified, registered or licensed health care professional with expertise in treating effects of autism when such care is determined to be medically necessary." (These are licensed providers such as, Psychologist, Licensed Clinical Social Worker, Registered Nurse, Occupational Therapist, or Speech and Language Pathologist; that have always been covered.)
 - These are providers that are still not covered; school psychologist, school social worker, school speech pathologist, or service coordinator.
- Medically necessary as defined in the law means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: prevent the onset of an illness, condition, injury, disease or disability, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability, or assist to achieve or maintain maximum functional activity in performing daily activities.

Q5. Is DME for autism related treatment covered under the law?

A5. Yes, DME is covered and is the HMO's responsibility as long as they are referred to a contracted DME vendor. It needs to be authorized by the PCP and or IPA.

Autism and Other Pervasive Developmental Disorders (PDD) Inpatient and Outpatient (cont.)

Q6. What is ABA?

A6. Applied Behavior Analysis (ABA) is a mixture of psychological and educational techniques that are utilized based upon the needs of each individual child. Applied Behavior Analysis is the use of behavioral methods to measure behavior, teach functional skills, and evaluate progress. ABA approaches such as discrete trial training (DTT), Pivotal Response Training (PRT), Picture Exchange Communication System (PECS), Self- Management, and a range of social skills training techniques are all critical in teaching children with autism.

The intent is to increase skills in language, play and socialization while decreasing behaviors that interfere with learning. Many children with autism have ritualistic or self-injurious behaviors and this treatment reduces or eliminates these behaviors.

The law defines it as “the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.”

Q7. What diagnosis codes are covered under the law?

A7. Autism Spectrum Disorders Diagnosis Code table:

CODE	DIAGNOSIS
299.00-299.01	Autistic disorder – childhood autism, infantile psychosis, Kanner’s syndrome
299.10-299.11	Childhood disintegrative disorder – Heller’s syndrome
299.80-299.81	Other specified pervasive developmental disorders – Asperger’s disorder, atypical childhood psychosis, borderline psychosis of childhood
299.90-299.91	Unspecified pervasive developmental disorder - Childhood psychosis NOS, pervasive developmental disorder NOS, childhood type schizophrenia NOS, schizophrenic syndrome of childhood NOS
330.8	Rett’s syndrome - is a neuro-developmental disorder that is classified as a pervasive developmental disorder by the DSM-IV. Stereotypic, repetitive hand movements such as mouthing or wringing are noted. Symptoms of the disorder include cognitive impairment and problems with socialization, the latter during the regression period.

Q8. The IPA is at risk for ABA providers and for contracting with them. How will the IPA determine what providers to contract with?

A8. This is up to the IPA. The HMO no longer requires any certification by BACB or Early Intervention by the State of IL.

Q/A9.

Do these unlicensed providers need an NPI number? Yes

Are they eligible for one? Yes

Is the HMO requiring they have one? Yes

Q10. What CPT codes can providers use related to ABA therapy?

A11. Providers need to bill using narrative means for services rendered. For ABA we are suggesting the IPA use 99199 to release claim payment, but this is internal only. We do not tell providers what codes to use. There is currently no CPT code for ABA therapy.

Q11. If the ABA providers are not licensed, can we allow them to treat and submit claims?

A11. Yes

Autism and Other Pervasive Developmental Disorders (PDD) Inpatient and Outpatient (cont.)

Q12. Can ABA be performed in the home?

A12. Yes, it is predominantly performed in the home. Services that may be included and covered under the benefit:

An in-home ABA evaluation is usually a multidisciplinary evaluation with a team leader. This person may be called the “director”, the “lead therapist”, or the “therapist”. Usually, the team leader has a Master’s degree or a Doctorate and may be a psychologist, nurse, social worker, or a special education teacher.

- Training of family and tutor staff.
- Tutor staff hours, including documentation of all activities (15-40 hrs per week).
- Supervision hours by a therapist
- Clinic or team meetings with the family and tutor staff

The above services can also be performed in a facility and remain the IPA risk.

Q13. Do we pay ABA providers for their travel expenses to members’ homes?

A13. No.

Q14. Do we pay ABA providers for telephone consultation?

A14. No, therapy sessions must be face to face.

Q15. Is ABA therapy considered mental health treatment or medical?

A15. Neither, it is alternative treatment and is tracked under the \$36,000 benefit. The IPA is responsible for tracking the \$36, 000.00.

Q16. What co-pay is used for ABA therapy?

A16. The rehab co-pay. A single date of service by the same provider will be counted as one treatment/visit for the collection of a co-payment.

Automatic External Defibrillator

Benefit: The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes.

Interpretation: The automatic external defibrillator (AED) is a portable electronic device designed to recognize ventricular fibrillation (VF) or ventricular tachycardia (VT) and deliver a shock to terminate the arrhythmia. It is designed for home use by a trained layperson (e.g., family member or companion). It is intended to restore cardiac function until a physician or trained technician can attend the member.

The evidence does not support the conclusion that the AED can reliably recognize ventricular fibrillation and deliver the appropriate shock. Improvement in member survival has not been demonstrated. The risk of inappropriate delivery of shock, which is potentially lethal, is a major concern.

Paid by: **HMO (if referred by the PCP)**
Member (if not referred by the PCP)

Automatic Implantable Cardioverter Defibrillator (AICD)

Benefit: Automatic implantable defibrillators are in benefit.

Interpretation: The Automatic Implantable Cardioverter Defibrillator (AICD) is an electronic device designed to monitor a member's heartbeat, recognize ventricular fibrillation (VF) or ventricular tachycardia (VT), and deliver an electronic shock to terminate the life-threatening arrhythmia. The device consists of a pulse generator and two surgically-implanted sensing electrodes. One of the electrodes is placed in the superior vena cava and the other is placed on the heart over the cardiac apex. The pulse generator is placed in a subcutaneous pocket, normally in the abdominal area.

An automatic implantable defibrillator is in benefit for treatment of ventricular fibrillation or ventricular tachycardia. Typically, the criteria include:

- There is documentation of an episode of symptomatic VF or VT.
- The episode of VF or VT has not occurred during an evolving myocardial infarction.
- The member should have a life expectancy of at least 6 months.
- Members should have adequate psychological resources to be able to comply with post-operative long-term follow-up.

Paid by:	Device	HMO
	Facility charges	HMO
	Professional fees	IPA

Autopsy Examination

Benefit: Autopsy is not a covered benefit.

Paid By: Member

Biofeedback Therapy

Benefit: Biofeedback is in benefit for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm or weakness.

Interpretation: Biofeedback is a therapeutic technique and training experience, by which the member is taught to exercise control over a physiologic process occurring in the body. Biofeedback therapy often uses electrical devices to transform body signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone, into sound or light, the loudness or brightness of which shows the extent of activity in the functions being measured. Such visual, auditory or other evidence aids the member in efforts to assert voluntary control over the functions, and thereby alleviate an abnormal body condition or symptom.

Biofeedback is typically provided in conjunction with behavior modification and relaxation techniques. Clinical studies that document that biofeedback is superior to behavior modification and relaxation exercises alone have been difficult to design and carry out. Biofeedback may have added benefit when muscle re-education is a predominant factor for obtaining an improved clinical outcome.

Using the above criteria, biofeedback would rarely be expected to provide added therapeutic benefit for the following conditions:

- Anxiety Disorders
- Asthma
- Hypertension
- Headaches
- Insomnia
- Raynaud's Syndrome

Paid by: Physician Charges: **IPA**
Device Charges: **HMO**
Facility Charges: **IPA**

Coverage variation: Benefit plan DIRPY: Device charges excluded.

Blood and Blood Derivatives

- Benefit:** All charges for blood related services are covered, including:
- Blood and blood derivatives, plasma, plasma expanders, and other blood elements and derivatives
 - Use of blood transfusion equipment
 - Administration of blood, including blood typing and cross-matching
 - Blood processing
 - Expenses incurred in obtaining blood

Interpretation: Blood components include frozen red cells; fresh, frozen or liquid single donor plasma, cryoprecipitate, leukocyte poor blood, packed red cells, platelet concentrate, leukocyte concentrate, and plasma.

Blood derivatives extracted from whole blood or manufactured are utilized as drugs to treat specific conditions. Blood derivatives are covered as injectable drugs (see separate benefits interpretation on Drugs):

Benefits are also provided for Rho(D) Immune Globulins as drugs (such as RhoGAM, Gamulin Rh, Hyp Rho-D) and for FDA-approved blood substitutes.

Donation and storage of autologous blood (blood that member donates for his/her own later use) is covered for use in elective surgery that is scheduled. Storage of either autologous or non-autologous blood for unforeseeable surgery, emergencies, or other reasons is not in benefit.

Paid by:	Physician Charges:	IPA
	Inpatient Facility Charges for Administration of Blood Derivatives or Blood Components:	HMO
	Outpatient Facility and Other Outpatient Charges for Administration of Blood Derivatives or Blood Components:	IPA
	Autologous Blood Donation and Storage charges, when elective surgery is scheduled:	HMO
	Autologous Blood donation and storage charges, when elective surgery is NOT scheduled	Member
	Home Health charges (from contracted provider):	HMO
	Home Health charges (from non-contracted provider):	IPA

Coverage Variation: Benefit Plan DIRPY: Excluded

Note: When autologous blood donation/storage charges are group approved for a member scheduled for elective surgery, please record date of scheduled surgery along with group approval status.

Boarder Babies

Benefit: Hospital benefits are available for a boarder baby when the mother requires extended hospitalization.

Interpretation: A boarder baby is a normal newborn infant who stays in the hospital only because the baby is breast feeding and the mother requires continued hospitalization.

Paid by: Physician Charges: **IPA**
Facility Charges: **HMO**

Bone Marrow Transplantation

Benefit: Bone marrow transplantation and related services are a covered benefit, as specified below, when ordered by the Primary Care Physician. Please refer to the benefits interpretation on Organ and Tissue Transplantation for information about notification, review, authorization and claims procedures.

Interpretation: Allogenic (Homologous) bone marrow transplantation involves harvesting bone marrow from a healthy donor for infusion (transplanting) into a member whose bone marrow is compromised either as a result of a primary disease or as a result of a treatment for a disease. Immunologic compatibility (matching) between donor and member (recipient) is a critical factor in success of this service and frequently involves donor searches and histocompatibility (HLA) studies.

Autologous bone marrow transplantation (ABMT) refers to the process in which bone marrow is removed from a member (self-donor), the member is treated with high dose chemotherapeutic drugs and then the previously removed bone marrow is returned to the member. This process "rescues" the bone marrow from the toxic and potentially fatal effects of the chemotherapeutic drugs.

Peripheral stem cell harvesting is an alternative to bone marrow harvesting. In this process members are treated with various parenterally administered growth stimulating factors. These factors cause precursor cells (stem cells) to leave the bone marrow and enter the blood stream. By a series of phlebotomies (blood drawings) enough stem cells can be harvested and utilized in the same manner as bone marrow material. This service is in benefit for the same conditions as autologous or allogenic bone marrow transplant.

Bone Marrow Transplantation (cont.)

Malignancies

Condition	Allogeneic	Autologous
ALL=Acute Lymphocytic Leukemia-Adult (>15 yrs.)	In first remission/ high risk for relapse	See "Allogeneic"
ALL=Acute Lymphocytic Leukemia-Child (< 15 yrs.)	In first or subsequent remission/ high risk for relapse	See "allogeneic"
AML=Acute Myelogenous Leukemia	In first complete remission, to treat primary refractory AML or relapsed AML	See "allogeneic"
CML=Chronic Myelogenous Leukemia	Yes	Not generally allowed
Breast Cancer	Not generally allowed	<ul style="list-style-type: none"> • Stage IV: chemosensitive, with previous chemotherapy and response to subsequent first line chemotherapy or relapse after complete response to first-line chemotherapy • Stage II or III: non-metastatic (except lymphatic spread) • Inflammatory: non-metastatic
Breast Cancer (continued)		
Germ Cell Tumors (testicular, ovarian germ cell type (not epithelial), extra-gonadal)	Not generally allowed	Advanced disease with no complete remission, or in second complete remission or relapse receiving HDC
Hodgkin's Disease	Primary refractory, or relapse < 1 year after initial chemotherapy	See "allogeneic"
Non-Hodgkin's Lymphoma	Salvage therapy of intermediate or high grade lymphoma; therapy of relapse low-grade follicular lymphoma without transformation	See "allogeneic"
Multiple Myeloma	Stage I, II or III disease, aged <50, HLA identical donor	Newly diagnosed with no previous treatment, OR in complete or partial remission and in responsive relapse
Sarcoma, Ewing's	Syngeneic Allogeneic BMT in metastatic, disseminated, relapsed or primary refractory disease	See "allogeneic"
Neuroblastoma	Initial treatment of stage II or stage IV; OR high-risk, primary refractory, or recurrent neuroblastoma	See "allogeneic"
Primitive neuroepithelial tumors, including: <ul style="list-style-type: none"> • Medulloblastoma • Ependyoblastoma • Pinealblastoma <p>NOTE: does <u>not</u> include ependymomas</p>	Not generally allowed	Treatment of recurrent or refractory disease
Glial cell tumors, including: <ul style="list-style-type: none"> • Astrocytoma • Oligodendrogloma • Glioblastoma multiforme 	Not generally allowed	Treatment of recurrent or refractory disease

Bone Marrow Transplantation (cont.)

Non-Malignant Conditions

Condition	Allogeneic	Autologous
Agnogenic Myeloid Metaplasia with Myelofibrosis (=Primary myelofibrosis)	Allowed with progression to myelofibrosis	Not generally allowed
Aplastic Anemia	Allowed in severe disease after failure of antihymocyte globulin therapy	Not generally allowed
Thalassemia (Beta)	Yes	Not generally allowed
Essential Thrombocythemia	When associated with thrombotic or hemorrhagic disorder	Not generally allowed
Hemophagocytic Lymphohistiocytosis	Yes	Not generally allowed
Kostmann's Syndrome	Yes	Not generally allowed
Leukocyte Adhesion Deficiency	Yes	Not generally allowed
Megakaryocytic Thrombocytopenia	Yes	Not generally allowed
Mucopolidoses (ie. Gaucher's Disease, Metachromatic and Globoid Cell Leukodystrophies, Adrenoleukodystrophy)	Yes, if conventional dietary and enzyme therapy failed and patient is neurologically intact	Not generally allowed
Mucopolysaccharidoses (ie. Hunter's Syndrome, Hurler's Syndrome, etc.)	Yes, if patient is neurologically intact	Not generally allowed
Myelodysplastic Syndromes	Yes, if increasing blasts signaling possible leukemic transformation, OR in refractory anemia with chromosomal abnormalities OR with development of significant cytopenias	Not generally allowed
Osteopetrosis	Yes	Not generally allowed
Polycythemia Vera	Yes, ONLY when progression to acute leukemia	Not generally allowed
Severe Combined Immunodeficiency Syndrome (SCIDS)	Yes	Not generally allowed
Sickle Cell Disease	Yes with HLA related donor AND history of stroke OR high risk of stroke or end-organ disease	Not generally allowed
Wiskott-Aldrich Syndrome	Yes	Not generally allowed
X-Linked Lymphoproliferative Syndrome	Yes	Not generally allowed

Bone Marrow Transplantation (cont.)

Bone marrow transplants recommended by the transplant center and the PCP for treatment of any condition not listed may be submitted to the HMO for review and consideration.

Peripheral stem cell harvest is eligible for any clinical indication noted under allogenic or autologous bone marrow transplantation.

Donor search expenses as defined by the HMO may be covered for approved bone marrow transplants.

Paid by: HMO (when pre-authorized by the HMO)

Note: See related benefits interpretation on Organ and Tissue Transplantation for details on notification, review, authorization and claims procedures.

Botulinum Toxin

- Benefit:** Botulinum toxin is in benefit when utilized to treat the following medical conditions:
- Strabismus
 - Essential Blepharospasm
 - Hemifacial spasm
 - Spasmodic Dysphonia
 - Cervical dystonia (spasmodic Torticollis)
 - Oromandibular Dystonia—jaw closing type only
 - Focal segmental limb Dystonia
 - Achalasia of the esophagus if the member is not a surgical candidate
 - Children with cerebral palsy with pain resulting from spastic joint deformity
 - Other members who have painful spastic limb deformity, or where joint deformity significantly interferes with provision of supportive care.

Other medical uses: The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes for the following conditions:

- Oromandibular dystonia, other than jaw closing type
- Stuttering
- Vocal akathesia and other tremors
- Urinary or anal sphincter dysfunction
- **Cosmetic Uses:** Botulinum toxin is not in benefit when used for cosmetic services unrelated to restoration of bodily function, correction of congenital deformities, or for conditions resulting from accidental injuries, tumors, disease or previous therapeutic processes. Such cosmetic services may include, but are not limited to, denervation for elimination of laugh lines, worry lines, crows' feet, dynamic wrinkles, or other cosmesis.

Interpretation: Botulinum toxin is a complex protein derived from bacterial culture. The toxin has the ability to cause muscle paralysis and when occurring in contaminated food can cause fatal paralysis. In therapeutic doses, it is effective in treating conditions that feature muscle spasm as a major component. Botulinum toxin is administered by injection into the involved muscle.

Paid by: Professional Charges: **IPA**
Facility Charges: **HMO**
Drug Charges: **IPA**

Breast Surgery

Benefit: Breast reduction surgery is a covered benefit if determined medically necessary by an IPA Physician.

Breast reconstruction post- mastectomy is also covered; the mastectomy need not have been performed while the member was enrolled in the HMO.

Interpretation: Breast Reduction

Breast reduction performed strictly for cosmetic reasons is not covered (see also "Cosmetic Reconstructive Surgery"). Breast reduction for psychological reasons is also excluded.

Reasons for covered breast reduction surgery include, but are not limited to, the following documented conditions:

- Severe back pain related to breast size, incurable by other means
- Intertrigo, excoriation and skin breakdown due to the weight of the breasts
- Postural problems or deep shoulder grooves from brassiere straps

If the member is more than 20 percent over optimal weight, as found in the Metropolitan Life Height and Weight Tables, weight loss may be the first line of treatment. If the member has hypermastia with clinically demonstrable pathology or the member is still symptomatic after at least 6 months of weight reduction under a physician's continued guidance, then breast reduction is in benefit if the PCP refers the member for the surgery. In general, at least 500 grams of tissue is removed from each breast if reduction surgery is medically necessary. The surgeon's preoperative estimates of the extent of tissue removal may thus influence decisions regarding medical necessity. Benefits cannot be retroactively denied if less tissue is removed.

Prophylactic Mastectomy With Reconstruction

Prophylactic mastectomy and reconstruction are covered if the primary care physician and appropriate consultant agree that such a procedure is necessary for a member at high risk of developing breast cancer. A second surgical opinion may be obtained to confirm the risk and the appropriateness of the procedure. (See benefits interpretation on Second Opinions.)

Breast Reconstruction

Post-mastectomy breast reconstruction with or without prosthesis, including reconstruction of nipple and areola, is in benefit. The mastectomy need not have occurred while the member was an HMO member.

Surgery and reconstruction of the other breast to produce a symmetrical appearance is also in benefit post-mastectomy.

Breast Surgery (cont.)

Breast Augmentation

Augmentation of small but otherwise normal breasts is considered purely cosmetic and is not in benefit.

Augmentation mammoplasty and mastopexy to construct congenitally absent breast tissue is in benefit.

Complications

If a breast prosthesis becomes encapsulated, infected, or otherwise causes significant symptoms, surgery to remove the prosthesis is covered regardless of the reason that the original prosthesis was placed. However, if a breast prosthesis was originally placed for purely cosmetic reasons, neither the replacement prosthesis nor the reimplantation procedure is covered.

Bras and Prostheses

Bras for mastectomy members are covered as medical supplies. Post-mastectomy breast prostheses are also covered (See Prosthetic Devices).

Paid by:	Physician Charges:	IPA
	Facility Charges:	HMO
	Prosthetic Charges:	HMO
	Medical Supply Charges:	HMO

Note: See related benefits interpretations on Cosmetic/Reconstructive Surgery, Medical Supplies, and Prosthetics

Cardiac Rehabilitation

Benefit: Phase One and Phase Two Cardiac rehabilitation therapy are covered benefits under the conditions outlined below. Phase Three is not in benefit. The number of visits is subject to the maximum of 60 treatments per calendar year for outpatient rehabilitative therapies.

Interpretation: Cardiac rehabilitation programs offer a structured approach to progressive increase in exercise tolerance for members with a variety of cardiac conditions. Many facilities provide cardiac rehabilitation care through formal organized cardiac rehabilitation programs. The degree of rehabilitative services and treatment modalities vary. Cardiac rehabilitation is traditionally divided into three phases. Phase one begins as soon as possible while the member is still hospitalized and continues until discharge. Phase two consists of medically supervised sessions conducted up to three times a week. Most programs have a maximum of 36 sessions for 30-60 minutes per session during the initial 6 months after hospital discharge. Phase three consists of life-long behavioral changes to promote exercise and a healthier lifestyle. Phase three is not in benefit. Cardiac rehabilitation for general strengthening and conditioning is not a covered benefit in the absence of cardiac disease.

The IPA physician's expectation that the member will improve within 60 days is the key to determining whether or not services are in benefit. Referrals for covered cardiac rehabilitation services should not be denied unless there is documentation that the PCP does not anticipate significant improvement within 60 days. Cardiac rehabilitation is in benefit when the PCP refers the member for the service.

Typically, the member must have had one or more of the following:

- Acute myocardial infarct
- Coronary artery bypass
- Cardiac transplantation
- Cardiac valve surgery
- Percutaneous transluminal angioplasty (PTCA)
- Thrombolysis for coronary artery occlusion
- Stable angina
- Cardiac decompensation (CHF or "heart failure")

Facilities with cardiac rehabilitation programs may at times use ancillary services, such as psychological or dietary services. They may also provide services to members who have non-cardiac medical conditions. Benefits for ancillary services to cardiac members, or services given in a cardiac rehabilitation program to non-cardiac members, should not be billed as cardiac rehabilitation. Such services should be considered for benefit under whatever additional certificate provision might apply.

Covered cardiac rehabilitation visits are counted against the member's outpatient therapy visits limits per the member's Certificate (typically 60 visits).

Paid by:	Professional Charges:	IPA
	Inpatient Facility Charges:	HMO
	Outpatient Facility Charges:	IPA
	Phase Three rehabilitation:	Member

Chemical Dependency Services

Benefit: Chemical Dependency is defined as a dependency or addiction to substances such as alcohol, illicit or prescription drugs. Process addictions such as internet, sex and food are not considered chemical dependency. These are considered mental illness.

Benefits are available for the treatment and rehabilitation of chemical dependency. The extent of benefits for chemical dependency available to any given member is defined by the member's benefit plan. (Refer to the HMO Benefit Matrix for a description of these benefits.) Benefits for mental health services are separate from those for chemical dependency.

Interpretation: To obtain benefits for chemical dependency treatment, call the HMO Chemical Dependency Hotline at 1-800-346-3986. The IPA is required to refer all members to the Hotline or to one of the treatment facilities in the HMO Chemical Dependency Network. An IPA physician may write a referral for a Chemical Dependency Evaluation directly to a contracted Chemical Dependency Facility; however, referring the member directly to the Hotline is the preferred method. The IPA physician should not admit the member to a facility but should refer the member to the chemical dependency program at the facility. (However, please see the Note at the end of this guideline).

The HMO has financial responsibility for chemical dependency services. However, if the IPA refers a member to a non-contracted facility, the IPA will become responsible for all professional fees and will also be charged days (units) towards their Utilization Management Fund. There are no days (units) charged for Chemical Dependency Services provided at a contracted Chemical Dependency Facility.

If the member has dual mental health and chemical dependency diagnoses, the primary diagnosis determines authorization procedures. If the mental health diagnosis is primary, even if chemical dependency is contributing to the mental health problem, the IPA should authorize treatment. If the chemical dependency diagnosis is primary, the Hotline authorizes treatment. **In all instances of chemical dependency care, the IPA remains responsible for the coordination of care and payment for associated medical or psychiatric problems that arose either prior to admission or while the member is hospitalized or in a partial hospitalization program or intensive outpatient program (IOP).** Please call the HMO Behavioral Health Liaison with any questions.

Non-medical (usually community-based) ancillary services (i.e., Alcoholics Anonymous) and/or educational programs (i.e., smoking cessation classes) are not covered; however, these services may be valuable, and their recommendation is encouraged. Any charges incurred for non-medical services are the financial responsibility of the member.

Chemical Dependency Services (cont.)

Many facilities provide specialized programs for the treatment of chemical dependency that may include a period of detoxification (usually 2-5 days). The chemical dependency Hotline may authorize inpatient detoxification, but since detoxification is primarily a medical treatment, days utilized for detoxification are not counted against the member's inpatient chemical dependency benefits. If Detoxification care is directed by the Chemical Dependency Hotline, the HMO is financially responsible for professional and facility charges. No days (units) will be charged to the IPA's Utilization Management Fund. If the IPA directs Detoxification care, the IPA will become financially responsible for the professional fees associated with this care. All days (units) will be charged to the IPA's Utilization Management Fund, as appropriate.

Every two days of care in a participating partial day program or intensive outpatient treatment program are charged as one day against the days available for inpatient chemical dependency treatment. Every two sessions of outpatient group therapy are charged as one day against days available for outpatient chemical dependency treatment. These conversions are summarized on the following table:

Chem. Dep. Program Type	# of Visits	UM Fund Charge	Member's Benefit Level Charge	Copayment (see Benefit Matrix)
Partial Day	1	0	0.5 inpatient	1 inpatient
Intensive Outpatient	1	0	0.5 inpatient	1 inpatient
Group Therapy	1	0	0.5 outpatient	1 per session per family
Individual Therapy	1	0	1 outpatient	1 outpatient mental health
Detox (inpatient)	1 inpatient	No- if directed by Hotline Yes- if directed by IPA	NA	1 medical (inpatient)
Detox (outpatient)	1	No- if directed by Hotline Yes- if directed by IPA	NA	1 medical (outpatient)

Chemical Dependency Services (cont.)

Paid by:	Outpatient professional/facility charges:	HMO
	Inpatient professional/facility charges:	HMO
	Detoxification (directed by IPA)— professional charges:	IPA
	Detoxification (directed by Hotline)— professional charges:	HMO
	Detoxification—facility charges:	HMO

Note: Authorization and/or payment details may vary for members enrolled in certain IPAs.
#098 Physicians Care Network, Inc.
#351 Southern Illinois Health Care Association

Please call the HMO with questions regarding members enrolled in these groups.

Note: See related benefits interpretations on Mental Health (inpatient) and Mental Health (outpatient)

Chemotherapy

Benefit: Outpatient or inpatient treatment of malignant neoplastic conditions with pharmaceutical or antineoplastic agents, including administration of drugs by parenteral, infusion, perfusion, intracavitary or intrathecal means, is a covered benefit. The benefit includes the cost of drugs, administration of drugs, and ancillary services and supplies.

Interpretation: The IPA is responsible for all charges including the cost of chemotherapy drugs provided in the physician's office or outpatient facility. Injectable chemotherapeutic drugs are **not** covered under the Prescription Drug Program.

Investigational drugs are not in benefit.

Paid by:	Physician Charges:	IPA
	Inpatient Facility Charges:	HMO
	Outpatient Facility Charges:	IPA
	Outpatient Drug Charges:	IPA
	Home Health Care Charges: (for homebound member- from contracted provider).	HMO
	Home Health Care Charges: (for ambulatory member or from non contracted provider):	IPA

Note: Hospital days or home health care visits are charged to the Utilization Management Fund.

Note: Therapy should be provided in the most clinically-appropriate and cost-effective setting. If care is provided at home and the member is homebound, the HMO is responsible for charges under the home health benefit. However, the IPA is responsible for one hundred percent of home health charges inappropriately ordered for ambulatory members for whom care could have been provided in the office or an outpatient setting (see Medical Service Agreement).

Note: If the member has limited or no pharmacy benefits for self-administered home-based chemotherapy, please contact the HMO Customer Assistance Unit.

Chiropractic Services

Benefit: The use of chiropractic services in the treatment of an illness or injury is a covered benefit when referred by the IPA physician.

Interpretation: Chiropractic is a system of therapeutics based upon the theory that disease is caused by abnormal function of the nervous system. It attempts to restore normal function by manipulation and treatment of the structures of the human body. Chiropractors in Illinois are licensed to treat human ailments without the use of operative surgery or drugs.

If an PCP or WPHCP feels that chiropractic services will benefit the member and refers the member to a chiropractor, the services are covered. As with all clinical services, referral to a chiropractor should be based on the clinical judgment of the PCP or WPHCP, not the insistence of the member.

Paid by: Professional Charges: **IPA**

Cochlear Implantation

Benefit: Cochlear implants are in benefit if determined by the PCP to be medically necessary.

Interpretation: A cochlear implant is an electronic device, part of which is surgically implanted into the inner ear and part of which is worn like a pocket type hearing aid. The purpose of the device is to restore a sense of sound recognition to a profoundly deaf person.

These devices can be either single channel (providing a single frequency stimulation) or multi-channel (providing multiple frequency stimulation). These devices do not restore normal hearing capability, but merely restore the member's ability to recognize sounds originating in the external environment.

An intensive pre-surgical evaluation is usually performed. This evaluation may include:

- Auditory brainstem response studies
- Stapedial reflex testing
- Otoacoustic emission testing
- Auditory behavioral response evaluation
- MRI or CT Scans

The implantation of a single or multi-channel device may be appropriate for selected deaf members who:

- Are pre-lingual or post-lingual members of any age who have failed to achieve a functional level of hearing despite an appropriate trial of adequate amplification and intensive auditory training.
- Have x-ray evidence of a developed cochlear apparatus.
- Have the ability to cooperate with the complex post-surgical regimen needed to gain optimum benefit from the device.
- Do not have any of the following:
 1. Acoustic (8th) nerve damage
 2. Central auditory pathway damage
 3. Active middle ear infections

Post-implant aural therapy is important for adults and is critical for children to maximize the benefits available from cochlear implantation, especially speech development. Such therapy is outpatient rehabilitation therapy. If the member continues to improve and the IPA physician refers the member for ongoing therapy, the therapy is in benefit subject to the limitations of the member's outpatient rehabilitation therapy benefits. See Benefits Matrix for details, as these benefits vary.

Paid by:

Physician Charges:	IPA
Device Costs:	HMO
Facility Charges:	HMO
Aural Therapy:	IPA

Note: See related benefits interpretation on Speech Therapy

Cognitive Therapy

Benefit: The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes.

Interpretation: The ability of the human brain to survive and maintain normal activity after an injury varies greatly from person to person. Post-traumatic changes vary from subtle personality alterations noticeable only to close family members to various levels of coma.

Several techniques have been advanced to improve brain function. These are collectively termed “cognitive therapy.”

Cognitive therapy as defined by the National Association of Rehabilitation Facilities consists of a series of retraining activities that are individual instructional services developed from an assessment based upon behavioral observation. These instructional activities are introduced in a systematic fashion utilizing available skills in order to rebuild intellectual processes including, but not limited to concentration, perception, and problem solving ability.

The wide variety of approaches to the member with cognitive impairment suggests that an optimal approach to cognitive therapy has not yet been developed. Additionally, no well-controlled studies document that any outside stimulus or modality influences whatever inherent recuperative capacity an individual brain may possess.

Collagen Implant

Benefit: Collagen implanted by injection is a benefit when utilized in connection with:

- Covered reconstructive surgery (i.e. for treatment of depressed scars).
- Urological procedures to treat stress incontinence.

Interpretation: Collagen is the most abundant protein found in all mammalian connective tissue, cartilage and bone. It provides the form and support structure for these tissues. Bovine (cow) collagen is used to treat various conditions resulting from disease, trauma, surgery or congenital anomalies. Supplemental treatments are occasionally required.

Collagen implanted by injection is **not** in benefit when used in connection with:

- Palliative treatment of corns or calluses.
- Any treatment primarily for cosmetic indications unless other criteria for cosmetic and reconstructive surgery are met

Paid by:	Physician Charges:	IPA
	Drug Charges:	IPA
	When used for treatment of corns, calluses, or for cosmetic indications	Member

Note: See related benefits interpretation on Cosmetic/Reconstructive Surgery

Computerized Knee Evaluation

Benefit: Computerized knee evaluation is a covered benefit, when part of an otherwise-approved program of physical therapy.

Interpretation: This system is intended to provide a standardized and reproducible evaluation of knee laxity/stability by use of tests such as the anterior/posterior drawer test, the dual A/P drawer test, varus/valgus stress test, and pivot shift test.

Paid by: Outpatient Charges: **IPA**

Contact Lenses/Eyeglasses

Benefit: Contact lenses for correction of vision are in benefit to the extent described in the Vision Care benefits interpretation. Separately, contact lenses are in benefit under the medical coverage for the treatment of certain diseases of the eye.

Interpretation: Keratoconus is a congenital defect of the cornea in which there is a conical deformity of the cornea due to noninflammatory thinning of the membrane. Keratoconus can be corrected with the use of hard or semi-rigid contact lenses. Contact lenses and eyeglass lenses (lenses only – frames are not covered) are covered for this condition under the medical benefit.

Contact lenses are in benefit following trauma or infection to the cornea to restore regular curvature to the eye.

Contact lenses and eyeglass lenses (only lenses –frames are not included) are in benefit following cataract surgery without intraocular lens implantation. (aphakic post surgery members).

Paid by:	For Correction of Vision: Professional Charges (including those related to refraction and fitting: Lens charges:	Member (as described in the Vision Care Benefits.) Member (as described in the Vision Care Benefits.)
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Paid by:	For Medical treatment of certain diseases of the eye: Professional Charges: Lens charges:	IPA HMO
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Coverage Variation: Benefit Plan DIRPY- Excluded

Note: See related benefits interpretation on Vision Care on Vision Screening/Routine Vision Care and Prosthetic Devices

Note: Eyeglass lenses and contact lenses do not require use of a non-contracted Provider. The IPA may refer the member to a supplier of its choice.

Cosmetic/Reconstructive Surgery

Benefit: Cosmetic/reconstructive surgery is in benefit if performed to restore bodily function, to correct congenital deformities, or for conditions resulting from accidental injuries, tumors, disease or previous therapeutic processes. Psychological or psychiatric indications do not, by themselves, qualify cosmetic surgery for coverage.

Interpretation: Many cosmetic surgical procedures may be performed for medical, rather than cosmetic, reasons. **The etiology of the underlying condition for which the surgery is performed, rather than the type of procedure, is the factor which determines benefit eligibility.**

Covered Procedures: Reconstructive surgery to correct or revise previous surgery (including non-cosmetic revision of procedures done purely for cosmetic reasons), disease or accidental injury is in benefit regardless of insurance coverage at the time the causative condition developed. Covered procedures may include, *but are not limited to*, the following:

- Reconstruction or repair of congenital anomalies.
- Reconstruction of any body member if absent or deformed as a result of trauma, disease or covered therapeutic processes.
- Revision or treatment of complications of procedures originally considered "cosmetic" if such treatment is not done for purely cosmetic reasons.
- Removal of implant material when encapsulated, infected, displaced or hardened; replacement of an implant is not covered if the implant was originally cosmetic in nature. (See benefits interpretation on Breast Surgery—section on complications)
- Revision of symptomatic scars (i.e. scar tissue restricts movement, affects the function of another organ, is painful, infected or keloidal in nature).
- Revision of scars secondary to congenital deformity, injury, tumor, or disease, *whether symptomatic or not*.
- Removal of traumatic or therapeutic tattoos.
- Dermabrasion or chemical peel for severe acne scarring.
- Rhytidectomy for correction of functional impairment (any body part).
- Sex-reassignment (transgender) surgery
- Hairplasty clearly associated with scarring or alopecia resulting from disease, trauma or previous therapeutic processes.
- Post-mastectomy reconstruction with or without prosthesis, including reconstruction of nipple and areola.
- Mammoplasty or mastopexy of the contralateral breast to bring it into symmetry with the post-mastectomy reconstructed breast.
- Augmentation mammoplasty and mastopexy to construct congenitally absent breast tissue.
- Reduction mammoplasty for excessively large pendulous breasts, justified by documentation relative to pain from deep shoulder grooving, postural problems or inflammatory intertrigo.
- Abdominal lipectomy for panniculus adiposus when the excess tissue causes significant symptoms or major disfigurement, such as folds hanging below the pubis.
- Revision of excess remaining tissue after massive weight loss, when such tissue causes significant symptoms or major disfigurement.
- Diastasis recti repair incidental to a covered abdominal lipectomy or midline hernia.

Cosmetic/Reconstructive Surgery (cont.)

Covered Procedures— (cont.)

- Blepharoplasty (upper eye lids only) for marked blepharochalasis or skin excess with secondary impairment of peripheral vision (documentation with photographs or visual field chart necessary).
- Strabismus surgery regardless of the age of the member or date of origin of the condition. Also, subsequent surgical corrections required to obtain the desired results.
- Mentoplasty with or without implant for deformities of the maxilla and mandible resulting from birth defects, disease or injury. (See benefit interpretation on orthognathic surgery.)
- Mandibular or maxillary resection for prognathism or micrognathism in the presence of severe handicapping malocclusion with documenting cephalometric x-rays and occlusal models. (See benefit interpretation on orthognathic surgery.)
- Rhinoplasty or septoplasty for external nasal/septal deformity with airway impairment due to nasal bone deformity.
- Otoplasty (unilateral or bilateral) for congenital or acquired malformation.
- Pectus excavatum.
- Treatment of warts
- Laser treatment of rosacea

Not in Benefit

Benefits are not provided for **purely** cosmetic procedures, **unless there is documentation that the surgery/treatment is being performed for correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease. The Etiology of the Underlying Condition for Which the Surgery/treatment Is Performed, Rather Than the Type of Procedure, Is the Factor Which Determines Benefit Eligibility.** In the absence of appropriate documentation, the following procedures are considered cosmetic and not in benefit:

- Revision or treatment of complications, procedures or conditions that were originally considered cosmetic and revision is performed for purely aesthetic purposes.
- Excision or treatment of decorative or self-induced tattoos.
- Chemical peel or dermabrasion of face or other areas for wrinkling or pigmentation.
- Rhytidectomy solely for aging skin; buttock and thigh lifts; neck tucks.
- Excision or correction of glabellar frown lines.
- Revision of vaccination scars.
- Insertion or injection of prosthetic material to replace absent adipose tissue
- Hairplasty (any type) for male pattern alopecia (male or female member).
- Electrolysis for hirsutism.
- Augmentation of otherwise normal breasts, regardless of size.
- Reduction or repositioning mammoplasty when asymptomatic.
- Lipectomy when asymptomatic.
- Diastasis recti repair in absence of true midline hernia (ventral or umbilical) or overhanging lower abdominal panniculus adiposis.
- Blepharoplasty of upper or lower eyelids for blepharochalasis or skin excess without documentation of visual impairment.
- Ear or other body piercing. (however, revision of keloids associated with ear piercing and repair of torn ear lobes resulting from ear piercing are in benefit).

Cosmetic/Reconstructive Surgery (cont.)

The IPA is encouraged, when possible, to perform covered procedures as outpatient surgery. (See "Outpatient Surgery").

Paid by: Physician Charges: **IPA**
Facility Charges: **HMO**

Note: See related benefits interpretations on Breast Surgery and Orthognathic Surgery

Custodial Care

Benefit: Custodial care services are not in benefit.

Interpretation: Custodial Care Service means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without clinical likelihood of improvement of the condition. Custodial Care Services also means those services which do not require the technical skills or professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of medications etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by the member.

The nature of a service, rather than the licensure or certification of the person(s) providing the service, determines whether the service is skilled or custodial.

If a court mandates the member's site of care and the member is receiving custodial services only, such services are not in benefit.

Paid by: **Member**

Note: See related benefits interpretations on Skilled Nursing Facility and Home Health Care

Day Rehabilitation Program

Benefit: Day rehabilitation programs for speech, occupational and/or physical therapy or for pain management are a covered benefit if services are received in an HMO-approved facility.

Interpretation: A day rehabilitation program is a non-residential planned rehabilitative program of speech, occupational, and/or physical therapy. Day rehabilitation is considered outpatient rehabilitative therapy and is counted against the maximum benefit for these services.

Outpatient rehabilitative therapy visits should be counted as follows: A single date of service by the same provider will be counted as one treatment/visit for the calculation of the outpatient therapy maximum. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided.

Paid by: Physician charges: **IPA**
Facility charges: **IPA**

Dental

Benefit: Coverage of routine dental care and services is excluded.

Dental treatment for accidental injury to sound natural teeth is covered. Only services directly related to teeth damaged by the accident are eligible for benefits.

Certain oral surgical procedures are covered, such as the removal of fully bony impacted teeth (See “Oral Surgery”).

Hospitalization for non-covered dental procedures is in benefit under certain conditions specified below.

Interpretation: **Routine dental care; The following services are not covered:** Routine dental exams, cleaning, fillings, orthodontics (braces), endodontics, prosthodontics, periodontal services, and restorative or prosthetic services that alter jaw or teeth relationships.

The member may have dental coverage for routine care and should ask his/her employer about such insurance.

Injury to sound natural teeth: Treatment following sudden physical trauma to sound natural teeth is covered. Misadventures while eating are not covered (i.e. tooth breaks while biting into a hard substance). Repair of the injury, including the need for root canals, and the use of caps, crowns, bonding materials and other procedures to repair the structure and function of the tooth is covered. Orthodontic benefits apply only to those teeth directly involved in the accident. Bridges or partial dentures are covered when used to replace sound natural teeth lost in the accident. Repair or replacement of damaged removable appliances is not covered. Non-removable dental appliances are considered to be sound natural teeth for purposes of this benefit. Therefore, repair or replacement of non-removable dental appliances damaged by trauma would be in benefit. Temporary restorative services should be included in the final restoration, and are not a separate benefit.

Injury to the tooth may not be obvious. All of the treatment mentioned above continues to be in benefit, even if the injury becomes apparent several months later. Only directly injured teeth are covered. Treatment for a pre-existing dental, periodontal or orthodontic condition is not in benefit.

Hospitalization /Ambulatory Surgical Facility use for non-covered dental

procedures: An admission (or use of an ambulatory surgical facility) for non-covered dental services is a covered benefit when one or more of the following conditions exist:

- A non-dental physical condition makes hospitalization or use of an ambulatory surgical facility medically necessary to safeguard the health of the member.
- The member requires medical management during a dental procedure because of serious systemic disease.
- The member needs anesthesia because of inability to cooperate with extensive dental procedures while conscious. Examples include, but are not limited to, members who are mentally or physically handicapped, or young children.
- The surgical procedures are complex and carry a high probability of life-threatening complications.

Dental (cont.)

When a hospital or ambulatory surgical facility is used for non-covered dental surgery, the HMO will pay the facility charges. The IPA is responsible for all physician services related to treatment of the member's medical condition. The member is responsible for the dentist or oral surgeon. The member is also responsible for the anesthesia charges, unless the member meets the following criteria for anesthesia coverage:

1. A child who is 6 years and under
2. The member has a chronic disability that is the result of a mental or physical impairment, is likely to continue and that substantially limits major life activities such as self-care and expressive language
3. The member has a medical condition requiring hospitalization or general anesthesia for dental care

Paid by:

Injury to Sound Natural Teeth	
Professional Charges:	IPA
Hospital Charges:	HMO
Outpatient Facility Charges:	See Outpatient Surgery Benefit

Routine dental care	
Professional Charges:	Member

Hospitalization/Ambulatory Surgical Facility use for Non-Covered Dental Procedures

Professional fees for dental procedures:	Member
Anesthesia Charges (If member does not meet above criteria:	Member
Anesthesia Charges (If member does meet above criteria:	IPA
Professional fees for treatment of medical condition:	IPA
Facility Charges:	HMO

Note: See related benefits interpretations on:
Oral Surgery
Orthognathic Surgery
Temporomandibular Joint Disorder

Diabetes Self-Management

Benefit: Members with diabetes, whether or not they are insulin-dependent, have coverage for specified care, education, and supplies, subject to benefits provisions and limitations in their health care policy. This coverage also applies to members with gestational diabetes.

Interpretation: Diabetic instruction in nutrition, blood glucose monitoring and interpretation, exercise/activity, foot and skin care, medication and insulin treatment plans, and prevention of diabetic complications is covered. The primary care physician, a consulting physician, or a certified health care professional who has expertise in diabetes management may instruct the member. Training can take place in the office, at home, or in an outpatient department.

Training is limited to three medically necessary visits after a new diagnosis of diabetes.

If a member has repeated symptomatic hyperglycemia (blood glucose over 250 mg/dl), severe symptomatic hypoglycemia for which he/she needed the help of another person, or a significant change either in the progression of his/her diabetes or its treatment, the PCP may determine that the member needs up to two more visits for diabetic instruction.

Diabetic supplies including lancets, alcohol pads and testing strips are in benefit. These can be obtained either through the member's pharmacy benefits or with a group approved referral to a contracted DME provider. Some employer groups have limited or no drug or DME benefits. Member benefits are subject to usual contractual deductibles, co-payments, and coinsurance.

Glucose Monitors (including those for the visually impaired) are also in benefit. The HMO may have a special program available that would allow the member to receive certain monitors at no cost. The member should contact the HMO's customer service department for details.

Paid by:	Professional fees:	IPA
	DME (from contracted provider):	HMO
	DME (from non contracted provider):	IPA
	Prescription Drugs:	HMO (through prescription benefit)

Coverage Variation: Benefit Plan DIRPY—no DME or pharmacy benefit

Note: See related benefits interpretations on Drugs, DME, and Infusion Pumps

Drugs

Benefit: Members eligible for the HMO prescription drug benefit have this benefit noted on their HMO ID card. **Please note that a small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors, whose formularies differ from that of BCBSIL.**

Outpatient prescription drugs, including self-injectable drugs, are covered through the Prescription Drug Program. If the member purchases the medication(s) at a Blue Cross and Blue Shield participating pharmacy, he/she pays only a designated copayment. If the member fills the prescription at a non-participating pharmacy, he/she may be reimbursed for 75% of the cost of the prescription, less the copayment.

Most outpatient drugs are available up to a 34-day supply at participating pharmacies. Some maintenance drugs in larger quantities will be covered when purchased from a participating mail order prescription drug provider. The member will be charged only their co-payment. Benefits for contraceptive drugs will be provided only for certain contraceptives dispensed by a participating mail order prescription drug provider. Please refer to the current HMO Drug Formulary for a listing of drugs covered in these programs.

Benefit limitations exclude certain drugs used for cosmetic purposes (i.e. Propecia for male pattern baldness, Retin A or Renova for skin wrinkles).

The prescription drug program is based on a formulary. When possible, physicians should prescribe efficacious generic or brand name drugs identified in the HMO Drug Formulary. The formulary is distributed to the IPA annually and is available on the BCBSIL website. It is also available upon request from your Provider Network Consultant.

Interpretation: Drugs administered during an inpatient admission or during procedures in an ambulatory facility are billed as part of the facility charges and are paid by the HMO. The HMO also pays for drugs administered to a homebound member by a home health agency.

The IPA pays for all drugs and supplies given to the member during an office visit. This is true regardless of route of administration. The IPA may NOT ask a member to use the prescription benefit to obtain medications intended for administration during an office visit or require the member to procure the medications.

Drugs (cont.)

The IPA provides injectable drugs given to the member in the office or in other outpatient settings at no cost to the member. Such injectables include but are not limited to:

- All intravenous injectables including chemotherapy and antibiotics, **except for** heparin preparations and anithemophelic factors
- All biologicals
- Sandostatin
- Alferon
- Lupron-Depot
- Leukine Prokine
- Amvisc
- Amvisc Plus
- Healon
- Healon GV
- Provisc
- Vitrax
- childhood and adult vaccinations
- required immunizations for planned travel
- allergy immunizations/allergens/desensitization injections

The FDA classifies some injectable therapeutic agents as devices. The IPA purchases these injectables for subsequent reimbursement from the HMO. These include:

- Synvisc®
- Hyalgan®

Most employers cover self-injectable drugs as part of the Prescription Drug Benefit when the HMO classifies the drug as a self-injectable. Members must use a network pharmacy. Preauthorization is not required.

Coverage Variation: Benefit plan DIRPY- no prescription drug benefit.

Some employer groups have limitations on their prescription benefits. Such limitations may include self-injectable or contraceptive drugs. Other employer groups do not offer prescription benefits through BCBSIL.

Note: See related benefits interpretations on:

Erythropoietin, Family Planning, Growth Hormone Therapy, Hematopoietic Growth Factors, Immunizations, Intravenous Immunoglobulin, Lupron

Durable Medical Equipment (DME)

- Benefit:** Durable medical equipment is in benefit. DME items:
- withstand repeated use (are reusable);
 - are appropriate for home use;
 - primarily and customarily serve a medical rather than a comfort or convenience purpose;
 - generally are not useful to a person in the absence of illness or injury;
 - are ordered and/or prescribed by an IPA Physician.

Interpretation: The IPA is not required to be a "supplier" of medically necessary medical equipment. A contracting DME provider may bill the HMO directly, in which case the HMO may contact the IPA to confirm that the DME is approved by the IPA. The DME provider may also bill the IPA. In this case, the IPA should stamp the bill group approved or not group approved and send the bill to the HMO. In addition to the usual information required on all claim submissions, claim documentation must show:

- Name of medical supplier
- Date of purchase or rental
- Type of medical equipment
- Purchase price (if applicable)
- Quantity (if applicable)
- IPA Physician name and approval or prescription
- Diagnosis
- Receipt(s) which verify payment of purchase or rental.

DME items that are in benefit are generally not useful to a person in the absence of an illness or injury. Such examples include but are not limited to commodes, shower seats, walkers and raised toilet seats.

Items of equipment not primarily used for a medical purpose do not meet the definition of DME and are not covered. Personal hygiene, comfort or convenience items commonly used for other than medical purposes are excluded and not in benefit. Such examples include but are not limited to are air conditioners, humidifiers, physical fitness equipment, televisions and telephones.

Back-up equipment or equipment which duplicates the function of DME already possessed by the member is not in benefit. For example, separate pieces of DME would not be provided for use at home and at school.

If DME can be rented for a cost less than purchase, payment for the rental will be made. Once purchase price is reached, no more benefits will be available for that piece of equipment. Purchase will be covered only if:

- the item of equipment is unavailable on a rental basis; or
- the member will use the item of equipment for a long enough period of time to make its purchase more economical than continuing rental fees.

It is the IPA's responsibility to monitor usage and efficacy of rented DME. Rental should be terminated when the DME is no longer used or is no longer medically indicated.

Durable Medical Equipment (DME) (cont.)

Non-reusable supplies used with DME are covered as medical supplies.

Generally, replacement of an item of DME is covered, if it is less expensive to replace than to repair. The member need not have been a member of the HMO at the time the DME was originally obtained for supplies or repair to be covered. However, a contracted vendor should be used.

Non-covered DME items include:

- Mechanical or electrical features which usually serve only a convenience function, unless documentation is provided as to the medical need for such items;
- Devices and equipment used for environmental control or enhancement, e.g., air conditioners, humidifiers, air filters, portable Jacuzzi pumps;
- Back-up equipment or duplicative equipment ;
- Equipment utilized in a facility that would normally provide for such an item, e.g., a mechanical bed while a member is in a hospital or extended care facility

If an IPA orders DME that is not in benefit and does not inform the member that the DME is not covered, the member cannot be held responsible for the cost of the DME. If the IPA uses a non-contracting provider, the member cannot be held responsible for the cost of the DME. The HMO will reject the claim and the IPA is liable for the cost of the DME.

Paid by:	Physician Charges:	IPA
	Equipment Charges (from a contracted provider):	HMO
	Equipment Charges (from a non-contracted provider):	IPA

Coverage Variation: Benefit Plan DIRPY- Excluded

Note: In order to streamline the process to ensure appropriate claims processing, effective May 1, 2010, all DME exception requests must be submitted directly to the CAU. You may call to request the DME exception at (312) 653-6600 or send your request via fax at (312) 938-7859. It is the intent of the CAU to respond to your requests within two business days.

Earplugs

Benefit: Earplugs to protect the external auditory canal are not a covered benefit.

Interpretation: Earplugs used to prevent swimmer's ear or other disorders caused by submersion of the auditory canal are considered a hygienic item and therefore not covered.

Earplugs used to block the auditory canal after tympanostomy tubes have been inserted are also not covered.

Paid by: Equipment Charges: **Member**

Electrical Bone Growth Stimulation

Benefit: Electrical bone growth stimulation is covered for members with specific clinical conditions.

Interpretation: Electrical bone stimulation can be performed in three ways:

- Non-Invasive: The casted fracture is placed between two coils of wire through which pulsed currents signal the release of calcium to the injured area which stimulates healing. The power source is external.
- Invasive: A device consisting of two electrodes and an electric assembly is surgically implanted in an intramuscular space and an electrode is implanted within the two pieces of bone to be joined. The power source is later removed surgically.
- Percutaneous: An external power source is used. Several electrodes are inserted through the skin and into the affected bone.

The non-invasive method is accepted medical practice for the treatment of long bone, pelvis and shoulder girdle non-union secondary to trauma meeting the following criteria:

- at least threemonths have passed since the date of the fracture; and
- serial radiographs have shown no progression of healing; and
- the fracture gap is one centimeter or less; and
- the member is adequately immobilized and is able to comply with non-weight bearing.

The non-invasive method is also used to treat patient with failed spinal fusion, in which:

- the fusion has not healed six or more months after the operation and
- serial radiographs for the preceding three months have shown no progression of healing

Either invasive or non-invasive method may be used as an adjunct to spinal fusion surgery for patient with any of these risk factors:

- one or more previous failed spinal fusion(s)
- grade 3 or worse spondylolisthesis
- fusion to be performed at more than one level
- current smoking habit
- diabetes
- renal disease
- alcoholism

Electrical Bone Growth Stimulation (cont.)

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes.

Paid by:	Physician Charges:	IPA
	Facility Charges:	HMO
	Device Charges: (rental or purchase)	HMO

Coverage Variation: Benefit Plan DIRPY: Rental or purchase of device is excluded.

Note: See related benefits interpretation on **Ultrasonic Bone Stimulation**

Emergency Communication Devices

Benefits: Emergency communication devices are not a covered benefit, as they are not primarily medical in nature.

Interpretation: Emergency communication devices are electronic devices that transmit signals notifying a central location that the wearer of the device requires emergency assistance. Components include a transmitter that is worn and a console that ties in to the telephone system.

Paid by: Device Charges: **Member**

Emergency Services

Benefit: Emergency services are covered.

Interpretation: The HMO is responsible for paying for facility charges for all services for Emergency Medical Conditions provided to a Member within 30 miles of the IPA. In addition, the HMO pays for facility, physician and ancillary charges for all services for Emergency Medical Conditions provided to a Member outside of 30 miles of the IPA. Prior authorization or approval by the IPA is not required for payment of hospital-based emergency services.

The IPA is responsible for paying physician and other professional charges for all services for an Emergency Medical Condition provided to a Member within 30 miles of the IPA. Prior authorization or approval by the IPA is not required for hospital emergency room services for an Emergency Medical Condition. The IPA is not responsible for services for an Emergency Medical Condition provided to Members outside of 30 miles of the IPA.

In the event that the Member is hospitalized within 30 miles of the IPA for an Emergency Medical Condition, the IPA is responsible for the Physician and other professional charges from the point of notification. For services within 30 miles of the IPA, all units will be charged for inpatient days when a member is admitted through an emergency room even if the IPA is not notified.

Paid by:

Professional charges	IPA
Facility charges	HMO

Coverage Variation: The emergency copayment listed in the Benefit Matrix is applicable ONLY to treatment provided in a hospital emergency room.

Epidural Anesthesia

Benefit: Epidural anesthesia is a covered benefit.

Interpretation: Anesthetic agents may be effectively and safely administered by the epidural route. Anesthetic is injected by direct conventional transepidermal means, or through a catheter port. Epidural anesthesia may be appropriate in a number of clinical settings, including, but not limited to, obstetrical anesthesia for cesarean section.

Paid by: Physician charges: **IPA**
Facility charges: **HMO**

Erythropoietin (EPO)

Benefit: Erythropoietin (EPO) is in benefit for selected members.

Interpretation: Erythropoietin is a hormone produced by recombinant technology. It stimulates production of erythrocytes (red blood cells) in specific anemias.

Erythropoietin may be used to treat anemias resulting from:

- Chronic renal failure
- AZT therapy in HIV -infected members (AIDS)
- Chemotherapeutic drugs utilized to treat non-myeloid cancers
- Anemia following allogenic bone marrow transplant
- Myelodysplastic syndromes if a three (3) month trial documents effectiveness in reducing transfusion dependence

Paid by: **HMO** (if self-injected)
IPA (if administered in physician office)

Benefit Variation: Benefit Plan DIRPY- Excluded

Note: See related benefits interpretation on Drugs

Family Planning

Benefit: Family planning services, including family planning counseling, prescribing of contraceptive drugs, fitting of contraceptive devices and sterilization is in benefit. **Due to a legislative mandate beginning January 1, 2004, contraceptive devices and injectable contraceptives are now in benefit.** Oral contraceptives and the birth control patch are included in the pharmacy benefit.

Interpretation: The actual drug or device is in benefit. In addition, the fitting, insertion, implantation and/or administration of the device or drug is also in benefit for the following:

- IUD
- Diaphragms
- Norplant
- Depo-Provera
- Implanon

Paid by:	Physician Charges:	IPA
	Device Charges (except Diaphragms):	IPA
	Depo-Provera:	IPA
	Norplant:	IPA
	Diaphragms (member must submit bills to HMO for reimbursement with)	HMO
	<ul style="list-style-type: none"> ▪ Name of medical supplier ▪ Date(s) of purchase ▪ Purchase price ▪ IPA physician prescription or approval ▪ Diagnosis 	
	Receipt(s) verifying payment for supplies	
	Pharmacies and suppliers are not required to bill the HMO. The member must forward bills to the HMO for reimbursement.	

Coverage Variations: Prescription Drugs are excluded from some benefit plans. Any member that has Prescription Drug coverage under HMO is eligible for the birth control patch and oral contraceptives.

Note: See related benefits interpretations on Abortion, Drugs, and Sterilization

Growth Factors for Wound Healing

Benefit: FDA-approved growth factors are in benefit as adjunctive therapy for neuropathic ulcers extending into or beyond subcutaneous tissue, if these ulcers have an adequate blood supply.

Interpretation: Growth factors are substances that play a role in normal wound healing. These substances occur naturally, but can also be obtained from blood or by genetic recombinant techniques. Once obtained and compounded into a salve, growth factor preparations reportedly stimulate regrowth of soft tissue, capillaries and skin.

Only FDA-approved preparations are in benefit. Preparations prescribed for use by the member in the member's home are covered by the prescription benefit. Preparations used in a physician's office or another outpatient setting are the financial responsibility of the IPA.

Paid by: Preparations for home use: **HMO (through prescription benefit)**
Preparations for use in physician's office or **IPA**
other ambulatory setting:

Benefit Variation: Benefit plan DIRPY- No drug benefit.
Some employer groups have no, or limited, pharmacy benefits. Other employers have no pharmacy benefits provided through BCBSIL.

Growth Hormone Therapy

Benefit: Growth hormone therapy is in benefit for selected members.

Interpretation: Growth hormone is responsible for linear growth of long bones and is, therefore, the major factor responsible for attainment of adult height. Growth hormone also has multiple subtle effects on carbohydrate, protein and lipid metabolism, causes "maturation" of multiple body tissues, and serves as a counter-regulatory hormone for other hormones including insulin.

Recombinant growth hormone is produced by several manufacturers and has been approved by the FDA since 1985.

Growth hormone replacement is considered appropriate treatment for members in the following categories:

1. Pediatric members with growth hormone deficiency. established by:
 - A. Failure to reach a peak growth hormone level of at least 10 mg/ml by at least two provocative tests. Test agents include:
 - Clonidine
 - Arginine
 - Levodopa
 - Insulin hypoglycemia
 - Glucagon
 - Exercise
 - B. A 24-hour secretory test showing a mean growth hormone level of less than 3 mg/ml with fewer than 4 growth hormone spikes and no spike greater than 10 mg/ml.
 - C. A documented history of ablative pituitary radiation (usually because of brain tumor).
2. Members with short stature resulting from chronic renal failure when these members are awaiting kidney transplantation.
3. Pediatric members with short stature associated with Turner's Syndrome
4. Members with AIDS wasting or cachexia
5. Burn patients (limited to patients with third degree burns).

For member in categories 1, 2, and 3, other supportive but non-diagnostic documentation includes:

- Documentation of growth velocity under 5 cm/yr. with height at least 2 standard deviations below mean.
- Bone age determined by standard x-ray techniques to be two (2) years or more behind chronological age.

Growth Hormone Therapy (cont.)

Verification of continued medical necessity for continued growth hormone administration should be obtained according to the following recommendations:

- Members in categories 1, 2, or 3, in whom growth hormone deficiency is established in childhood, no further documentation of need is required through age 18.
- Members in category 1 in whom growth hormone deficiency is established as an adult, reevaluation every two years should establish ongoing efficacy of treatment with growth hormone.

There is insufficient evidence to support the use of growth hormone for other conditions.

Paid by: **HMO** (through prescription drug benefit, if self-injected at home)
 IPA (if administered in physician office)

Benefit Variation: Benefit plan DIRPY- Excluded.
 Members without prescription drug benefit—self-injectable excluded.

Note: See related benefits interpretation on Drugs

Health Examinations

Benefit: Routine health exams including medical history, physical examination, necessary lab and diagnostic testing, immunizations, and other services that are clinically appropriate to the age, sex, and history of member are in benefit. Exams required by law, such as premarital exams and school exams are covered. Exams required by an agency or organization, but not by statute, are not covered.

Interpretation: The frequency and content of the examination may be determined by the IPA Physician, but must meet or exceed standards of generally accepted medical practice and quality assurance guidelines. An exception to this is the school eye exam mandated by law – refer to the Vision Screening Scope in this section. The HMO preventive care guidelines provide evidence-based guidance to preventive care services.

Physical examinations solely for employment or insurance purposes are not covered. However, if a member receives a physical that can serve as both an employment/insurance exam and a routine physical exam, then the exam is covered. If a non-covered physical examination requires specific laboratory or diagnostic procedures that are not clinically indicated, the member is responsible for payment of such services.

Paid by:	Physician charges:	IPA
	Outpatient Test Charges:	IPA
	Non-covered examinations	Member

Hearing Aids

Benefit: Hearing aids (including bone anchored hearing aids – BAHA/auditory osseointegrated implant) are excluded except for members with benefit plans that specifically cover hearing aids. Refer to the list below.

The IPA may refer the member to a supplier of its choice.

Paid by: Member with benefits for hearing aid:
Professional fees: **IPA**
Hearing aid **HMO**

Member without benefits for hearing aid:
Professional fees (related to hearing aid) **Member**
Professional Charges (related to audiometry) **IPA**
Hearing aid **Member**

Note: See related benefits interpretation on Hearing Screening

Employer Group	Group Number	Hearing Aid Benefit	Benefit Plan Number	Benefit Plan Name	Cancel Date
Associated Banc Corp.	H51837	1 Pair Covered Every 36 Months From Date of Purchase	877	M6G15	1/1/2010
Associated Banc Corp.	H51837	1 Pair Covered Every 36 Months From Date of Purchase	894	BFG20	
Beam Global Spirits & Wine/Future Brands, LLC	H81651 & H81652	\$1,000 every 36 months from date of purchase	41/341	U4F20	
Caterpillar IAM Union	H51460, B51460	1 Pair Covered Every 36 Months From Date of Purchase	410	Z2F10	1/1/2010
Caterpillar Salary	H22200, H64076, B22200	1 Pair Covered Every 36 Months From Date of Purchase	963, 680	W7F15, R8G20	1/1/2010
Caterpillar UAW	H22201, B22201	1 Pair Covered Every 36 Months From Date of Purchase	887	W8F00	1/1/2010
CATERPILLAR SALARIED ACTIVE/COBRA	B51314	\$50 co-pay for 1 pair of hearing aids once every 36 months.	B41	GLG20	
CATERPILLAR AURORA ACTIVE/COBRA	B51315	\$50 co-pay for 1 pair of hearing aids once every 36 months.	C41	GMG10	
CATERPILLAR JOLIET IAM ACTIVE/COBRA	B51316	\$50 co-pay for 1 pair of hearing aids once every 36 months.	527	6YQ40	
Electro Motive Diesel	H17106	1 Pair Covered Every 36 Months From Date of Purchase	730/430	7TA10,7QA10	
Elmhurst College	B63088	1 Pair Covered Every 36 Months From Date of Purchase	977	N6G15	
Elmhurst College	H63088	1 Pair Covered Every 36 Months From Date of Purchase	977	N6G15	
Elmhurst College	H63088/B63088	1 Pair Covered Every 36 Months From Date of Purchase	696	DG15	
FORD PROTECTED RETIREE \$ORX	B50892	1 Pair Covered Every 36 Months From Date of Purchase	901	CKA10	
FORD MOTOR SPONSORED DEP W/MED	H51503	1 Pair Covered Every 36 Months From Date of Purchase	315	2ME20	6/1/2006
FORD HOURLY AMENDED RETIREEES SPS DEP	B50896	1 Pair Covered Every 36 Months From Date of Purchase	102	CLS10	
FORD HOURLY AMENDED RETIREEES	B37901	1 Pair Covered Every 36 Months From Date of Purchase	G41	GRG10	
FORD HOURLY ACTIVES	B50897	1 Pair Covered Every 36 Months From Date of Purchase	701	BYG25	
FORD PROTECTED RETIREE	B37900	1 Pair Covered Every 36 Months From Date of Purchase	901	CKA10	
General Motors	H50016	1 Pair Covered Every 36 Months From Date of Purchase	892	X8A10	1/1/2008
General Motors Corp - Retirees	H22102	1 Pair Covered Every 36 Months From Date of Purchase	221	4HE10	1/1/2008
General Motors Hourly	H22101	1 Pair Covered Every 36 Months From Date of Purchase	221	4HE10	1/1/2008
General Motors Salaried	H22100/B22105	1 Pair Covered Every 36 Months From Date of Purchase	992/513/615	X9E15/1PE20/2QE20	1/1/2008
Gerresheimer Glass Policy	H94876, H94877	1 Pair Covered Every 36 Months From Date of Purchase	661	12E05	
HEALTH CARE SERVICE CORP	B81026	\$5,000 maximum per lifetime coverage	684	K4G20	
HEALTH CARE SERVICE CORP	H81027	\$5,000 maximum per lifetime coverage	684	K4G20	
Ispen International, Inc.	B15862	1 Pair Covered Every 36 Months From Date of Purchase	265	15E10	
STANDARD BAHMO ACTIVE	B19847	\$5,000 maximum per lifetime coverage	716	3AG15	
STANDARD HMOT ACTIVE	H19848	\$5,000 maximum per lifetime coverage	716	3AG15	
State of Illinois	H06800	\$100 For Exam(s) and up to \$500 for hearing aids every 3 years	714	2GH10	6/3/2009
State of Illinois	H06800	\$100 For Exam(s) and up to \$500 for hearing aids every 3 years	819/528	4EM15/SYM15	6/3/2009
State of Illinois	H06800	\$100 For Exam(s) and up to \$500 for hearing aids every 3 years	185	K8M15	6/3/2009
State of Illinois	H06800	\$150 For Exam(s) and up to \$600 for hearing aids every 3 years	303	CXM15	
Volkswagen of America	H81931	1 Pair Covered Every 12 Months From Date of Purchase	398	Y1F15	

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Hearing Screening

Benefit: Hearing screening is a covered benefit for all members, regardless of age. Diagnostic audiometry is also covered.

Interpretation: Hearing screening is performed by an audiometrist, nurse, physician, or technician to determine whether an individual has normal hearing. Screening may or may not determine the degree of hearing loss, and will generally not give enough information to prescribe a hearing aid. Hearing screening will only determine a need for additional audiometric testing, which is also covered.

Paid by: Physician/Professional Charges: **IPA**

Note: See related benefits interpretation on Hearing Aids

Hematopoietic Growth Factors (HGF)

Benefit: Hematopoietic growth factors are in benefit for selected members.

Interpretation: Hematopoietic growth factors are naturally occurring substances produced by all humans. They modulate the development and maturation of white blood cells. A variety of such substances, including those listed below, have been identified:

- Granulocyte Colony Stimulating Factor (G-CSF)
- Granulocyte-Macrophage Colony Stimulating Factor (GM-CSF)
- Macrophage Stimulating Factor (M-CSF)
- Interleukin-3 (IL-3)

FDA-approved hematopoietic growth factors are in benefit unless the member's pharmacy benefit excludes these agents.

Coverage for these drugs is available in the following clinical situations:

- As a priming agent prior to collection of autologous stem cells when the member is to be treated with high dose chemotherapy (HDC) with a drug known to cause myelosuppression.
- As an adjunct to HDC and autologous stem cell rescue for any malignancy known to respond to such a treatment regimen.
- After any cancer treatment in which autologous or allogenic stem cell rescue has been utilized and engraftment has been delayed.
- In conjunction with treatment utilizing a drug generally known to cause febrile neutropenia or when prior treatment with a drug has caused febrile neutropenia in a specific member and this drug must be utilized again.
- Symptomatic patients with congenital or idiopathic neutropenia.
- Following myelosuppressive chemotherapy for non-myeloid malignancies as a treatment to reduce or prevent the incidence of infection or the duration of neutropenia.

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes when used:

- As a priming agent prior to collecting cells for allogenic stem cell harvest.
- As a preventive treatment for anticipated cytopenia in members not yet receiving chemotherapy.
- As treatment of chronic marrow failure from prior chemotherapy.

Paid by: **HMO** (as self-injectable)
IPA (if administered in physician office)

Benefit Variations: Benefit Plan DIRPY—self-injectable excluded
Some employer groups have limited or no self-injectable drug benefits.

Note: See related policies on Erythropoietin, Drugs

Hemodialysis and Peritoneal Dialysis

Benefit: Acute and chronic hemodialysis and peritoneal dialysis are covered benefits.

Interpretation: Acute dialysis is performed for abrupt loss of kidney function and may be necessary on only a short-term basis. Chronic hemodialysis is performed on a long-term basis because kidney function is significantly impaired or absent.

Coverage includes equipment, supplies and administrative services provided by a hospital or freestanding dialysis facility. Self-dialysis conducted in the member's home with equipment and supplies provided and installed under the supervision of a Hospital or Dialysis Facility Program or Home Health Care Program is covered.

Inpatient - in benefit when performed during an eligible hospital stay.

Outpatient - in benefit when performed in:

- Outpatient department of a hospital, or
- Free-standing facility; or
- Self-dialysis in the member's home

Benefits apply to equipment, supplies, and physician services.

Peritoneal dialysis and continuous ambulatory peritoneal dialysis are covered. Hemoperfusion, a modified form of hemodialysis, is also in benefit for selected members.

Medicare: Medicare becomes the primary payer for chronic hemodialysis services after the initial 30 months of dialysis.

The 30 months in which Medicare is the secondary payer is called the coordination period. The coordination period begins with Medicare entitlement. Entitlement because of ESRD normally begins the third month after the month in which a beneficiary starts a regular course of dialysis. The 3 month waiting period plus the 30 month coordination period would make Medicare the secondary payer for 33 months after the month in which dialysis began. The three-month waiting period is waived in certain situations:

If the member takes a course in self-dialysis, the 3 month waiting period is eliminated. Entitlement would then start the month that dialysis began. The coordination period in which Medicare would be secondary would be 30 months rather than 33 months.

If the member has a kidney transplant during the first three months of dialysis, the waiting period is shortened and entitlement begins the month in which the transplant occurred. The coordination period begins the month of the transplant and ends 30 months later.

Hemodialysis and Peritoneal Dialysis (cont.)

At the end of the period of coordination, Medicare becomes primary and entitlement continues as long as the member remains on dialysis. Although Medicare becomes primary, the IPA must continue appropriate case management.

Paid by:	Physician charges:	IPA
	Outpatient Facility and related pharmaceutical charges (from a contracted provider):	HMO
	Outpatient Facility and related pharmaceutical charges (from a non-contracted provider):	IPA
	Outpatient lab services billed independently of the Dialysis Facility:	IPA
	Home Health Charges (from a Contracted provider):	HMO
	Home Health Charges (from a non-contracted provider):	IPA
	Inpatient Facility Charges and Ancillary Charges	HMO

Hepatitis B Vaccine

Benefit: Vaccination against Hepatitis B is covered in full if recommended by the PCP

Interpretation: The Advisory Committee on Immunization Practices of the Centers for Disease Control endorses Hepatitis B vaccination for all newborn infants. This is in benefit.

Hepatitis B vaccination required by the state for school attendance is in benefit.

Other indications for Hepatitis B vaccination include, but are not limited to:

- Health care workers with risk of blood product exposure
- Employees or residents in institutions for developmentally disabled
- Staff of non-residential day care program or correctional facility
- Those with occupational exposure to blood/body fluids
- Hemodialysis patients
- Members with multiple sex partners
- Members using illicit drugs or having history of same
- Sexual or household contact HBV carrier

Hepatitis B vaccine is also in benefit in other situations not listed above when it is recommended by the PCP, including travel to areas with risk of exposure to Hepatitis B.

Paid by: Professional charges: **IPA**
Vaccine charges: **IPA**

Note: See related benefits interpretation on Immunizations

Home Health Care Services

Benefit: Home health care is a covered benefit. When services are obtained from a contracting home health care provider, the HMO pays the charges. If the IPA uses a non-contracting provider for approved home health care services, all charges are the financial responsibility of the IPA. **In addition, the IPA is financially responsible for one hundred percent of covered charges for home health care services ordered for ambulatory patients for whom care could have been provided in the office or an outpatient setting.**

Interpretation: Comprehensive coverage is available to a homebound member as long as care is medically necessary, skilled, approved by the IPA physician, and provided through an agency meeting the criteria mentioned below. There should be medical reasons why services cannot be provided in the office or other ambulatory setting.

Coordinated Home Care Program means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. The member must be homebound (that is unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Service on an intermittent basis under the direction of a Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, hospital laboratories and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

A home health care visit is considered an intermittent skilled nursing visit of not more than two hours' duration. Up to three visits per day can be ordered (one per eight-hour shift). Visits of longer duration are considered private duty nursing. Outpatient private duty nursing is not in benefit (see Benefit Interpretation – for Private Duty Nursing).

Comprehensive coverage includes:

- Skilled nursing care visits
- Injectable medications
- Supplies, dressings
- Equipment
- Physical therapy
- Administration of blood components
- Total parenteral nutrition
- Foley catheter care
- Decubitus and wound care
- Home hemodialysis

Home Health Care Services (cont.)

A Home Health Agency must meet the following requirements:

- is primarily engaged in providing skilled nursing services or therapeutic skilled services in home or places of residence
- has policies established by professional personnel
- is supervised by a Physician or Registered Professional Nurse
- is licensed according to applicable state and local laws, and is certified by the Social Security Administration for participation under Title XVIII, Health Insurance for the Aged and Disabled
- is certified as a Medicare Provider or licensed by the state
- maintains clinical records on all members served

Each home health visit is charged as 0.33 units for purposes of the Utilization Management Fund.

Paid by:	Home Health Services (for a homebound member and when provided by a contracted provider):	HMO
	Home Health Services (for an ambulatory member or when Provided by a non-contracted provider):	IPA
	Outpatient lab services billed independently of the Home Health Services	IPA

Home Uterine Activity Monitoring (HUAM)

Benefit: Home uterine activity monitoring is not a covered benefit because efficacy has not been documented.

Interpretation: Home Uterine Activity Monitoring (HUAM) is a diagnostic procedure performed in the pregnant member's home to detect changes in uterine activity that may have predictive value in managing pre-term labor. The procedure utilizes a sensor that is attached to the member's abdomen and which records and stores uterine activity for subsequent telephone transmission to a monitoring center. The monitoring center analyzes the transmitted data, assesses the need for additional medical intervention and provides this data to the attending obstetrician. A daily nursing contact as well as availability of nursing consultation on a 24-hour basis is an essential component of this service. A variety of medications including tocolytic agents may be utilized.

Home uterine activity monitoring services have become a component of many pre-term labor treatment regimes. This technology has continued to undergo clinical study. The American College of Obstetricians and Gynecologists in May of 1996, after review of all available studies concluded that it does not recommend the use of this system of care. Subsequent review has not changed this recommendation. Therefore, HUAM is not covered because its use is investigational.

While HUAM is not covered, claims for related services, such as home health care nursing visits and medications, are in benefit subject to the same restrictions that are present for other conditions.

Paid by: HUAM: Member

Note: See related benefits interpretation on Home Health Care

Hospice Care

Benefit: Hospice care is a benefit for terminally ill members with a life expectancy of less than one year who are receiving palliative rather than curative therapy, and for whom such services are appropriate. The physician must document both life expectancy estimate and appropriateness of hospice care.

Interpretation: Hospice care is a coordinated program of palliative and supportive services. It provides physical, psychological, social and spiritual care for dying persons and their families. Hospice care is available in hospital, nursing facility and home health settings.

For hospice services to be in benefit, the following conditions should be documented:

- The physician certifies that the member has a terminal illness and a life expectancy of less than one year.
- The member will not benefit from curative medical care or has chosen to receive hospice rather than curative care.
- A family member, friend, or caretaker is able to provide appropriate custodial care if services are provided in the home setting.

The following services are covered under the Hospice Care Program:

- Coordinated Home Care Program
- Medical supplies and dressings
- Medication
- Nursing Services: Skilled and non-skilled
- Occupational Therapy
- Pain management services
- Physical Therapy
- Physician visits
- Social and spiritual services
- Respite Care Services

The following services are not covered under the Hospice Care Program:

- Durable medical equipment
- Home delivered meals
- Homemaker services
- Traditional medical services provided for the direct care of the terminal illness, disease or condition
- Transportation, including but not limited, to Ambulance Transportation

Notwithstanding the above, there may be clinical situations (e.g. treatment of a fracture) when short episodes of traditional care would be appropriate even when the member remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of the medical coverage.

Benefits are subject to the same provisions and day limitations as specified in the Benefit Matrix, depending upon the particular Provider involved (Hospital, Skilled Nursing Facility, Coordinated Home Care Program or Physician).

Hospice Care (cont.)

Hospice service days are counted against the Utilization Management Fund in accordance with the usual UM Fund charge for the type of facility in which hospice services are rendered (inpatient, SNF, home health care.)

Paid by: Hospice charges **HMO**

Hospital Beds

Benefit: Hospital beds are covered as durable medical equipment for selected bed-confined members.

Interpretation: Hospital beds must be medically necessary as determined by the physician. Typically:

- The member requires positioning not feasible in an ordinary bed (e.g., to alleviate pain, prevent aspiration or treat decubitus ulcers) or
- The member needs special attachments that cannot be affixed to and used on an ordinary bed.

The physician should document the member's medical condition. The severity and frequency of symptoms pertinent to use of a hospital bed for positioning must be described. Special attachments must be medically necessary, and documentation of this necessity should be as specific as possible.

Electric powered hospital beds are covered only when frequent or immediate changes in body position are necessary, and when no delay in such repositioning is tolerable. Also, the member must be able to operate the controls and cause the adjustments.

All electric hospital beds or those with special features require prior approval of the HMO Medical Department.

Paid by: HMO

Coverage Variation: Benefit Plan DIRPY- Excluded

Hyperalimentation (TPN)

- Benefit:** Hyperalimentation is in benefit in inpatient or home settings. Benefit includes:
- Cost of the nutrients/solutions
 - Cost of the infusion pump and heparin lock
 - Supplies and equipment necessary for proper functioning and effective use of a TPN System
 - Home visits by a physician or nurse in conjunction with TPN.

Interpretation: **Total Parenteral Nutrition (TPN)** is the intravenous administration of a concentrated sterile solution containing prescribed amounts of dextrose (sugar), amino acids (protein), electrolytes (sodium, potassium), vitamins and minerals (calcium, zinc) needed for daily activities and health. Members who receive TPN have a non-functioning gastrointestinal tract and/or have caloric needs that cannot be met other than with TPN.

Paid by: Home Health, nutrients/solutions, supplies and equipment. **HMO**
Professional Charges: **IPA**

Note: See related benefits interpretation on **Nutritional Supplements/Enteral Nutrition**

Hyaluronan (Synvisc[®], Hyalgan[®], Supartz[®], Euflexxa[®], Orthovisc[®])

Benefit: Treatment with Hyaluronan (Synvisc[®], Hyalgan[®], Supartz[®], Euflexxa[®], Orthovisc[®]) is in benefit for members with painful osteoarthritis of the knee if medications or other conservative therapy insufficiently relieves their symptoms. According to FDA-approved package labeling, safety and effectiveness of the use of either preparation in joints other than the knee have not been established. Additionally, the safety and effectiveness of repeat treatment cycles of Synvisc[®] have not been established.

Interpretation: Hyaluronan is a naturally-occurring polysaccharide macromolecule. It is a major component of synovial fluid and of articular cartilage. Hyaluronan contributes to the viscosity of the synovial fluid and lubricates the joint. The joint is thus subject to less wear and damage.

Osteoarthritis is a common disease in which synovial fluid is less abundant or less viscous. These and other disease factors result in pain, deformity and stiffness of the arthritic joint.

Commercial preparations of hyaluronan are currently derived from rooster combs. The preparation is injected directly into the knee joint in a series of weekly treatments. The FDA has classified hyaluronan as a device, rather than a drug. The IPA purchases these injectables for subsequent reimbursement from the HMO.

Paid by: Professional fees: **IPA**
Injection material: **HMO***

*The IPA may either purchase the material and receive reimbursement from the HMO
OR

*Forward the claim to the HMO who will pay the provider directly.

Claims should be stamped group approved.

Please make a notation on the claim that this is a Hyaluronan (Synvisc[®], Hyalgan[®]), Supartz[®], Euflexxa[®], Orthovisc[®]) claim.

Hyperthermia Therapy

Benefit: Local hyperthermia is in benefit when used in combination with radiation or chemotherapy, for the treatment of members with primary or metastatic cutaneous or subcutaneous superficial malignancies who have not responded to previous therapy or are not candidates for conventional therapy. Whole body hyperthermia: The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes for patients with cancer.

Interpretation: Hyperthermia can be administered using local and whole body techniques.

Local hyperthermia involves elevating the temperature of superficial or subcutaneous tumors while sparing surrounding normal tissue, using either external or interstitial modalities.

Whole body hyperthermia requires the member to be placed under either general anesthesia or deep sedation. The member's body temperature is raised to 108° F by packing the member in hot water blankets or a hyperthermia suit and allowing hot water to flow through the wrap. The elevated body temperature is maintained for a period of four hours while the essential body functions are closely monitored. Approximately one hour is required for a "cooling off" period after which the member is constantly monitored for a minimum of twelve hours.

Paid by: Local Hyperthermia
Physician charges: **IPA**
Facility charges: **HMO**

Hypnosis

Benefit: Hypnosis is specifically excluded in the member certificate. It is **not** in benefit for any condition or indication.

Paid by: **Member**

Immunizations

Benefit: Immunizations are covered if administered or recommended by the PCP. These include all childhood and adult immunizations, and those vaccines recommended or required for travel.

Interpretation: Childhood immunizations are defined as those recommended by the American Academy of Pediatrics, the American Academy of Family Practice, and the Advisory Committee on Immunization Practices of the Centers for Disease Control according to the designated schedule and dosages.

Adult immunizations, including influenza, meningococcal and pneumococcal vaccines, are in benefit if administered or recommended by the PCP.

Travel immunizations or prophylactic treatment (i.e., cholera vaccines, immunoglobulin), which are required and/or recommended for travel to foreign countries are covered, and are the financial responsibility of the IPA.

Paid by: Inpatient Immunization **HMO**
Immunization in office or outpatient setting **IPA**

Note: See Benefits Interpretation on Hepatitis B Vaccine

In-Vitro Chemotherapeutic Drug Assays

Benefit: There are two types of in-vitro chemotherapeutic drug assays, the tumor chemosensitivity assay (also known as the human tumor stem cell assay) and the tumor chemoresistance assay (also known as the nonclonogenic cytotoxic drug resistance assay (NCDRA). Neither is in benefit, because both tests are considered investigational.

Paid by: Member

Infertility

Benefit: The evaluation and treatment of infertility is in benefit to the extent described below. Members should be referred to a provider in the HMO Infertility Network for the Chicago metropolitan area. A list of network infertility providers has been distributed to all IPAs, and updated lists are available through the BCBSIL Web site. Additional information can be found in the HMO Policy and Procedure section in this manual.

Interpretation: Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy. Infertility presumes that a male and female couple has had the frequency and timing of sexual intercourse during the previous year permitting satisfactory opportunity for conception.

In the event that a voluntary sterilization has been reversed successfully, infertility benefits will be available if the member's current clinical situation meets the definition of infertility. The success of a reversal of sterilization may be determined by the following:

Female: Evidence of dye penetrating fallopian tubes on a post-operative hysterosalpingogram

Male: Normal semen analysis (Sperm count of at least 20 million per ml, motility greater than 50 percent, and greater than 30 percent normal forms.)

The inability to sustain a successful pregnancy is present after the third spontaneous miscarriage occurring before 12 weeks of gestational age or after the first spontaneous pregnancy loss occurring after 12 weeks of gestational age.

Infertility is a medical diagnosis determined by the Primary Care Physician or Woman's Principal Health Care Provider.

Evaluation and treatment of infertility in men and women is in benefit and includes:

1. General evaluation and treatment which could include, but is not necessarily limited to:
 - Semen analysis
 - hormone levels
 - Pap smear
 - cervical cultures
 - medical endocrine workup (such as thyroid functions & prolactin)
2. Advanced evaluation and treatment (usually provided by infertility specialists) could include but is not necessarily limited to:
 - luteal phase progesterone
 - mid cycle ultrasounds
 - timed endometrial biopsy
 - hysterosalpingogram
 - laparoscopy - hydrotubation
 - hysteroscopy
 - immune studies (various antibodies)
 - sperm penetration test
 - surgical correction of anatomic causes of infertility
 - infertility treatment with ovulation induction agents
3. Assisted reproductive technology services are performed at specialized centers, including but not limited to in vitro fertilization (IVF), uterine embryo lavage, embryo transfer, artificial insemination, Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), low tubal ovum transfer, epididymal sperm aspiration, and intracytoplasmic sperm injection (ICSI).

Infertility (cont.)

All drugs (injectable, oral, patches, suppositories, etc.) required in the evaluation and treatment of infertility are a covered benefit.

These services are NOT in benefit:

- Services rendered to a surrogate for purposes of childbirth. (If the HMO member is the surrogate, the infertility services are not in benefit, but the prenatal and delivery services are in benefit).
- Non-medical costs of an egg, sperm, or embryo donor (psychological counseling, transportation fees, shipping and handling fees, donation fees, etc.)
- Reversal of voluntary sterilization
- Cryo-preservation (freezing) and storage of sperm, or embryo.
- Selected termination of embryo (in cases where the person's life is not in danger)
- Travel costs for travel within 100 miles of the covered person's home or which is not medically necessary or which is not required by the Plan
- All investigational infertility procedures, tests, treatments, or drugs.
- More than four complete oocyte retrievals per lifetime (unless a live birth follows a completed oocyte retrieval; the individual is only permitted 2 additional completed oocyte retrievals).

The following policies and procedures apply to the referral of HMO members to a network infertility:

- Primary Care Physicians or gynecologists are responsible for establishing a diagnosis of infertility. Referral for infertility services should not be made without an established diagnosis of infertility. This requires an appropriate history documenting inability to conceive after at least one year of appropriate efforts, and may include certain baseline tests (such as a semen analysis) as well as any appropriate medical work-up (thyroid, prolactin) indicated by the clinical history.
- If infertility is due to an underlying medical condition, the member will return to the IPA for the treatment of that condition (e.g., pituitary adenoma, thyroid disease, etc.). If the initial history and exam suggest any underlying medical condition, this condition should be ruled out before the member is referred for primary infertility treatment.
- If a member has a gynecological condition (such as endometriosis, fibroid tumors or pelvic inflammatory disease) that increases the risk of infertility but she is not trying to become pregnant, she should receive care from her primary gynecologist.
- Members should take a copy of all pertinent records and tests to the infertility specialist the time of their initial visits to avoid redundancy. They should identify the primary physician who will receive reports and feedback from the infertility specialist.
- If members are hospitalized by a network provider for an infertility procedure, the facility days will not be charged against the IPA's UM fund. If a member develops medical or surgical problems during infertility treatment, he/she may be referred back to his/her IPA and Primary Care Physician or WPHCP.
- Once pregnancy is established and fetal heart tones are detected by ultrasound (approximately six weeks), the member will be referred back to her Primary Care Physician or Woman's Principal Health Care Provider for prenatal care.

Infertility (cont.)

- The network provider will manage any urologic surgery that a male member may require for the treatment of infertility. These urology costs are not the responsibility of the IPA.
- Habitual aborters will be referred back to their regular obstetrician once pregnancy is established, but will also be followed by physicians from the network provider until the time of threatened abortion is past.

Note: Once pregnancy is established, the member receives all subsequent obstetrical care through the IPA. Perinatology services are not part of infertility care and are the responsibility of the IPA.

Paid by: If referred to an HMO Infertility Network provider (see below) **HMO**
If referred by an IPA physician to a provider not in the **IPA**
HMO infertility network

- Coverage Variation:**
- Some employer groups may exclude infertility services from coverage. For example, employees of a religious institution or organization that finds the procedures required to be covered under this mandate in violation of its religious and moral teachings and beliefs may have limited or no coverage. Below is a list of these employer groups. This list may not be all inclusive.
 - Benefit Plan DIRPY—excluded.

Employer Groups with Limited Infertility Benefits: The mandated A.R.T. services, if in violation of a religious institution organization's moral teachings and beliefs, may be excluded from the benefit plan. Below is a list of the religious groups who are exempt from incorporating the infertility legislation into their HMO Program.

HMO Group Number	Group Name	Services Covered*
H00097	Wellgroup Health Partners	1 only (effective 01/01/07)
H18189	Alverno Clinical Laboratories	1, 2, 3 (IVFGI only) 4 (IVFDG only)
H22209	Provena Fox Knoll	1 only
H22237	Provena McAuley Manor	1 only
H23021	Holy Cross Hospital	1 only
H42666	Direct Pay HMO	1 only
H50005	Direct Pay HMO	1 only
H50739	Direct Pay HMO	1 only
H51038	Catholic Bishops	1 only
H51720	Mercy Center for Health	1 only
H51723	Provena Health Corporate	1 only
H51724	Provena Service Corp	1 only
H51728	Provena Villa Franciscan	1 only
H51729	Provena St Anne Center	1 only
H51730	Provena Cor Mariae	1 only
H51731	Provena St Joseph	1 only
H51735	Provena St Joseph	1 only
H51736	Provena Senior Services	1 only
H51737	Provena Senior Services	1 only
H51738	Provena Home Care	1 only
H55970	Catholic Cemeteries	1 only
H56913	Direct Pay HMO	1 only
H56914	Direct Pay HMO	1 only
H56915	Direct Pay HMO	1 only
H56916	Direct Pay HMO	1 only

Infertility (cont.)

HMO Group Number	Group Name	Services Covered*
H56917	Direct Pay HMO	1 only
H56918	Direct Pay HMO	1 only
H56919	Direct Pay HMO	1 only
H56920	Direct Pay HMO	1 only
H57003	Christian Brothers Ireland	1,2,3,4,5
H57028	St. Coletta's of Illinois	1,2,3(IVFGI only), 4(IVFDG only)
H59051	RHC St Francis Hospital of Evanston	1 only
H59060	RHC Behavioral Health	1 only
H59074	West Lake Hospital	1 only
H59075	RHC Home Health	1 only
H59076	RHC Ambulatory	1 only
H59081	Resurrection System Service	1 only
H59082	RHC Holy Family	1 only
H59083	RHC St Joseph Hospital	1 only
H59084	St Mary and Elizabeth Hospital	1 only
H59085	RHC Ambulatory	1 only
H59173	West Suburban	1 only
H59316	Our Lady of Resurrection	1 only
H59999	Resurrection Nursing Home	1 only
H61124	St. James Farm	1 only
H64255	Catholic Health Partners	1,2,3(IVFGI only),4(IVFDG only)
H64507	Holy Family Hospital	1 only
H64512	St. Margaret Mercy	1 only
H64528	Wheaton Franciscan Service	1, 2, 3, 4, 5 (standard)
H64536	St. James Hospital	1 only
H64592	Our Lady of Resurrection	1,2,3 (IVFGI only), 4(IVFDG only)
H64593	Resurrection	1 only
H73160	Mother McCauley School	1,2,3,4,5
H80308	Midwest Health Ventures	1, 2, 3 (IVFGI only), 4(IVFDG only)
H81295	St. Francis Hospital	1,2,3(IVFGI only), 4(IVFDG only)
H81911	Catholic Charities	1,2,3(IVFGI only), 4 (IVFDG only)
H81912	Catholic Charities	1,2,3(IVFGI only), 4 (IVFDG only)
H81915	Catholic Charities	1,2,3(IVFGI only), 4(IVFDG only)
H81916	Catholic Charities	1,2,3(IVFGI only),4(IVFDG only)
H91321	Provena Pineview Care Center	1 only
H91319	Provena Geneva Care Center	1 only
H91785	St Francis Hospital Evanston	1,2,3(IVFGI only), 4(IVFDG only)
H95377	PROVENA Health	1 only
H98900	Alexian Brothers of Illinois	1,2,3(IVFGI only), 4(IVFDG only)
H98835	Loyola	1, 2, 3(IVFGI only), 4(IVFDG only)

Infertility (cont.)

Blue Advantage Group Number	Group Name	Services Covered*
B00097	Wellgroup Health Partners	1 only (effective 01/01/07)
B22209	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B22237	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B23021	Holy Cross Hospital	1 only
B51038	Archdiocese of Chicago	1 only
B51720	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51722	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51723	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51725	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51728	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51729	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51730	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51731	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51736	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51737	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51739	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B51740	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B59051	RHC St Francis Hospital of Evanston	1 only
B59060	RHC Behavioral Health	1 only
B59074	Resurrection Healthcare	1 only
B59075	RHC Home Health	1 only
B59076	RHC Ambulatory	1 only
B59081	Resurrection Systems Services	1 only
B59082	RHC Holy Family	1 only
B59083	RHC St Joseph Hospital	1 only
B59084	RHC St Mary and Elizabeth Hospital	1 only
B59085	RHC Ambulatory	1 only
B59173	West Suburban	1 only
B59316	Our Lady of the Resurrection	1 only
B59999	Resurrection Healthcare	1 only
B64528	Wheaton Franciscan Service	1,2,3,4, 5 (standard)
B64536	St James Hospital	1 only
B64592	Resurrection Healthcare	1,2,3(IVFGI only), 4(IVFDG only)
B64593	Resurrection Healthcare	1 only
B81915	Catholic Charities	1 only
B81916	Catholic Charities	1 only
B91319	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B91321	Provena Health	1,2,3(IVFGI only), 4(IVFDG only)
B91785	Resurrection Healthcare	1,2,3(IVFGI only), 4(IVFDG only)
B91786	Alexian Brothers of Illinois	1,2,3(IVFGI only), 4(IVFDG only)
B92749 Effective 09/01/07	Little Company of Mary Hospital	1 only

LEGEND CODE:

1	Medical Evaluation and Treatment
2	Intrauterine Insemination
3	In Vitro Fertilization
3 IVFGI ONLY	Only covers GIFT only. No other IVF covered.
4	In Vitro Fertilization with Donor OOCYTES
4 IVFDG ONLY	Only covers DONOR GIFT only. No other IVF covered.
5	Frozen Embryo Thaw (FET) cycle

Infusion Pumps (Implanted-Permanent)

Benefit: The implantation and the device are covered in full for perfusion therapy using FDA approved drugs for:

- Malignancies for which infusion therapy is effective
- Severe chronic intractable pain
- Chronic spastic conditions when less invasive therapies have been unsuccessful

Interpretation: An implantable pump (IP) delivers long-term continuous or intermittent drug infusion. Routes of administration include intravenous, intra-arterial, subcutaneous, intraperitoneal, intrathecal, epidural, and intraventricular.

The drug reservoir may be refilled as needed by an external needle injection through a self-sealing septum in the IP. Bacteriostatic water or physiological saline is often used to dilute therapeutic drugs. A heparinized saline solution may also be used during an interruption of drug therapy to maintain catheter patency.

Paid by: Physician charges: **IPA**
Facility charges: **HMO**
Device charges: **HMO**

Infusion Pumps (Portable - Temporary)

- Benefit:** The use of a portable infusion pump is covered as a DME item:
- When used to administer cancer chemotherapy agents or iron chelating agents.
 - When used to administer insulin (see benefits interpretation on Diabetes Self-Management)
 - When used to administer heparin in members with severe thromboembolic disease.
 - When used to administer hyperalimentation.
 - When used to administer tocolytic agents in pre-term labor. (Note that the subcutaneous route may be an alternative for some agents.)
 - When used to administer other recognized non-investigational therapeutic agents.

Interpretation: A portable infusion pump is a small portable battery-driven pump which provides continuous infusion of medications. The pump is worn on a belt around the member's waist and is attached to a needle or catheter. The device is FDA approved for intravenous, intra-arterial, and subcutaneous routes of administration.

The rental or purchase of the device is covered under the Durable Medical Equipment benefit.

Paid by:	Physician charges:	IPA
	Equipment charges (from contracted provider):	HMO
	Equipment charges (from non-contracted provider):	IPA
	Equipment charges (in physician office or outpatient setting):	IPA

Coverage Variation: Benefit Plan DIRPY-Excluded

Note: See Benefits Interpretation for Hyperalimentation, Diabetes self-management, DME

Intravenous Immunoglobulin (IVIG)

Benefit: Intravenous immunoglobulin is in benefit for selected members.

Interpretation: Immunoglobulins are protein antibodies produced by plasma cells. Immunoglobulins have been used since 1952. Preparations suitable for intravenous use have been available since 1980. Clinical indications for use of this drug product continue to expand. Mechanisms of action vary from simple replacement, such as in primary hypogammaglobulinemia to complex antibody-antigen interactions, such as in idiopathic thrombocytopenic purpura. There are many manufacturers of immunoglobulin preparations. All of these preparations may cause significant side effects including high fever, headache, nausea, vomiting, vasomotor and cardiovascular reactions, or hypersensitivity/anaphylactic reactions.

Intravenous immunoglobulin is in benefit for treatment of the following conditions:

- Primary immunodeficiency states (with gamma globulin levels below 500 mg/dl)
- Idiopathic Thrombocytopenic Purpura (ITP) in children and adults
- Kawasaki syndrome
- Chronic inflammatory demyelinating polyneuropathy
- Biopsy-proven dermatomyositis
- Bone marrow transplant recipients to prevent graft versus host disease
- Prevention of infections in members with B-Cell lymphocytic leukemias

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes for:

- Multiple sclerosis
- Refractory rheumatoid arthritis
- Infection prophylaxis for low birth weight infants
- Guillain-Barré syndrome
- Recurrent fetal loss

Paid by:	Administration in physician office:	IPA
	Inpatient Facility Charges:	HMO
	Outpatient Facility Charges:	IPA
	Administration in home health setting (for homebound member and from contracted provider):	HMO
	Administration in home health setting (for ambulatory Member or when services are provided by a non-contracted provider):	IPA

Laboratory Tests

Benefit: All non-investigational laboratory and pathology procedures performed in any inpatient or outpatient setting are in benefit when ordered by a PCP, WPHCP or other managing physician.

Investigational laboratory and pathology procedures are **not** in benefit.

Interpretation: HMO pays for the facility charges for laboratory and pathology services (i.e., blood tests, cultures, frozen sections and pathology on specimens) for inpatient hospitalizations and outpatient surgery at a hospital or outpatient surgical facility. The professional component is the portion of the diagnostic procedures charged for the physician's services.

Paid by: Outpatient Laboratory and Pathology Services

Facility charges **IPA**

Professional charges **IPA**

Inpatient Laboratory and Pathology Services

Facility charges **HMO**

Professional charges **IPA**

Outpatient Surgical Facility—Laboratory and Pathology Services

Facility charges **HMO**

Professional charges **IPA**

Lithotripsy (Percutaneous and Extracorporeal)

Benefit: Electroshock wave lithotripsy, when performed by percutaneous or extracorporeal method for renal stones, is a covered benefit.

Interpretation: Electroshock wave lithotripsy focuses acoustic shock waves on renal calculi to pulverize them into small particles without damaging the surrounding tissue. The particles are then excreted.

The percutaneous method involves making a percutaneous nephrostomy and inserting a catheter either into the renal pelvis or down the ureter into the bladder. An ultrasonic wand delivers an acoustic shock to disintegrate the stone. This procedure may be performed in two stages, on different days.

The extracorporeal method involves the use of sound waves transmitted through water. The member is placed in a bathtub-type device or on a specialized waterbed. This method is used for stones in the renal calyx, renal pelvis, and upper third of the ureter when stones are at least 3 millimeters in diameter.

Paid by: Inpatient facility charges: **HMO**
Outpatient facility charges: **HMO**
Physician charges: **IPA**

Lupron/Lupron Depot

Benefit: Lupron is in benefit. When used as a self-injectable in the home setting, Lupron is provided through the prescription drug benefit. If Lupron is administered subcutaneously, it can be self-injected. However, when Lupron is given in the physician office (whether IM or SC), it is in benefit as an injectable medication for which the IPA is financially responsible. Lupron Depot is not classified as self-injectable. It must be given in the physician's office. Therefore, it is the financial responsibility of the IPA and is not covered by the prescription benefit.

Interpretation: Lupron is used for palliative treatment of advanced prostate cancer and as an infertility treatment.

Lupron Depot is administered intramuscularly once a month to treat endometriosis or uterine fibroids. This method of treatment requires administration by a health care professional.

Paid by:	Lupron for infertility treatment	HMO
	Lupron (home use, self-injectable)	Prescription Drug benefit
	Lupron given in the physician office	IPA
	Lupron Depot	IPA

Benefit Variation: Benefit plan DIRPY- Excluded

Note: Some employer groups do not have BCBSIL prescription drug coverage; Some employer groups do not have self-injectable coverage.

Mammography

Benefit: Mammography is a covered benefit.

Interpretation: Mammography is a roentgenologic procedure performed to evaluate breast disease. Images are created by one of two methods: screen film mammography and xeromammography.

Diagnostic mammography is indicated in the evaluation of breast abnormalities found on physical examination, or when signs or symptoms suggest possible malignancy.

Routine screening mammography is recommended for women in certain age groups. The BCBSIL Preventive Health Care Guidelines recommend that mammography be performed every 1-2 years for women age 50 and over, and every 1-2 years age 40-49 if there is increased risk, or at member or physician discretion. The PCP determines the appropriateness of screening mammography for the individual member.

Note: The Illinois Insurance Code requires all health insurers to provide coverage for mammography, including: one baseline study age 35-39, and an annual mammogram for women 40 and older. Should a member request the test within these parameters, it is in benefit.

Paid by: Outpatient facility charges **IPA**
Professional charges **IPA**

Maternity/Obstetrical Care

Benefit: Maternal/obstetrical care is a covered benefit.

Interpretation: Inpatient facility service is covered for the care of maternal conditions related directly to intra-uterine pregnancy and/or abnormal conditions and complications of pregnancy.

Covered physician services include outpatient prenatal and post-partum care as well as delivery.

There are no waiting periods or pre-existing condition clauses in the subscriber certificate for HMO members. Therefore, an individual is covered for maternity services from the effective date of her HMO coverage. If an individual becomes an HMO member in her third trimester of pregnancy, IPA Physicians may be reluctant to assume responsibility for her care. In that situation, the IPA may choose to refer the member, at the IPA's expense, to the obstetrician who had been caring for the member before her enrollment in the HMO program.

Not covered: Prenatal classes (i.e. Lamaze, lactation, sibling classes, etc.) are not in benefit. If a fee is charged, a physician may recommend these services and any associated supplies, but should make it clear to the member that these services and supplies are her responsibility and not in benefit.

Paid by:

Professional charges:	IPA
Facility charges:	HMO
Ancillary charges:	IPA

Note: For members new to the HMO and who are in the third trimester of pregnancy, please refer to the Transition of Care Policy.

Medical Supplies (Non-Durable Medical Equipment)

- Benefit:** Non-durable medical supplies are in benefit. Such items:
- Are usually disposable in nature or have a very limited useful lifetime;
 - Cannot withstand repeated use;
 - Primarily and customarily serve a medical purpose;
 - Generally are not useful to a person in the absence of illness or injury.
 - Are ordered and/or prescribed by an IPA physician.
- Items that are primarily for comfort or convenience or serve other than a primarily medical purpose, are not in benefit.

Medical Supplies for Home Use

- Interpretation:** These supplies are generally used to treat a medical condition by the member in the home. Examples of covered medical supplies are: lancets, chemstrips, urine drainage bags, catheters, colostomy supplies, slings, sterile bandages, sterile dressings, sharps containers, sterile alcohol prep pads, non-custom made compression stockings, batteries for insulin pumps, and stock orthotics not supplied in the physician's office such as cervical collars, elastic back braces, and tennis elbow bands.

Medical supplies that are generally useful even in the absence of a specific medical condition, injury, or disease are not covered. Examples include rubbing alcohol, Betadine[®] and other antiseptic solutions, cotton swabs or balls, Q-tips[®], or adhesive tape. If the member has a chronic or long-term condition like osteomyelitis or dialysis-dependent chronic renal failure, he/she should contact the HMO Administrative offices for possible coverage of these items.

Note: Pharmacies and suppliers are not required to bill the HMO, but if a BCBSIL HMO Contracting Provider is used, the provider will most likely bill for the supplement. If the IPA receives a bill, the IPA would follow the normal group approval process. If the member pays up front for the supplement, the member must forward bills to the HMO for reimbursement.

In addition to the usual information, all claims submissions should include:

- Name of medical supplier
- Date(s) of purchase
- Type of medical equipment/supplies
- Purchase price
- Quantity
- IPA physician prescription or approval
- Diagnosis
- Receipt(s) verifying payment for supplies

Medical Supplies (Non-Durable Medical Equipment) (cont.)

Medical Supplies Used by the IPA

The IPA is responsible for medical supplies used in the office setting by an IPA professional. Examples include, but are not limited to:

- Band-Aids®
- Splints
- 4x4 sterile dressings
- Ace® bandages
- Sutures
- Cervical collars
- Tissues
- Casting supplies
- Unna® boots
- Alcohol swabs

Paid by:	Routine supplies used in office setting:	IPA
	Professional charges:	IPA
	Medical supplies used in home setting:	HMO

Note: Diabetic supplies are available through the pharmacy benefit program for those members with a BCBSIL drug card.

Mental Health Care (Inpatient)

Benefit: Mental health services are in benefit when provided for the treatment of a mental illness. The extent of inpatient benefits available to any given member is defined by the member's benefit plan and state law. (Refer to the HMO Benefit Matrix for a description of these benefits.) Separate benefit programs cover Mental Health and Chemical Dependency.

In June 2006, the law Public Act (PA) 094-0906 and PA 094-0921 was signed impacting the existing Illinois Serious Mental Illness (SMI) statute (215 ILCS 5/37oc). This law will require all HMOs to comply with all provisions of the SMI statute effective January 1, 2007.

SMI includes psychiatric illnesses of:

- Schizophrenia,
- Paranoid and other disorders,
- Bipolar disorders (hypomaniac, manic, depressive and mixed),
- Schizoaffective disorders.

Refer to the note at the end of this section for a detailed explanation of these benefits, and a list of SMI diagnosis.

Interpretation: Based on medical necessity, the Primary Care Physician should approve a referral for all inpatient services with a primary psychiatric diagnosis (except for chemical dependency services—please see Benefits Interpretation for Chemical Dependency). All services must be delivered by a mental health professional (defined as a psychiatrist, psychologist, psychiatric social worker, or other mental health professional under the supervision and guidance of a physician). Services may include individual psychotherapy, group therapy, family therapy, pharmacotherapy, or electroconvulsive therapy.

Justification for an inpatient admission can include, but is not limited to the following:

- Manic, markedly agitated and/or depressed behavior.
- Incapacitating physical and/or mental changes.
- Disorientation, depersonalization or confusion.
- Homicidal or suicidal acts or significant threats; uncontrolled destructive behavior towards self, others, or personal property.
- Child and adolescent behavioral disorder that reflects a recent onset or exacerbation - usually with a precipitating event- with the capacity to establish a therapeutic alliance and a reasonable expectation for a positive response to treatment.

A mental health inpatient admission is **not** in benefit for reasons such as:

- Behavioral dysfunction such as truancy, family conflicts, runaways, clashes with authority, delinquent behavior, drug abuse, manipulative provocation, rebelliousness, or as an alternative to jail.
- Diagnostic evaluations that could be performed on an outpatient basis.
- Non-medical purposes such as the need for a structured environment, non-supportive home environment, court-mandated admission (in absence of medical necessity), or absence of a halfway house, boarding school, or other such facility. If a necessary mental health inpatient admission is prolonged for these or other non-medical reasons, benefits will not be extended past the period of medical necessity.

Partial hospitalization and intensive outpatient psychiatric programs and residential programs are included in the member's inpatient mental health benefit.

Mental Health Care (Inpatient) (cont.)

Members admitted to BCBSIL contracted psychiatric partial hospitalization programs or intensive outpatient programs will have every 1 day in the program charged as 0.25 units against the Mental Health Care (Inpatient) IPA UM Fund, and as 0.5 days against the member's inpatient benefit. Hospitalization on a psychiatric unit for treatment of a primarily medical problem is considered a medical admission. The days should not be deducted from the inpatient mental health benefits. These conversions are summarized on the following table:

Inpatient Utilization Mental Health Conversions

Mental Health Program Type	# Visits made	UM Fund Charge	Member's inpatient benefit charge	Copayment see Benefit Matrix)
Partial Day	1	0.25	0.5 (inpatient)	1 inpatient MH
Intensive Outpatient	1	0.25	0.5(inpatient)	1 inpatient MH
Residential	1	0.5	0.5 (inpatient)	1 inpatient MH

Paid by: Professional charges: **IPA**
Facility fees: **HMO**

Since mental health benefits are usually limited, the IPA must notify the member in writing of impending exhaustion of inpatient mental health benefits. Please refer to the HMO procedure in the UM Plan regarding this written communication.

Special Coverage Note—Electroconvulsive Therapy (ECT)
(see Mental Health Care- Inpatient and Outpatient)

Inpatient and outpatient ECT services are in benefit. These services are considered to be medical services. ECT is subject to usual Utilization Management Fund chargebacks and **not** counted against the mental health benefit. The member must not be charged a mental health copayment for outpatient ECT services.

Paid by: Professional charges: **IPA**
Facility fees: **HMO**

Note: Payment details may vary for members enrolled in certain IPA's listed below. (However, benefits are not different for these members.)

#098 Physicians Care Network, Inc.

Please call the HMO with questions regarding members enrolled in these groups.

Mental Health Care (Inpatient) (cont.)

HMO Serious Mental Illness (SMI) Scripting

Q1: What is the law for Serious Mental Illness?

A1: For the first time, the law mandates that HMOs are subject to the provisions of 215 ILCS 5/370c Serious Mental Illness. For HMO business, the law takes effect at issue or first renewal on or after January 1, 2007 by:

- Providing 60 visits each year for outpatient treatment for “serious mental illness” (this includes PDD) and 45 inpatient days.
- Members with a PDD diagnosis only, will be able to utilize their Rehabilitative Therapy (PT, OT, ST) benefit first, then their Outpatient SMI benefit (Mental Health {MH}, PT, OT, ST). Members with PDD still have an additional 20 speech therapy only visits after they have utilized all of the above benefits first.
- Allowing HMO members “open access” to seek mental health care for non-serious mental health.

The new SMI law does not affect the Chemical Dependency benefit.

To comply with the law, Blue Cross and Blue Shield of Illinois will provide the following HMO benefits on January 1, 2007, effective for new groups and for existing groups upon renewal:

Upon renewal date starting October 1, 2008, we are aligning the mental health and chemical dependency co-pays with the specialist co-pay when the member sees a specialist.

Serious Mental Illness (SMI)

- 45 Inpatient Days in addition to the purchased days. (eg 20)
- 60 Outpatient Visits in addition to the purchased days (eg 20).
- 20 Additional Outpatient Speech Therapy Visits for Pervasive Developmental Disorder (PDD)
- Must obtain referral from PCP / Medical Group or IPA. Note, some medical groups allow direct access to their panel of mental health providers. Please refer to previous training materials to determine if member has this option.)

Non-Serious Mental Illness

- 20 Inpatient Days
- 20 Outpatient Visits
- In and Out-of-Network Benefits
- 50% of covered expenses for out-of-network benefits (Note: Should the member choose an out-of-network facility, the HMO will reimburse the facility up to 50% of the covered expense. HMOI will reimburse the member up to 50 % for out-of-network professional fees for inpatient or outpatient treatment. The member is responsible to pay the remaining 50% of professional fees to the provider. (The above visits/days will vary based on benefit plan.)

Q2: What is a Serious Mental Illness (SMI)?

A2: The law defines the following conditions as a serious mental illness

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar disorders (hypo manic, manic, depressive, and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive)'
- Pervasive developmental disorders (PDD)
- Obsessive-compulsive disorders
- Depression in childhood and adolescence
- Panic disorder
- Post traumatic stress disorders (acute, chronic, or with delayed onset)

Mental Health Care (Inpatient) (cont.)

Q3: What are the mandatory benefits provided under the Serious Mental Illness legislation?

- A3:** The legislation requires that we provide the following benefits for medical conditions that fall into the category of serious mental illness:
- 45 inpatient days in addition to the purchased days for SMI – paid at the inpatient benefit level
 - 60 outpatient visits in addition to the purchased days for SMI—. If services are for med management, see question 10.
 - Members with a PDD diagnosis only, will be able to utilize their Rehabilitative Therapy (PT, OT, ST) benefit first, then their Outpatient SMI benefit (Mental Health {MH}, PT, OT, or ST). Members with PDD still have an additional 20 speech therapy only visits after they have utilized all of the above benefits first.
 - If these members with a PDD diagnosis also have a non-serious mental illness they have their purchased days (eg 20) to use for non-SMI MH visits. If these members are seeing a MH professional for an SMI, they would use the purchased days first then the additional SMI benefit days.

A member will need to obtain a referral. If a PCP determines that specialist care is medically indicated they will refer the member to a specialist for a consultation and/or covered services. Referrals are usually made within the member's PCP medical group and will include the name of the specialist, services to be provided, time frame for receiving the services and the specified visits. Please see previous note for those medical groups that allow members to self-refer to their specific panel of mental health providers.

Q4: What are some examples that will be considered Non-Serious Mental Illness?

- A4:** Some of the Non-Serious Mental Illness diagnoses (non-inclusive list) are:
- Personality Disorders (e.g. histrionic 301.50, borderline dependent 301.83)
 - Dysthymia Disorder 300.4 a chronic depressed mood that occurs most of the day more days than not for at least 2 yrs.
 - Cyclothymic Disorder 301.13 numerous periods of hypo manic symptoms fluctuating with numerous periods of depressive symptoms
 - Seasonal Affective Disorder (SAD)
 - Generalized Anxiety Disorder 300.02
 - Anxiety Disorder non-specific origin 300.00
 - Acute Stress Disorder, adjustment disorders 308.3
 - Adjustment Disorder with depressed mood 309.0
 - Attention Deficit / Hyperactivity Disorder 314.9
 - Social Phobia 300.23
 - Dissociative Identity Disorder 300.14

Mental Health Care (Inpatient) (cont.)

Q5: How do I determine the correct payment level for a claim that was self-referred?

A5: The following grid outlines the payment criteria for each claim:

	Place of Treatment	Dx- Non Serious Mental Illness	Dx- Serious Mental Illness
Out of Area	Outpt Office Visit	50% of covered expenses	OOA Guidelines apply
	Admit	50% of covered expenses	OOA Guidelines
	Outpt emergency	Prudent layperson guidelines	Prudent layperson guidelines
	ER Admit	ER- prudent layperson Inpatient- 50% of covered expenses	OOA Guidelines
Out of Network	Outpt Office Visit	50 % of covered expenses	NGA
	Admit	50% of covered expenses	NGA
	Outpt Emergency Room	Prudent Layperson guidelines	Prudent Layperson guidelines
	ER> Admit	ER-prudent layperson Inpatient- 50% of covered expenses	ER- prudent layperson Inpatient- GA from point of notification
	Admit	50% of covered expenses	NGA

Q6: What ineligible code will be used for the denial of services when a member seeks services for non-serious mental illness out of network?

A6: Ineligible reason code will be 454

Q7: When paying a claim for non-serious mental illness for an out of network provider should payment go to the member or provider?

A7: Payment will be made to the member, for professional fees up to 50 %, if they seek non-serious mental illness services out of network. Payment up to 50 % will be made to the facility for facility charges. Member is responsible for the other 50 % of billed charges.

Q8: How will Medical Groups respond to PDC, 64/095, or 039 claims for non-serious mental illness diagnosis that was provided out of network?

A8: See the following chart for appropriate responses for each category:

PDC claims	NGA- OON Non-SMI
095 claim report	NGA- OON Non-SMI
039	NGA- OON Non-SMI

Q9: What co-pay will apply for *outpatient serious mental illness (SMI)* claims?

A9: If benefit plan has one co-pay, all visits are treated the same.
If benefit plan has a differential co-pay for PCP, specialist and if the SMI visit is with a specialist, the specialist co-pay applies.
If the SMI visit is with the member's PCP, the PCP co-pay applies.

Q10: What co-pay will apply for *outpatient SMI Medicine Management (90862)*?

A10: If provided by the PCP, the PCP co-pay will apply. If provided by the Specialist, the specialist visit co-pay will apply, if there is a specialist differential co-pay.

NOTE: Services for SMI Medicine Management will not accumulate towards the member's outpatient SMI benefit.

Mental Health Care (Inpatient) (cont.)

Q11: What co pay will apply for *non-serious mental illness* claims?

A11: For outpatient non SMI, if the visit is with the PCP, the PCP co-pay will apply. With an approved referral, if the visit is with the mental health specialist, the specialist co-pay applies. With an approved referral, if the benefit has a mental health co-pay and the visit is with the mental health specialist, the mental health co-pay will apply till renewal date starting October 1, 2008. Upon renewal date, many groups' MH co-pay will be in alignment with the PCP/Specialist co-pay. If no approved referral, the claim is paid at 50 % of covered expense with no co-pay.

Q12: What co-pay will apply for *non-SMI medicine management (90862)*?

A12: If provided by the PCP, the PCP co-pay will apply. If provided by the specialist, the specialist visit co-pay will apply.

If the benefit plan has a mental health co-pay and the visit is with a specialist, the mental health co-pay applies till renewal date starting October 1, 2008. Upon renewal date many groups' MH co-pay will be in alignment with the PCP/Specialist co-pay.

NOTE: Services for non-SMI medicine management will not accumulate towards the member's outpatient non-SMI benefit.

Q13: What co pay will apply if I am admitted for a non-serious mental illness that was self-referred and I choose to go to an OON provider?

A13: The co pay will be waived since the HMO will only cover 50% of covered expenses for out-of-network benefits and member will be responsible for the remainder 50 % balance.

Q14: I self-referred to a provider for a non-serious mental illness and now a portion of my claim is being denied.

A14: In order to receive the highest level of benefits you should work with your Primary Care Physician. If your PCP determines that a specialist care is medically indicated they will refer you to a specialist for a consultation and/or covered services. If you feel the claim was paid incorrectly you may follow the appeal guidelines.

Q15: What are Pervasive Developmental Disorders (PDD)?

A15: These disorders are characterized by severe deficits and pervasive impairment in multiple areas of development. These include impairment in reciprocal social interaction, impairment in communication, and the presence of stereotyped behavior, interests, and activities.

The listed below are the codes and names:

- 299.0 Autistic Disorder: childhood autism, infantile psychosis, Kanner's syndrome
- 299.1 Childhood Disintegrative Disorder: Heller's syndrome
- 299.8 Other Specified Pervasive Developmental Disorders: Asperger's disorder, Atypical childhood psychosis and Borderline psychosis of childhood
- 299.9 Unspecified Pervasive Developmental Disorder: Child psychosis, not otherwise specified; pervasive developmental disorder, not otherwise specified; schizophrenia, childhood type, not otherwise specified; and schizophrenic syndrome of childhood, not otherwise specified

There will be a fifth digit to these 299 codes:

- 0 is for current or active and 1 is for residual state

Mental Health Care (Inpatient) (cont.)

Q16: Will the patient with PDD need to show that significant improvement within 2 months will occur, in order to be approved, as in the past?

A16: Yes, the need for assessing whether significant improvement will occur within the next 60 days, applies to the initial rehabilitative therapy benefit only, and NO longer applies to a patient with a PDD diagnosis for their outpatient SMI visits or the additional 20 speech therapy visits.

Q17: Will the 20 outpatient speech therapy visits added for the treatment of pervasive developmental disorder replace the 60 combined visits for rehabilitative therapy?

A17: No, once the member has exhausted their current rehabilitative (Physical, Occupational, Speech) therapy as well as their outpatient SMI benefit, they will be allowed 20 additional outpatient speech therapy visits specific for PDD.

Q18: What is the co-pay for PDD?

A18: The outpatient therapy co-pay applies for outpatient rehabilitative therapy, SMI therapy if used for rehab therapies and the additional 20 speech therapy.

If the member is being treated by a rehab professional such as occupational therapist or speech therapist, the rehab co-pay applies. If the member is being treated by their PCP, the PCP co-pay applies. If the member is being treated by a mental health provider, the specialist co-pay applies.

Co-pay for Outpt. Rehab Therapies (PT OT ST)	Co-pay for non-smi MH therapy	Co-pay for SMI Therapies (MH PT OT or ST)	Co-pay for PCP visit
Provided by Rehab therapist-Rehab Co-Pay	Provider MH specialist-MH co-pay if employer group has one till renewal date starting October 1, 2008, then MH co-pay may align with PCP/Specialist co-pay	Provider-Rehab Therapist-Rehab co-pay	PCP Co-pay
Provided by PCP-PCP co-pay		Provider- MH specialist for MH therapy-specialist co-pay	
Additional 20 speech therapy visits provided by speech therapist-rehab co-pay		Provider PCP-PCP co-pay	

Q19: What ICD-9 code is used for depression in childhood and adolescence?

A19: ICD-9 code 311-Depressive Disorder not otherwise specified. This is for members under 18 years of age only. This is because the law defines any depression in childhood or adolescence as a serious mental illness.

Please note: regardless of the diagnosis of the individual, the co-pay is contingent upon what type of provider the visit is with. The goal is to eliminate the MH and Chemical Dependency co-pays to align MH/CD HMO co-pays in two categories: PCP or Specialist. The exception is the rehab co-pay for SMI rehab visits for those members with PDD.

The small groups are in alignment. The renewal date starting October 1, 2008, applies to the large employer groups.

If there is no medical specialist co-pay we cannot charge a specialist co-pay for Mental Health services.

Mental Health Care (Inpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis

Diagnosis Code	DESCRIPTION
295	SCHIZOPHRENIC DISORDERS
2950	SCHIZOPHRENIA SIMPLEX SIMPLE X
29500	SCHIZOPHRENIA SIMPLE TYPE UNSPECIFIED
29501	SCHIZOPHRENIA SIMPLE TYPE
29502	SCHIZOPHRENIA SIMPLE TYPE CHRONIC
29503	SCHIZOPHRENIA SIMPLE TYPE W EXACERBATION
29504	SCHIZOPHRENIA SIMPLE TYPE W EXACERBATION
29505	SCHIZOPHRENIA IN REMISSION
2951	HEBEPHRENIC SCHIZOPHRENIA
29510	SCHIZOPHRENIA HEBEPHRENIC TYPE UNSPECIF
29511	SCHIZOPHRENIA HEBEPHRENIC TYPE
29512	SCHIZOPHRENIA HEBEPHRENIC TYPE CHRONIC
29513	SCHIZOPHRENIA HEBEPHRENIC W EXACERBATION
29514	SCHIZOPHRENIA HEBEPHRENIC W EXACERBATION
29515	SCHIZOPHRENIA HEBEPHRENIC TYPE REMISSION
2952	CATATONIC SCHIZOPHRENIA
29520	SCHIZOPHRENIA CATATONIC TYPE UNSPECIFIED
29521	SCHIZOPHRENIA CATATONIC TYPE
29522	SCHIZOPHRENIA CATATONIC TYPE CHRONIC
29523	SCHIZOPHRENIA CATATONIC W EXACERBATION
29524	SCHIZOPHRENIA CATATONIC W EXACERBATION
29525	SCHIZOPHRENIA CATATONIC TYPE IN REMISSIO
2953	SCHIZOPHRENIA PARANOID TYPE
29530	SCHIZOPHRENIA PARANOID TYPE UNSPECIFIED
29531	SCHIZOPHRENIA PARANOID TYPE
29532	SCHIZOPHRENIA PARANOID TYPE CHRONIC
29533	SCHIZOPHRENIA PARANOID TYPE
29534	SCHIZOPHRENIA PARANOID TYPE
29535	SCHIZOPHRENIA PARANOID TYPE IN REMISSION
2954	SCHIZOPHRENIA ACUTE EPISODE
29540	SCHIZOPHRENIFORM DISORDER, UNSPECIFIED
29541	SCHIZOPHRENIFORM DISORDER, SUBCHRONIC
29542	SCHIZOPHRENIFORM DISORDER CHRONIC
29543	SCHIZOPHRENIFORM DISORDER SUBCHRONIC WITH ACUTE EXACERBATION
29544	SCHIZOPHRENIFORM DISORDER CHRONIC WITH ACUTE EXACERBATION
29545	SCHIZOPHRENIFORM DISORDER IN REMISSION
2955	SCHIZOPHRENIA LATENT
29550	SCHIZOPHRENIA LATENT
29551	SCHIZOPHRENIA LATENT
29552	SCHIZOPHRENIA LATENT
29553	SCHIZOPHRENIA LATENT
29554	SCHIZOPHRENIA LATENT
29555	SCHIZOPHRENIA LATENT
2956	SCHIZOPHRENIA RESIDUAL TYPE
29560	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE UNSPECIFIED
29561	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE SUBCHRONIC

Mental Health Care (Inpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis (cont.)

Diagnosis Code	DESCRIPTION
29562	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE CHRONIC
29563	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE SUBCHRONIC WITH ACUTE EXACERBATION
29564	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE CHRONIC WITH ACUTE EXACERBATION
29565	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE IN REMISSION
2957	SCHIZOPHRENIA SCHIZO AFFECTIVE
29570	SCHIZOAFFECTIVE DISORDER UNSPECIFIED
29571	SCHIZOAFFECTIVE DISORDER SUBCHRONIC
29572	SCHIZOAFFECTIVE DISORDER CHRONIC
29573	SCHIZOAFFECTIVE DISORDER SUBCHRONIC WITH ACUTE EXACERBATION
29574	SCHIZOAFFECTIVE DISORDER CHRONIC WITH ACUTE EXACERBATION
29575	SCHIZOAFFECTIVE DISORDER IN REMISSION
2958	OTHER SPEC TYPES OF SCHIZOPHRENIA
29580	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29581	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29582	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29583	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29584	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29585	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
2959	SCHIZOPHRENIA UNSPECIFIED OR NOS
29590	SCHIZOPHRENIA UNSPECIFIED TYPE
29591	SCHIZOPHRENIA UNSPECIFIED TYPE
29592	SCHIZOPHRENIA UNSPECIFIED TYPE
29593	SCHIZOPHRENIA UNSPECIFIED TYPE
29594	SCHIZOPHRENIA UNSPECIFIED TYPE
29595	SCHIZOPHRENIA UNSPECIFIED TYPE
296	AFFECTIVE PSYCHOSES
2960	MANIC DISORDER SINGLE EPISODE
29600	BIPOLAR I DISORDER SINGLE MANIC EPISODE UNSPECIFIED
29601	BIPOLAR I DISORDER SINGLE MANIC EPISODE MILD
29602	BIPOLAR I DISORDER SINGLE MANIC EPISODE MODERATE
29603	BIPOLAR I DISORDER SINGLE MANIC EPISODE SEVERE W/O MENTION OF PSYCHOTIC BEHAVIOR
29604	BIPOLAR I DISORDER SINGLE MANIC EPISODE SEVERE SPEC AS WITH PSYCHOTIC BEHAVIOR
29605	BIPOLAR I DISORDER SINGLE MANIC EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
29606	BIPOLAR I DISORDER SINGLE MANIC EPISODE IN FULL REMISSION
2961	MANIC DISORDER RECURRENT EPISODE
29610	MANIC DISORDER RECURRENT EPISODE
29611	MANIC DISORDER RECURRENT EPISODE
29612	MANIC DISORDER RECURRENT EPISODE
29613	MANIC DISORDER RECURRENT EPISODE
29614	MANIC DISORDER RECURRENT EPISODE
29615	MANIC DISORDER RECURRENT EPISODE
29616	MANIC DISORDER RECURRENT EPISODE
2962	MAJOR DEPRESSIVE DISORDER SINGLE EPISODE
29620	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29621	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29622	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE

Mental Health Care (Inpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis (cont.)

Diagnosis Code	DESCRIPTION
29623	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29624	ACUTE PSYCHOTIC DEPRESSION
29625	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29626	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
2963	MAJOR DEPRESSIVE DIS RECURRENT EPISODE
29630	DEPRESSIVE DISORDER RECURRENT EPISODE
29631	DEPRESSIVE DISORDER RECURRENT EPISODE
29632	DEPRESSIVE DISORDER RECURRENT EPISODE
29633	DEPRESSIVE DISORDER RECURRENT EPISODE
29634	DEPRESSIVE DISORDER RECURRENT EPISODE
29635	DEPRESSIVE DISORDER RECURRENT EPISODE
29636	DEPRESSIVE DISORDER RECURRENT EPISODE
2964	MANIC DEPRESSIVE DISORDER MANIC PHASE
29640	BIPOLAR I DISORDER MOST RECENT EPISODE (OR CURRENT) MANIC UNSPECIFIED
29641	BIPOLAR I DISORDER MOST RECENT EPISODE (OR CURRENT) MANIC MILD
29642	BIPOLAR I MOST RECENT EPISODE (OR CURRENT) MANIC MODERATE
29643	BIPOLAR I DISORD MOST RECENT EPISODE (ORCURRENT)MANIC SEV W/O MENT PSYCHOT BEHAV
29644	BIPOLAR I DISORD MOST REC EPISODE (OR CURRENT)MANIC SEVERE SPEC W PSYCHOT BEH
29645	BIPOLAR I DISORD MOST REC EPI (OR CURRENT) MANIC IN PARTIAL/UNSPEC REMISSION
29646	BIPOLAR I DISORD MOST REC EPI (OR CURRENT) MANIC IN FULL REMISSION
2965	MANIC DEPRESSIVE DISORD DEPRESSED PHASE
29650	BIPOLAR I DISORD MOST RECENT EPISODE (ORCURRENT) DEPRESSED UNSPECIFIED
29651	BIPOLAR I DISORDER MOST RECENT OR CURRETN DEPRESSED MILD
29652	BIPOLAR I MOST RECENT EPISODE OR CURRENTDEPRESSED MODERATE
29653	BIPOLAR I DISORD MOST REC EPI OR CURRENTDEPRESSED SEVERE W/O MENTION PSYCHOTIC BEHAVIOR
29654	BIPOLAR I DISORD MOST REC EPI OR CURRENTDEPRESSED SEVERE AS WITH PSYCHOTIC BEHAVIOR
29655	BIPOLAR I DISORD MOST REC EPI OR CURRENTDEPRESSED IN PARTIAL OR UNPSECIFIED REMISSION
29656	BIPOLAR I DISORD MOST RECENT EPISODE OR CURRENT DEPRESSED IN FULL REMISSION
2966	MANIC DEPRESSIVE DISORDER MIXED PHASES
29660	BIPOLAR I DISORDER MOST RECENT EPISODE OR CURRENT MIXED UNSPECIFIED
29661	BIPOLAR I DISORDER MOST RECENT EPISODE OR CURRENT MIXED MILD
29662	BIPOLAR I DISORDER MOST RECENT EPISODE OR CURRENT MIXED MODERATE
29663	BIPOLAR I DISORD MOST REC EPI OR CURRENTMIXED SEVERE W/O MENT PSYCHOTIC BEHAVIOR
29664	BIPOLAR I DISORD MOST REC EPI OR CURRENTMIXED SEVERE SPEC AS WITH PSYCHOTIC BEHAVIOR
29665	BIPOLAR I DISORD MOST REC EPI OR CURRENTMIXED INPARTIAL OR UNSPECIFIED REMISSION
29666	BIPOLAR I DISORD MOST RECENT EPISODE OR CURRENT MIXED IN FULL REMISSION
2967	BIPOLAR I DISORD MOST RECENT EPISODE OR CURRENT UNSPECIFIED
2968	MANIC DEPRESSIVE PSYCHOSIS OTHER OR UNSP
29680	BIPOLAR DISORDER UNSPECIFIED
29681	ATYPICAL MANIC DISORDER
29682	ATYPICAL DEPRESSIVE DISORDER
29689	OTHER AND UNSPECIFIED BIPOLAR DISORDERS OTHER
2969	AFFECTIVE PSYCHOSES OTHER OR UNSPECIFIED
29690	UNSPECIFIED EPISODIC MOOD DISORDER
29699	OTHER SPECIFIED EPISODIC MOOD DISORDER
297	PARANOID STATES

Mental Health Care (Inpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis (cont.)

Diagnosis Code	DESCRIPTION
2970	PARANOID STATE SIMPLE
2971	DELUSIONAL DISORDER
2972	PARANOID STATE MENOPAUSAL OR INVOLUTIONA
2973	SHARED PSYCHOTIC DISORDER
2978	OTHER SPECIFIED PARANOID STATE
2979	UNSPECIFIED PARANOID STATE OR DISORDER
298	OTHER NONORGANIC PSYCHOSES
2980	DEPRESSIVE TYPE PSYCHOSIS
2981	PSYCHOSIS EXCITATIVE TYPE
2982	CONFUSION REACTIVE OR PSYCHOGENIC
2983	ACUTE PARANOID REACTION
2984	PSYCHOGENIC PARANOID PSYCHOSIS
2988	REACTIVE OR PSYCHOGENIC PSYCHOSIS UNSPEC
2989	ATYPICAL OR UNSP PSYCHOSIS PSYCHOSIS NOS
299	PSYCHOSES W ORIGIN SPECIFIC TO CHILDHOOD
2990	INFANTILE AUTISM CHILDHOOD AUTISM
29900	AUTISM DISORDER CURRENT OR ACTIVE STATE
29901	AUTISTIC DISORDER RESIDUAL STATE
2991	INFANTILE PSYCHOSIS HELLERS SYNDROME
29910	CHILDHOOD DISINTEGRATIVE DISORDER CURRENT OR ACTIVE STATE
29911	CHILDHOOD DISINTEGRATIVE DISORDER RESIDUAL STATE
2998	OTHER SPEC EARLY CHILDHOOD PSYCHOSIS
29980	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS CURRENT OR ACTIVE STATE
29981	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS RESIDUAL STATE
2999	UNSPECIFIED CHILDHOOD PSYCHOSIS
29990	UNSPECIFIED PERVASIVE DEVELOPMENTAL DISORDER CURRENT OR ACTIVE STATE
29991	UNSPECIFIED PERVASIVE DEVELOPMENTAL DISORDER RESIDUAL STATE
30001	PANIC DISORDER WITHOUT AGORAPHOBIA
30021	AGORAPHOBIA WITH PANIC DISORDER
3003	OBSESSIVE COMPULSIVE NEUROSIS REACTION
30981	POST TRAUMATIC STRESS DISORDER
307.51	BULIMIA NERVOSA
307.1	ANOREXIA NERVOSA

Mental Health Care (Outpatient)

Benefit: Mental Health Services are in benefit when provided for treatment of a mental illness. The extent of outpatient benefits available to any given member is defined by the member's benefit plan and state law. (Refer to the HMO Benefit Matrix for a description of these benefits.) Chemical dependency and Mental Health are separate benefit programs.

In June 2006, the law Public Act (PA) 094-0906 and PA 094-0921 was signed impacting the existing Illinois Serious Mental Illness (SMI) statute (215 ILCS 5/37oc). This law will require all HMOs to comply with all provisions of the SMI statute effective January 1, 2007.

SMI includes psychiatric illnesses of:

- Schizophrenia,
- Paranoid and other disorders,
- Bipolar disorders (hypomaniac, manic, depressive and mixed),
- Schizoaffective disorders.

Refer to the note at the end of this section for a detailed explanation of these benefits, and a list of SMI diagnosis.

Visits are considered to be mental health visits when the primary purpose is to provide psychotherapy services. Visits for medical management or medication adjustment are considered medical visits, NOT mental health visits. These should not be charged against the member's mental health outpatient benefit.

Interpretation: A member who is having mental health problems or is exhibiting inappropriate or unusual behavior should always be evaluated by the Primary Care Physician (PCP) and referred if appropriate for evaluation by a mental health professional. A determination about additional visits beyond the initial mental health evaluation can be made once the evaluation of the member has been completed. The PCP, with input from the mental health professional, should determine the medical necessity of further mental health visits, as well as their frequency and overall duration.

Outpatient mental health benefits are available for a member with a mental illness whose clinical record or psychological testing results demonstrate a need for outpatient therapy. Medical necessity may also be based on self-reported signs and symptoms and/or a decrease in the Global Assessment of Functioning Scale (GAF). Members should be referred to a mental health professional (defined as a psychiatrist, psychologist, psychiatric social worker, or other mental health professional working under the guidance of a physician) for covered services. These services include individual psychotherapy, group therapy, family therapy, and psychological testing.

If a member presents with a problem such as marital conflict or divorce, or if there is an adjustment disorder that interferes with the member's ability to function, the possibility of an underlying or resulting mental health condition should be considered.

Behavior problems in children raise the possibility of an underlying psychiatric condition. These problems may be noted by family members, school officials, law enforcement officials, or others. Children with such problems should be considered for evaluation for an underlying mental health condition.

Psychological testing services are in benefit. Each visit, regardless of length, counts as one mental health visit for purposes of copayment and utilization of the outpatient mental health benefit.

When a member has been ordered by a court to undergo mental health assessment and/or treatment, these services are in benefit if they are medically necessary AND the PCP refers the member for the service.

Mental Health Care (Outpatient) (cont.)

Court-ordered services are not in benefit if they are not medically necessary OR if the court orders services to be provided by a non-network practitioner.

Benefits are NOT available for:

- Services directed toward making one's personality more forceful or dynamic.
- Consciousness raising.
- Vocational or religious counseling.
- Group socialization
- Educational activities (i.e., smoking cessation classes)
- Simple lifestyle dissatisfactions which are a reaction to common life stresses
- Treatment of mental retardation
- IQ testing
- Treatment modalities not shown to be effective in the treatment of mental illness. One such example (but not limited to) is the photo therapy light used to treat Seasonal Affective Disorder (SAD).

Information about mental health services, UM fund charges, member benefit level changes and copayments are summarized in the following table. Please refer to the HMO Benefit Matrix for more detailed information.

Outpatient Program Types	# Visits made	UM Fund Charge	Member Benefit Level Charge	Copayment see Benefit Matrix)
Partial Day	1	0.25	0.5 inpatient	1 inpatient mental health
Intensive Outpatient	1	0.25	0.5 inpatient	1 inpatient mental health
Individual Psychotherapy	1	0	1 outpatient	1 outpatient mental health
Family Therapy	1	0	1 outpatient per family, not per attendee	1 outpatient mental health per family, not per attendee
Group Therapy	1	0	0.5 outpatient	1 outpatient mental health
Psychological testing	1	0	1 outpatient	1 outpatient mental health
Medication visit	1	0	NONE	1 MEDICAL

Mental Health Care (Outpatient) (cont.)

Special Coverage Notes

1. Electroconvulsive Therapy (ECT)

Inpatient and outpatient ECT services are in benefit. These services are considered to be medical services. ECT is subject to usual medical utilization fund chargebacks and not counted against the mental health benefit. The member must not be charged a mental health copayment for ECT services.

2. Visits for adjustment or monitoring of psychotropic medications

If a member is referred to a mental health professional to adjust or monitor his/her psychotropic medications, not to receive psychotherapy, this visit is a **medical** visit. These visits are not counted as mental health visits for purposes of assessing copayments or calculating utilization of outpatient mental health benefits. The member is assessed a medical copayment if applicable.

Note: Payment details may vary for members enrolled in certain IPA's listed below. (However, benefits are not different for these members.)

#098

Physicians Care Network, Inc.

Please call the HMO with questions regarding members enrolled in these groups.

Paid by:

Professional charges: **IPA**
Facility fees: **HMO**

Mental Health Care (Outpatient) (cont.)

HMO Serious Mental Illness (SMI) Scripting

Q1: What is the law for Serious Mental Illness?

A1: For the first time, the law mandates that HMOs are subject to the provisions of 215 ILCS 5/370c Serious Mental Illness. For HMO business, the law takes effect at issue or first renewal on or after January 1, 2007 by:

- Providing 60 visits each year for outpatient treatment for “serious mental illness” (this includes PDD) and 45 inpatient days.
- Members with a PDD diagnosis only, will be able to utilize their Rehabilitative Therapy (PT, OT, ST) benefit first, then their Outpatient SMI benefit (Mental Health {MH}, PT, OT, ST). Members with PDD still have an additional 20 speech therapy only visits after they have utilized all of the above benefits first.
- Allowing HMO members “open access” to seek mental health care for non-serious mental health.

The new SMI law does not affect the Chemical Dependency benefit.

To comply with the law, Blue Cross and Blue Shield of Illinois will provide the following HMO benefits on January 1, 2007, effective for new groups and for existing groups upon renewal:

Upon renewal date starting October 1, 2008, we are aligning the mental health and chemical dependency co-pays with the specialist co-pay when the member sees a specialist.

Serious Mental Illness (SMI)

- 45 Inpatient Days in addition to the purchased days. (eg 20)
- 60 Outpatient Visits in addition to the purchased days (eg 20).
- 20 Additional Outpatient Speech Therapy Visits for Pervasive Developmental Disorder (PDD)
- Must obtain referral from PCP / Medical Group or IPA. Note, some medical groups allow direct access to their panel of mental health providers. Please refer to previous training materials to determine if member has this option.)

Non-Serious Mental Illness

- 20 Inpatient Days
- 20 Outpatient Visits
- In and Out-of-Network Benefits
- 50% of covered expenses for out-of-network benefits (Note: Should the member choose an out-of-network facility, the HMO will reimburse the facility up to 50% of the covered expense.
HMOI will reimburse the member up to 50 % for out-of-network professional fees for inpatient or outpatient treatment. The member is responsible to pay the remaining 50% of professional fees to the provider.
(The above visits/days will vary based on benefit plan.)

Q2: What is a Serious Mental Illness (SMI)?

A2: The law defines the following conditions as a serious mental illness

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar disorders (hypo manic, manic, depressive, and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizoaffective disorders (bipolar or depressive)'
- Pervasive developmental disorders (PDD)
- Obsessive-compulsive disorders
- Depression in childhood and adolescence
- Panic disorder
- Post traumatic stress disorders (acute, chronic, or with delayed onset)

Mental Health Care (Outpatient) (cont.)

Q3: What are the mandatory benefits provided under the Serious Mental Illness legislation?

- A3:** The legislation requires that we provide the following benefits for medical conditions that fall into the category of serious mental illness:
- 45 inpatient days in addition to the purchased days for SMI – paid at the inpatient benefit level
 - 60 outpatient visits in addition to the purchased days for SMI—. If services are for med management, see question 10.
 - Members with a PDD diagnosis only, will be able to utilize their Rehabilitative Therapy (PT, OT, ST) benefit first, then their Outpatient SMI benefit (Mental Health {MH}, PT, OT, or ST). Members with PDD still have an additional 20 speech therapy only visits after they have utilized all of the above benefits first.
 - If these members with a PDD diagnosis also have a non-serious mental illness they have their purchased days (eg 20) to use for non-SMI MH visits. If these members are seeing a MH professional for an SMI, they would use the purchased days first then the additional SMI benefit days.

A member will need to obtain a referral. If a PCP determines that specialist care is medically indicated they will refer the member to a specialist for a consultation and/or covered services. Referrals are usually made within the member's PCP medical group and will include the name of the specialist, services to be provided, time frame for receiving the services and the specified visits. Please see previous note for those medical groups that allow members to self-refer to their specific panel of mental health providers.

Q4: What are some examples that will be considered Non-Serious Mental Illness?

- A4:** Some of the Non-Serious Mental Illness diagnoses (non-inclusive list) are:
- Personality Disorders (e.g. histrionic 301.50, borderline dependent 301.83)
 - Dysthymia Disorder 300.4 a chronic depressed mood that occurs most of the day more days than not for at least 2 yrs.
 - Cyclothymic Disorder 301.13 numerous periods of hypo manic symptoms fluctuating with numerous periods of depressive symptoms
 - Seasonal Affective Disorder (SAD)
 - Generalized Anxiety Disorder 300.02
 - Anxiety Disorder non-specific origin 300.00
 - Acute Stress Disorder, adjustment disorders 308.3
 - Adjustment Disorder with depressed mood 309.0
 - Attention Deficit / Hyperactivity Disorder 314.9
 - Social Phobia 300.23
 - Dissociative Identity Disorder 300.14

Mental Health Care (Outpatient) (cont.)

Q5: How do I determine the correct payment level for a claim that was self-referred?

A5: The following grid outlines the payment criteria for each claim:

	Place of Treatment	Dx- Non Serious Mental Illness	Dx- Serious Mental Illness
Out of Area	Outpt Office Visit	50% of covered expenses	OOA Guidelines apply
	Admit	50% of covered expenses	OOA Guidelines
	Outpt emergency	Prudent layperson guidelines	Prudent layperson guidelines
	ER Admit	ER- prudent layperson Inpatient- 50% of covered expenses	OOA Guidelines
Out of Network	Outpt Office Visit	50 % of covered expenses	NGA
	Admit	50% of covered expenses	NGA
	Outpt Emergency Room	Prudent Layperson guidelines	Prudent Layperson guidelines
	ER> Admit	ER-prudent layperson Inpatient- 50% of covered expenses	ER- prudent layperson Inpatient- GA from point of notification
	Admit	50% of covered expenses	NGA

Q6: What ineligible code will be used for the denial of services when a member seeks services for non-serious mental illness out of network?

A6: Ineligible reason code will be 454

Q7: When paying a claim for non-serious mental illness for an out of network provider should payment go to the member or provider?

A7: Payment will be made to the member, for professional fees up to 50 %, if they seek non-serious mental illness services out of network. Payment up to 50 % will be made to the facility for facility charges. Member is responsible for the other 50 % of billed charges.

Q8: How will Medical Groups respond to PDC, 64/095, or 039 claims for non-serious mental illness diagnosis that was provided out of network?

A8: See the following chart for appropriate responses for each category:

PDC claims	NGA- OON Non-SMI
095 claim report	NGA- OON Non-SMI
039	NGA- OON Non-SMI

Q9: What co-pay will apply for *outpatient serious mental illness (SMI)* claims?

A9: If benefit plan has one co-pay, all visits are treated the same.
If benefit plan has a differential co-pay for PCP, specialist and if the SMI visit is with a specialist, the specialist co-pay applies.
If the SMI visit is with the member's PCP, the PCP co-pay applies.

Q10: What co-pay will apply for *outpatient SMI Medicine Management (90862)*?

A10: If provided by the PCP, the PCP co-pay will apply. If provided by the Specialist, the specialist visit co-pay will apply, if there is a specialist differential co-pay.

NOTE: Services for SMI Medicine Management will not accumulate towards the member's outpatient SMI benefit.

Mental Health Care (Outpatient) (cont.)

Q11: What co pay will apply for *non-serious mental illness* claims?

A11: For outpatient non SMI, if the visit is with the PCP, the PCP co-pay will apply. With an approved referral, if the visit is with the mental health specialist, the specialist co-pay applies. With an approved referral, if the benefit has a mental health co-pay and the visit is with the mental health specialist, the mental health co-pay will apply till renewal date starting October 1, 2008. Upon renewal date, many groups' MH co-pay will be in alignment with the PCP/Specialist co-pay. If no approved referral, the claim is paid at 50 % of covered expense with no co-pay.

Q12: What co-pay will apply for *non-SMI medicine management (90862)*?

A12: If provided by the PCP, the PCP co-pay will apply. If provided by the specialist, the specialist visit co-pay will apply.

If the benefit plan has a mental health co-pay and the visit is with a specialist, the mental health co-pay applies till renewal date starting October 1, 2008. Upon renewal date many groups' MH co-pay will be in alignment with the PCP/Specialist co-pay.

NOTE: Services for non-SMI medicine management will not accumulate towards the member's outpatient non-SMI benefit.

Q13: What co pay will apply if I am admitted for a non-serious mental illness that was self-referred and I choose to go to an OON provider?

A13: The co pay will be waived since the HMO will only cover 50% of covered expenses for out-of-network benefits and member will be responsible for the remainder 50 % balance.

Q14: I self-referred to a provider for a non-serious mental illness and now a portion of my claim is being denied.

A14: In order to receive the highest level of benefits you should work with your Primary Care Physician. If your PCP determines that a specialist care is medically indicated they will refer you to a specialist for a consultation and/or covered services. If you feel the claim was paid incorrectly you may follow the appeal guidelines.

Q15: What are Pervasive Developmental Disorders (PDD)?

A15: These disorders are characterized by severe deficits and pervasive impairment in multiple areas of development. These include impairment in reciprocal social interaction, impairment in communication, and the presence of stereotyped behavior, interests, and activities.

The listed below are the codes and names:

- 299.0 Autistic Disorder: childhood autism, infantile psychosis, Kanner's syndrome
- 299.1 Childhood Disintegrative Disorder: Heller's syndrome
- 299.8 Other Specified Pervasive Developmental Disorders: Asperger's disorder, Atypical childhood psychosis and Borderline psychosis of childhood
- 299.9 Unspecified Pervasive Developmental Disorder: Child psychosis, not otherwise specified; pervasive developmental disorder, not otherwise specified; schizophrenia, childhood type, not otherwise specified; and schizophrenic syndrome of childhood, not otherwise specified

There will be a fifth digit to these 299 codes:

- 0 is for current or active and 1 is for residual state

Mental Health Care (Outpatient) (cont.)

Q16: Will the patient with PDD need to show that significant improvement within 2 months will occur, in order to be approved, as in the past?

A16: Yes, the need for assessing whether significant improvement will occur within the next 60 days, applies to the initial rehabilitative therapy benefit only, and NO longer applies to a patient with a PDD diagnosis for their outpatient SMI visits or the additional 20 speech therapy visits.

Q17: Will the 20 outpatient speech therapy visits added for the treatment of pervasive developmental disorder replace the 60 combined visits for rehabilitative therapy?

A17: No, once the member has exhausted their current rehabilitative (Physical, Occupational, Speech) therapy as well as their outpatient SMI benefit, they will be allowed 20 additional outpatient speech therapy visits specific for PDD.

Q18: What is the co-pay for PDD?

A18: The outpatient therapy co-pay applies for outpatient rehabilitative therapy, SMI therapy if used for rehab therapies and the additional 20 speech therapy.

If the member is being treated by a rehab professional such as occupational therapist or speech therapist, the rehab co-pay applies. If the member is being treated by their PCP, the PCP co-pay applies. If the member is being treated by a mental health provider, the specialist co-pay applies.

Co-pay for Outpt. Rehab Therapies (PT OT ST)	Co-pay for non-smi MH therapy	Co-pay for SMI Therapies (MH PT OT or ST)	Co-pay for PCP visit
Provided by Rehab therapist-Rehab Co-Pay	Provider MH specialist-MH co-pay if employer group has one till renewal date starting October 1, 2008, then MH co-pay may align with PCP/Specialist co-pay	Provider-Rehab Therapist-Rehab co-pay	PCP Co-pay
Provided by PCP-PCP co-pay		Provider- MH specialist for MH therapy-specialist co-pay	
Additional 20 speech therapy visits provided by speech therapist-rehab co-pay		Provider PCP-PCP co-pay	

Q19: What ICD-9 code is used for depression in childhood and adolescence?

A19: ICD-9 code 311-Depressive Disorder not otherwise specified. This is for members under 18 years of age only. This is because the law defines any depression in childhood or adolescence as a serious mental illness.

Please note: regardless of the diagnosis of the individual, the co-pay is contingent upon what type of provider the visit is with. The goal is to eliminate the MH and Chemical Dependency co-pays to align MH/CD HMO co-pays in two categories: PCP or Specialist. The exception is the rehab co-pay for SMI rehab visits for those members with PDD.

The small groups are in alignment. The renewal date starting October 1, 2008, applies to the large employer groups.

If there is no medical specialist co-pay we cannot charge a specialist co-pay for Mental Health services.

Mental Health Care (Outpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis

Diagnosis Code	DESCRIPTION
295	SCHIZOPHRENIC DISORDERS
2950	SCHIZOPHRENIA SIMPLEX SIMPLE X
29500	SCHIZOPHRENIA SIMPLE TYPE UNSPECIFIED
29501	SCHIZOPHRENIA SIMPLE TYPE
29502	SCHIZOPHRENIA SIMPLE TYPE CHRONIC
29503	SCHIZOPHRENIA SIMPLE TYPE W EXACERBATION
29504	SCHIZOPHRENIA SIMPLE TYPE W EXACERBATION
29505	SCHIZOPHRENIA IN REMISSION
2951	HEBEPHRENIC SCHIZOPHRENIA
29510	SCHIZOPHRENIA HEBEPHRENIC TYPE UNSPECIF
29511	SCHIZOPHRENIA HEBEPHRENIC TYPE
29512	SCHIZOPHRENIA HEBEPHRENIC TYPE CHRONIC
29513	SCHIZOPHRENIA HEBEPHRENIC W EXACERBATION
29514	SCHIZOPHRENIA HEBEPHRENIC W EXACERBATION
29515	SCHIZOPHRENIA HEBEPHRENIC TYPE REMISSION
2952	CATATONIC SCHIZOPHRENIA
29520	SCHIZOPHRENIA CATATONIC TYPE UNSPECIFIED
29521	SCHIZOPHRENIA CATATONIC TYPE
29522	SCHIZOPHRENIA CATATONIC TYPE CHRONIC
29523	SCHIZOPHRENIA CATATONIC W EXACERBATION
29524	SCHIZOPHRENIA CATATONIC W EXACERBATION
29525	SCHIZOPHRENIA CATATONIC TYPE IN REMISSIO
2953	SCHIZOPHRENIA PARANOID TYPE
29530	SCHIZOPHRENIA PARANOID TYPE UNSPECIFIED
29531	SCHIZOPHRENIA PARANOID TYPE
29532	SCHIZOPHRENIA PARANOID TYPE CHRONIC
29533	SCHIZOPHRENIA PARANOID TYPE
29534	SCHIZOPHRENIA PARANOID TYPE
29535	SCHIZOPHRENIA PARANOID TYPE IN REMISSION
2954	SCHIZOPHRENIA ACUTE EPISODE
29540	SCHIZOPHRENIFORM DISORDER, UNSPECIFIED
29541	SCHIZOPHRENIFORM DISORDER, SUBCHRONIC
29542	SCHIZOPHRENIFORM DISORDER CHRONIC
29543	SCHIZOPHRENIFORM DISORDER SUBCHRONIC WITH ACUTE EXACERBATION
29544	SCHIZOPHRENIFORM DISORDER CHRONIC WITH ACUTE EXACERBATION
29545	SCHIZOPHRENIFORM DISORDER IN REMISSION
2955	SCHIZOPHRENIA LATENT
29550	SCHIZOPHRENIA LATENT
29551	SCHIZOPHRENIA LATENT
29552	SCHIZOPHRENIA LATENT
29553	SCHIZOPHRENIA LATENT
29554	SCHIZOPHRENIA LATENT
29555	SCHIZOPHRENIA LATENT
2956	SCHIZOPHRENIA RESIDUAL TYPE
29560	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE UNSPECIFIED
29561	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE SUBCHRONIC

Mental Health Care (Outpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis (cont.)

Diagnosis Code	DESCRIPTION
29562	SCHZOPHRENIC DISORDERS RESIDUAL TYPE CHRONIC
29563	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE SUBCHRONIC WITH ACUTE EXACERBATION
29564	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE CHRONIC WITH ACUTE EXACERBATION
29565	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE IN REMISSION
2957	SCHIZOPHRENIA SCHIZO AFFECTIVE
29570	SCHIZOAFFECTIVE DISORDER UNSPECIFIED
29571	SCHIZOAFFECTIVE DISORDER SUBCHRONIC
29572	SCHIZOAFFECTIVE DISORDER CHRONIC
29573	SCHIZOAFFECTIVE DISORDER SUBCHRONIC WITH ACUTE EXACERBATION
29574	SCHIZOAFFECTIVE DISORDER CHRONIC WITH ACUTE EXACERBATION
29575	SCHIZOAFFECTIVE DISORDER IN REMISSION
2958	OTHER SPEC TYPES OF SCHIZOPHRENIA
29580	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29581	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29582	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29583	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29584	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
29585	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA
2959	SCHIZOPHRENIA UNSPECIFIED OR NOS
29590	SCHIZOPHRENIA UNSPECIFIED TYPE
29591	SCHIZOPHRENIA UNSPECIFIED TYPE
29592	SCHIZOPHRENIA UNSPECIFIED TYPE
29593	SCHIZOPHRENIA UNSPECIFIED TYPE
29594	SCHIZOPHRENIA UNSPECIFIED TYPE
29595	SCHIZOPHRENIA UNSPECIFIED TYPE
296	AFFECTIVE PSYCHOSES
2960	MANIC DISORDER SINGLE EPISODE
29600	BIPOLAR I DISORDER SINGLE MANIC EPISODE UNSPECIFIED
29601	BIPOLAR I DISORDER SINGLE MANIC EPISODE MILD
29602	BIPOLAR I DISORDER SINGLE MANIC EPISODE MODERATE
29603	BIPOLAR I DISORDER SINGLE MANIC EPISODE SEVERE W/O MENTION OF PSYCHOTIC BEHAVIOR
29604	BIPOLAR I DISORDER SINGLE MANIC EPISODE SEVERE SPEC AS WITH PSYCHOTIC BEHAVIOR
29605	BIPOLAR I DISORDER SINGLE MANIC EPISODE IN PARTIAL OR UNSPECIFIED REMISSION
29606	BIPOLAR I DISORDER SINGLE MANIC EPISODE IN FULL REMISSION
2961	MANIC DISORDER RECURRENT EPISODE
29610	MANIC DISORDER RECURRENT EPISODE
29611	MANIC DISORDER RECURRENT EPISODE
29612	MANIC DISORDER RECURRENT EPISODE
29613	MANIC DISORDER RECURRENT EPISODE
29614	MANIC DISORDER RECURRENT EPISODE
29615	MANIC DISORDER RECURRENT EPISODE
29616	MANIC DISORDER RECURRENT EPISODE
2962	MAJOR DEPRESSIVE DISORDER SINGLE EPISODE
29620	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29621	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29622	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE

Mental Health Care (Outpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis (cont.)

Diagnosis Code	DESCRIPTION
29623	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29624	ACUTE PSYCHOTIC DEPRESSION
29625	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29626	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
2963	MAJOR DEPRESSIVE DIS RECURRENT EPISODE
29630	DEPRESSIVE DISORDER RECURRENT EPISODE
29631	DEPRESSIVE DISORDER RECURRENT EPISODE
29632	DEPRESSIVE DISORDER RECURRENT EPISODE
29633	DEPRESSIVE DISORDER RECURRENT EPISODE
29634	DEPRESSIVE DISORDER RECURRENT EPISODE
29635	DEPRESSIVE DISORDER RECURRENT EPISODE
29636	DEPRESSIVE DISORDER RECURRENT EPISODE
2964	MANIC DEPRESSIVE DISORDER MANIC PHASE
29640	BIPOLAR I DISORDER MOST RECENT EPISODE (OR CURRENT) MANIC UNSPECIFIED
29641	BIPOLAR I DISORDER MOST RECENT EPISODE (OR CURRENT) MANIC MILD
29642	BIPOLAR I MOST RECENT EPISODE (OR CURRENT) MANIC MODERATE
29643	BIPOLAR I DISORD MOST RECENT EPISODE (ORCURRENT)MANIC SEV W/O MENT PSYCHOT BEHAV
29644	BIPOLAR I DISORD MOST REC EPISODE (OR CURRENT)MANIC SEVERE SPEC W PSYCHOT BEH
29645	BIPOLAR I DISORD MOST REC EPI (OR CURRENT) MANIC IN PARTIAL/UNSPEC REMISSION
29646	BIPOLAR I DISORD MOST REC EPI (OR CURRENT) MANIC IN FULL REMISSION
2965	MANIC DEPRESSIVE DISORD DEPRESSED PHASE
29650	BIPOLAR I DISORD MOST RECENT EPISODE (ORCURRENT) DEPRESSED UNSPECIFIED
29651	BIPOLAR I DISORDER MOST RECENT OR CURRETN DEPRESSED MILD
29652	BIPOLAR I MOST RECENT EPISODE OR CURRENTDEPRESSED MODERATE
29653	BIPOLAR I DISORD MOST REC EPI OR CURRENTDEPRESSED SEVERE W/O MENTION PSYCHOTIC BEHAVIOR
29654	BIPOLAR I DISORD MOST REC EPI OR CURRENTDEPRESSED SEVERE AS WITH PSYCHOTIC BEHAVIOR
29655	BIPOLAR I DISORD MOST REC EPI OR CURRENTDEPRESSED IN PARTIAL OR UNPSECIFIED REMISSION
29656	BIPOLAR I DISORD MOST RECENT EPISODE OR CURRENT DEPRESSED IN FULL REMISSION
2966	MANIC DEPRESSIVE DISORDER MIXED PHASES
29660	BIPOLAR I DISORDER MOST RECENT EPISODE OR CURRENT MIXED UNSPECIFIED
29661	BIPOLAR I DISORDER MOST RECENT EPISODE OR CURRENT MIXED MILD
29662	BIPOLAR I DISORDER MOST RECENT EPISODE OR CURRENT MIXED MODERATE
29663	BIPOLAR I DISORD MOST REC EPI OR CURRENTMIXED SEVERE W/O MENT PSYCHOTIC BEHAVIOR
29664	BIPOLAR I DISORD MOST REC EPI OR CURRENTMIXED SEVERE SPEC AS WITH PSYCHOTIC BEHAVIOR
29665	BIPOLAR I DISORD MOST REC EPI OR CURRENTMIXED INPARTIAL OR UNSPECIFIED REMISSION
29666	BIPOLAR I DISORD MOST RECENT EPISODE OR CURRENT MIXED IN FULL REMISSION
2967	BIPOLAR I DISORD MOST RECENT EPISODE OR CURRENT UNSPECIFIED
2968	MANIC DEPRESSIVE PSYCHOSIS OTHER OR UNSP
29680	BIPOLAR DISORDER UNSPECIFIED
29681	ATYPICAL MANIC DISORDER
29682	ATYPICAL DEPRESSIVE DISORDER
29689	OTHER AND UNSPECIFIED BIPOLAR DISORDERS OTHER
2969	AFFECTIVE PSYCHOSES OTHER OR UNSPECIFIED
29690	UNSPECIFIED EPISODIC MOOD DISORDER
29699	OTHER SPECIFIED EPISODIC MOOD DISORDER
297	PARANOID STATES

Mental Health Care (Outpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis (cont.)

Diagnosis Code	DESCRIPTION
2970	PARANOID STATE SIMPLE
2971	DELUSIONAL DISORDER
2972	PARANOID STATE MENOPAUSAL OR INVOLUTIONA
2973	SHARED PSYCHOTIC DISORDER
2978	OTHER SPECIFIED PARANOID STATE
2979	UNSPECIFIED PARANOID STATE OR DISORDER
298	OTHER NONORGANIC PSYCHOSES
2980	DEPRESSIVE TYPE PSYCHOSIS
2981	PSYCHOSIS EXCITATIVE TYPE
2982	CONFUSION REACTIVE OR PSYCHOGENIC
2983	ACUTE PARANOID REACTION
2984	PSYCHOGENIC PARANOID PSYCHOSIS
2988	REACTIVE OR PSYCHOGENIC PSYCHOSIS UNSPEC
2989	ATYPICAL OR UNSP PSYCHOSIS PSYCHOSIS NOS
299	PSYCHOSES W ORIGIN SPECIFIC TO CHILDHOOD
2990	INFANTILE AUTISM CHILDHOOD AUTISM
29900	AUTISM DISORDER CURRENT OR ACTIVE STATE
29901	AUTISTIC DISORDER RESIDUAL STATE
2991	INFANTILE PSYCHOSIS HELLERS SYNDROME
29910	CHILDHOOD DISINTEGRATIVE DISORDER CURRENT OR ACTIVE STATE
29911	CHILDHOOD DISINTEGRATIVE DISORDER RESIDUAL STATE
2998	OTHER SPEC EARLY CHILDHOOD PSYCHOSIS
29980	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS CURRENT OR ACTIVE STATE
29981	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS RESIDUAL STATE
2999	UNSPECIFIED CHILDHOOD PSYCHOSIS
29990	UNSPECIFIED PERVASIVE DEVELOPMENTAL DISORDER CURRENT OR ACTIVE STATE
29991	UNSPECIFIED PERVASIVE DEVELOPMENTAL DISORDER RESIDUAL STATE
30001	PANIC DISORDER WITHOUT AGORAPHOBIA
30021	AGORAPHOBIA WITH PANIC DISORDER
3003	OBSESSIVE COMPULSIVE NEUROSIS REACTION
30981	POST TRAUMATIC STRESS DISORDER
307.51	BULIMIA NERVOSA
307.1	ANOREXIA NERVOSA

Monoclonal Antibody Imaging

Benefit: This diagnostic test, also known as radioimmunoscintigraphy, uses radiolabeled antibodies directed against specific tumor cell markers. The labeled antibodies are injected and the member undergoes imaging 2-7 days later. The antibodies are expected to localize in metastatic areas. This test is available only for some cancers.

Interpretation: The FDA has approved the following antibody imaging agents:

1. Indium-III capromab pendetide (Prostascint[®]) for imaging of pelvic lymph nodes newly diagnosed members with biopsy-proven prostate cancer, or in post-prostatectomy members in whom there is a high clinical suspicion of occult metastatic disease.
2. Indium-III Pentetreotide (Octreoscan[®]) for use in localization of primary and metastatic neuroendocrine tumors bearing somatostatin receptors.
3. Indium-III satumamab pendetide (CYT-103, OncoScint CR/OV[®]) for imaging of colorectal and ovarian carcinomas
4. Technetium-99m arcitumomab (IMMU-4, CEA-Scan[®]) for imaging of colorectal and ovarian carcinomas
5. Technetium-99m nofetumomab merpentan (Verluma[®]) for imaging in members who have biopsy-proven small cell lung carcinoma, but who have received no treatment.

Monoclonal antibody imaging using agents 3 or 4 may be in benefit for members with known or suspected recurrent colorectal carcinoma under the following conditions:

- An elevated CEA with no evidence of disease on conventional imaging modalities, including CT scan, for whom second-look laparotomy would otherwise be performed, OR
- An isolated, potentially resectable recurrence; the detection of occult lesions would alter surgical management plans.

Monoclonal antibody imaging using agent 2 may be eligible for coverage for the localization of primary and metastatic neuroendocrine tumors bearing somatostatin receptors (i.e. pheochromocytoma).

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes.

Paid by: IPA

Nerve Stimulators (Percutaneous, Transcutaneous, Implanted)

Benefit: Benefits for percutaneous and implanted nerve stimulators are provided when used for chronic intractable pain. Electrical nerve stimulators are covered as Durable Medical Equipment.

Interpretation: Benefits are available according to the following guidelines:

1. Rental of the transcutaneous stimulator permits the physician to study the effects and benefits of, and member compliance with the device. Purchase should occur only if chronic or long-term pain is present and efficacy has been proven.
2. Benefits are provided for implantation of the electrical nerve stimulator, as well as for the purchase of the device (Durable Medical Equipment).

Paid by:	Physician charges:	IPA
	Facility charges:	HMO
	Equipment charges:	HMO

Coverage Variation: Benefit Plan DIRPY: (Rental and purchase) Excluded

Neuromuscular Stimulation for Scoliosis

Benefit: The use of surface neuromuscular stimulation in the treatment of scoliosis is a covered benefit if the PCP determines medical necessity.

Interpretation: Neuromuscular stimulation is used to halt or reverse spinal curvature in idiopathic scoliosis. Surface stimulation using FDA approved single channel device for progressive scoliosis in pediatric and adolescent members with at least 15 degrees curvature is accepted medical practice.

Paid by: **Equipment charges: HMO**
 Professional charges: IPA

Coverage Variation: Benefit Plan DIRPY: Excluded

Nutritional Services (Dietary Counseling)

Benefit: Nutritional services, or dietary counseling, in the treatment of disease, injury or congenital abnormality, are covered

Interpretation: Nutritional services should part of a total treatment plan. Nutritional services can be broken down into three categories:

- **Medical need** - Nutritional services for the resolution or maintenance care of a condition resulting from a disease, injury, surgery, congenital or genetic abnormality or eating disorders are covered. Examples include: special diets for hypertensive and cardiac members; newly diagnosed diabetic members; post-gastro-intestinal surgery members; individuals with celiac disease or other malabsorption syndromes; anorexics, bulimics. These members should be referred to a nutrition professional (physician, nurse, or registered dietitian) at the discretion of the Primary Care Physician. The number of visits should be based on medical necessity.
- **Obesity** - Because obese members are at higher risk for other disorders (cardiovascular disease, diabetes, back problems, gynecological disorders, etc.) they are candidates for nutritional counseling. The Primary Care Physician, who determines the number of visits, should refer these members to a nutrition professional. Members may be advised to attend Weight Watchers, TOPS, or other non-medical weight-loss programs. However, if the member is given a formal referral, the IPA becomes responsible for any charges.
- **Preventive nutritional counseling** - General nutritional counseling is normal member education which is done as part of a physical examination or routine visit. This counseling can be done by the doctor or by nursing staff. The IPA may charge for member-driven referral to other dietary personnel if there is no special medical need, but the member must be informed prior to receiving these services.

Paid by:	Outpatient professional charges:	IPA
	Inpatient professional charges:	IPA
	Inpatient facility charges:	HMO

Note: See related benefits interpretations on Obesity and Diabetes Self-Management

Obesity

Benefit: Benefits are available for treatment of obesity in certain clinical situations.

Interpretation: Obesity is caused by caloric intake persistently higher than caloric utilization. Obesity itself is not an illness. However, it may be caused by illnesses such as hypothyroidism, Cushing's disease, and hypothalamic lesions. Obesity can also aggravate a number of cardiac and respiratory diseases, diabetes, and hypertension.

Morbid obesity (or "clinically severe obesity") is a condition of persistent and uncontrollable weight maintenance or gain that constitutes a present or potential serious health risk. The member has a Body Mass Index (BMI) of at least 40, or 35 with at least two comorbidities (Hypertension, Dyslipidemia, Diabetes Mellitus, Coronary heart disease, and/or Sleep apnea).

Medical Treatment

Medical management of obesity is in benefit except for the cost of food supplements.

Surgical Treatment

Surgical treatment of obesity is in benefit if the PCP determines medical necessity. It is generally reserved for morbid obesity.

Surgical procedures in benefit include, but are not limited to:

- Gastric bypass using a Roux-en-Y anastomosis (short limb up to 100cm, open or laparoscopic)
- Vertical banded gastroplasty (open or laparoscopic)
- Adjustable gastric banding (adjustable Lap-Band®) performed laparoscopically or open and consisting of an external adjustable band placed high around the stomach creating a small pouch and a small stoma.
- Repeat bariatric surgery, if deemed medically necessary by the PCP.

Removal of the Gallbladder at the time of an Approved Gastric Bypass Surgical Procedure

Coverage is allowed for gallbladder removal at the time of a covered gastric bypass surgical procedure, either for documented gallbladder disease or for prophylaxis.

Paid by: Physician charges: **IPA**
Facility charges: **HMO**

Note: See related benefits interpretation on Nutritional Supplements

Obstructive Sleep Apnea (OSA) Syndrome

Benefit: Medical and surgical treatments for obstructive sleep apnea syndrome are in benefit.

Interpretation: Obstructive Sleep Apnea (OSA) syndrome consists of a collection of symptoms including daytime sleepiness, fatigue, snoring, and restless sleep with a disrupted sleep pattern. Significantly disrupted sleep patterns are associated with such physiologic findings as oxygen (O₂) desaturation or cardiac arrhythmia.

Apnea is cessation of breathing and can be:

1. Obstructive: Air flow ceases but respiratory effort continues
2. Central: Cessation of respiratory effort without evidence of airway obstruction
3. Mixed: Cessation of both air flow and respiratory effort

Sleep apnea is best evaluated in a sleep study lab designed specifically to measure various body functions as the member sleeps. Such a lab should be able to measure and record:

- Muscle and eye movements
- Airway flow
- EKG
- Chest movements
- Blood oxygen concentrations (oximetry)
- Leg movements
- Snoring sounds

Collectively these sleep studies are called polysomnography, which is in benefit.

Limited polysomnograms, done in the member's home, are appropriate only for follow-up evaluations.

A member with OSA syndrome will have more than one of the following. Only a rare member will have all findings in a single sleep session.

- Apnea episodes extending for at least 20 seconds each
- 5 or more apnea episodes per hour
- Oxygen saturation below 90% during at least some of the apnea episodes
- Potential life threatening cardiac arrhythmias associated with the apnea episodes

Obstructive Sleep Apnea (OSA) Syndrome (cont.)

Medical and surgical treatments for OSA are in benefit. Medical treatment may include the following:

- Weight loss - Many members with OSA are obese. Weight loss is the appropriate initial treatment for any such member.
- Thornton Adjustable Positioner (TAP) retainers – These are made by a dentist to place in the mouth at night to sleep instead of using a c pap machine.
- Positive Airway Pressure (PAP) Devices - These devices, including medically necessary accessories, are covered as DME. They have multiple clinical indications, and currently constitute the major treatment modality for any OSA member with reversible airway obstruction. These devices supply air under pressure through a tight fitting mask to overcome obstruction. These devices can be classified as:
 - Continuous (CPAP) devices. These provide constant air pressure levels.
 - Bi-Level (BIPAP) devices provide two levels of pressure alternately.
 - Demand (DPAP) devices continuously alter pressure in response to member's own breathing cycle.

Surgical treatments include any procedure designed to remove or correct any identifiable airway obstruction. Such procedures can include:

- Tracheostomy - This "gold standard" treatment has poor member acceptance.
- Tonsillectomy and adenoidectomy
- Uvulopalatopharyngoplasty (UPPP) when there is clear documentation of pharyngeal narrowing.
- Mandibular and maxillary advancement procedures for members who fail to respond to UPPP.

Laser-Assisted Uvulopalatoplasty (LAUP) is sometimes recommended as a treatment of OSA, but more often to correct snoring. (Treatment of snoring alone, without evidence of OSA, would not be in benefit as this is a social rather than a medical issue.) OSA treatment by LAUP should be recommended with caution. Some sleep disorder and otolaryngologic literature suggests that LAUP improves only the snoring component of OSA without improving clinical outcomes related to more serious adverse physiologic findings. However, if the PCP recommends this service, it would be in benefit.

Paid by:	Physician charges:	IPA
	Diagnostic Testing	IPA
	Facility charges (outpatient diagnostic testing or medical treatment)	IPA
	Facility charges (outpatient surgical or inpatient)	HMO
	Device charges (from contracted provider):	HMO
	Device charges (from a non-contracted provider):	IPA

Benefit variation: Benefit Plan DIRPY- excluded

Occupational Therapy

Benefit: Occupational therapy is covered, when an IPA physician determines that such therapy is expected to result in significant improvement within two months in the condition for which it is rendered. Anticipation of significant member improvement, not necessarily complete recovery, meets the criteria.

Interpretation: Occupational therapy is constructive therapeutic activity designed and adapted to promote restoration of useful physical function.

Treatment may include:

- Initial evaluation
- Exercises to increase range of motion
- Graded exercises to increase muscle strength
- Exercises and functional activities to improve coordination
- Exercises to upgrade physical tolerance
- Training in all areas of activities of daily living.

Sometimes, a trial of therapy may be helpful in determining whether or not ongoing occupational therapy is appropriate.

The IPA physician's expectation that a member will improve within 60 days is the key to determining whether or not services are in benefit. **Referrals for therapy services should not be denied unless there is documentation that the PCP does not anticipate significant improvement within 60 days.**

Not in benefit:

- Occupational therapy for social or psychological well-being or recreation
- Homemaking evaluation and training
- Work simplification training
- Vocational training
- Family consultation
- Home visits to assess the home situation

Most benefit plans have a maximum number of treatments that are in benefit for outpatient rehabilitation therapies (Speech Therapy, Physical Therapy and Occupational Therapy combined.) See HMO Benefit Matrix to confirm the extent of therapy benefits.

Outpatient rehabilitative therapy visits should be counted as follows: A single date of service by the same provider will be counted as one treatment/visit for the calculation of the outpatient therapy maximum. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided.

Paid by:	Professional charges:	IPA
	Facility charges (inpatient):	HMO
	Home Health charges: (if services given to homebound member)	HMO
	Outpatient facility charges:	IPA

Note: See related benefits interpretations on Day Rehabilitation, Home Health Services

Oral Surgery

Benefit: Surgical procedures to address certain conditions of the jaws, cheeks, lips, tongue, roof or floor of the mouth. These include congenital deformities and conditions resulting from injury, tumors or cysts, disease, or previous therapeutic processes. A PCP referral is required for all services.

Interpretation: Benefits include:

- Consultation by an oral surgeon or appropriate specialist. Included with this would be the cost of x-rays or other diagnostic tests performed in conjunction with given evaluation.
- Covered procedures include:
 - Surgical removal of completely-bony-impacted teeth.
 - Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth.
 - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
 - Treatment of fractures of the facial bones.
 - External incision and drainage of abscesses or cellulitis.
 - Incision or excision of accessory sinuses, salivary glands or ducts;
 - Surgical procedures to address congenital deformities and conditions resulting from disease or previous therapeutic processes affecting the jaws, cheeks, lips, tongue, roof or floor of the mouth.
 - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth.
 - Surgical treatment of accidental injuries to any teeth which had an intact root or were part of a permanent bridge, prior to the injury. This particular benefit covers complete restoration of the injured teeth.
- Implants to support a dental prosthesis when an integral part of treatment for conditions as described above. Any abutment or dental prosthesis resting on these implants is not covered, except to replace a tooth that had originally been injured, as described above.
- Facility and anesthesia fees, for treatment of conditions described above.
- Durable medical equipment or prosthetic appliances such as obturators or surgical splints are covered, when an integral part of treatment for conditions described above.

Oral Surgery (cont.)

- Exclusions:**
- With the exception of accidental injury of the teeth, services for conditions that are of dental origin. Conditions of dental origin include, but are not limited to, those resulting from tooth decay or inflammation of the gums.
 - Services for conditions resulting from misadventures while eating (i.e. tooth breaks while biting into a hard substance).
 - Services for conditions resulting from injuries that are not substantiated with concurrent medical or dental records.
 - Oral surgery performed for cosmetic purposes. This does not include reconstructive surgery. (See benefit interpretation on Cosmetic/Reconstructive Surgery.)
 - Repair or replacement of damaged removable appliances.
 - Services for conditions resultant from atrophy of the jaw or maxilla.
 - Preprosthetic surgery, to prepare the mouth and jaw for dentures or other appliances, is not covered unless it is part of an otherwise covered service.
 - Dentures and related services.
 - Implants, oral durable medical equipment, prosthetic appliances, and related services and supplies, except as described above.

Paid by: **All oral surgery procedures except extraction of completely-bony-impacted teeth:**

Professional Charges:	IPA
Facility charges:	HMO
Outpatient facility charges:	See Outpatient Surgery
Anesthesia (IV sedation or general) when determined to be medically necessary	HMO

Extraction of completely-bony-impacted teeth:

Professional charges:	HMO
Facility charges:	HMO
Outpatient facility charges:	HMO
Anesthesia (IV sedation or general) when determined to be medically necessary	HMO

Note: See related benefits interpretations on Cosmetic/Reconstructive Surgery, Dental, Orthognathic Surgery, Temporomandibular Joint Disorder, and Orthodontics

Organ and Tissue Transplantation

Benefit: Organ and tissue transplants as listed below are in benefit when ordered by the Primary Care Physician and when performed at a Blue Cross and Blue Shield of Illinois approved transplant center.

The following organs and tissues are in benefit for transplant:

- Bone marrow
- Cornea
- Heart
- Liver
- Lung
- Kidney
- Isolated pancreas and simultaneous pancreas/kidney

Notification and Authorization Process:

1. The IPA will initiate the approval process by contacting the Medical Management (MM) Medical Support Analyst who will verify contracting transplant facilities. A list is also included at the end of this section, but should be verified prior to sending the member to a facility as information can change.
2. The PCP sends a referral to the contracting transplant facility to initiate evaluation of the member.
3. If the member is accepted as a transplant candidate, the IPA will send to the Medical Support Analyst the following information via fax (312-938-4682):
 - Copy of the referral
 - Member's diagnosis, type of transplant, medical history
 - Letter from PCP indicating his/her approval
 - Letter from the transplant facility confirming the member's transplant candidate status

Note: If a member changes IPAs during the transplant workup or follow up care period, the new IPA will need to generate a new referral to the existing transplant facility. This referral should be faxed to the Medical Support Analyst. A new authorization request does not need to be initiated unless the transplant facility will be changing.

Note: If a member needs a second transplant, a new authorization request will need to be done.

4. The Medical Support Analyst will generate a letter to the IPA notifying them of the determination with copies to the HMO Nurse Liaison and FSU (Full Service Unit) via e-mail or fax. The usual turn-around time frame for all transplant approval letters is 2-4 business days provided all necessary documentation has been received.

The IPA is responsible for notifying the member within 15 days of the transplant approval from the HMO as per the IPA's member notification process. Examples of this process can include, but is not limited to: via a letter from the IPA, notification from the PCP, contact from the UM department, notification via a referral, etc. The IPA is also responsible for notifying the transplant facility of the approval.

5. The Medical Support Analyst will generate and send a monthly internal report listing all HMO transplant determinations to BCBSIL contacts. The FSU will enter the member's information into the organ transplant database, and follow the BCBSIL Concierge Customer Service Program Protocol. This includes, but is not limited to: contacting the member after the approval, ensuring the member is aware of the approval, a discussion of how to address any claim issues to BCBSIL, and monitoring the claim file for the member.

Organ and Tissue Transplantation (cont.)

Interpretation: Organ transplantation is a non-capitated service.

The IPA is expected to continue to perform Utilization/Referral and Case Management for both organ transplant related care and routine/unrelated medical needs. The IPA also remains responsible for care and payment (according to the terms of the Medical Service Agreement) of underlying medical conditions that led to the need for the transplant – one example of this is dialysis for a kidney transplant candidate. If the member is not accepted as a transplant candidate, the evaluation fees are the financial responsibility of the IPA.

Once the HMO has approved the transplant, these services are in benefit and are the financial responsibility of the HMO:

- Diagnostic workup performed by the designated transplant facility, whether or not the transplant ever takes place.
- The evaluation, preparation, removal and delivery of the donor organ, tissue, or marrow.
- (Lung) Lobar transplantation from a living related donor or a deceased matched donor is in benefit to treat a child or adolescent who has been approved for a lung transplant, but a complete lung has not become available.
- All inpatient and outpatient covered services related to the transplant surgery
- All follow up care directly related to the transplant within 365 days of the transplant.
- Transportation of the donor organ to the location of the transplant Surgery, limited to transportation in the United States or Canada.
- Donor screening and identification costs under approved matched unrelated donor programs.
- Benefits will be provided for both the recipient of the organ or tissue and the donor subject to the following rules:
 - If both the donor and recipient have coverage with the Plan, each will have his/her benefits paid by his or her own program.
 - If the member is the recipient and the donor does not have coverage from any other source, the member and donor's care are in benefit.
 - If the member is the donor and coverage is not available from any other source, the member's care is in benefit. However, benefits will not be provided for the recipient.
- Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant has been approved, and the member is the recipient of the transplant, benefits will be provided for transportation, lodging and meals for the member and a companion. If the recipient of the transplant is a dependent child, benefits for transportation, lodging, meals will be provided for the transplant recipient and two companions.

For benefits to be available, the member's place of residency must be more than 50 miles from the Hospital where the transplant will be performed. The member and the companion are each entitled to benefits for lodging and meals up to a combined maximum of \$200 per day. Benefits for transportation, lodging and meals are limited to a maximum of \$10,000 per transplant.

Organ and Tissue Transplantation (cont.)

These services are not in benefit:

- Organ transplant, and/or services or supplies rendered in connection with an organ transplant, which are investigational as determined by the appropriate technological body. One example of this is an islet cell (related to the pancreas) transplantation.
- Drugs which are Investigational
- Storage fees
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provisions.
- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for heart transplant surgery.
- Travel time or related expenses incurred by a Provider

Paid by: **HMO (when prior authorization from the HMO has been obtained)**
 IPA (if prior authorization from the HMO has not been obtained)
 IPA (if member is not accepted as a transplant candidate)

Claim Submission Notes:

- The HMO will reimburse the IPA directly, or at the IPA's discretion – pay the provider directly.
 - If the IPA is requesting reimbursement: The claim should be stamped group approved and submitted with a Catastrophic Claim Form.
 - If the IPA is requesting that the provider be paid directly: The claim should be stamped group approved, and "transplant – catastrophic claim" should be indicated directly on the claim
- Pre-transplant Evaluation related claims should be stamped group approved and "Pre-transplant Evaluation" should be indicated directly on the claims. These claims cannot be submitted prior to the HMO approving the transplant.
- Donor claims should be stamped group approved and "Transplant Donor Claim with the HMO recipient's name and identification number" should be indicated directly on the claim.

Organ and Tissue Transplantation (cont.)

Note: For Bone Marrow, Kidney or Cornea transplants, HMO member may go to any contracted facility in the state of Illinois, or in neighboring states if the facility is in a county immediately adjacent to the Illinois border.

Note: the BCBSIL HMO Plan Network is under development at this time for isolated pancreas transplants (not simultaneous Pancreas/Kidney transplant). Please contact the Medical Support Analyst for current information if patient is considered for isolated pancreas transplant evaluation.

BCBSIL HMO Plan Approved Centers For Human Organ Transplantation

Illinois Centers

Children's Memorial Hospital	Heart (Pediatric)	Chicago
Children's Memorial Hospital	Liver (Pediatric)	Chicago
Loyola Univ. Medical Center	Heart (Adult)	Maywood
Loyola Univ. Medical Center	Lung (Adult)	Maywood
Northwestern Memorial Hospital	Pancreas/Kidney (Adult SPK**)	Chicago
Northwestern Memorial Hospital	Liver (Adult)	Chicago
Northwestern Memorial Hospital	Heart (Adult)	Chicago
University of Chicago	Heart (Adult)	Chicago
University of Chicago	Pancreas/Kidney (Adult SPK**)	Chicago
University of Illinois Medical Center	Liver (Adult)	Chicago
University of Illinois Medical Center	Liver/Kidney (Adult)	Chicago

Border State Centers

Children's Hospital of Michigan	Heart (Pediatric)	Detroit, Michigan
Children's Hospital of Wisconsin	Bone Marrow Transplant (Pediatric)	Milwaukee, Wisconsin
Clarian Health Partners (Riley's)	Heart (Pediatric)	Indianapolis, Indiana
Froedtert Memorial Lutheran Hosp.	Liver (Adult)	Milwaukee, Wisconsin
Froedtert Memorial Lutheran Hosp.	Pancreas/Kidney (Adult SPK**)	Milwaukee, Wisconsin
Henry Ford Hospital	Liver (Adult)	Detroit, Michigan
Indiana University Hospital	Liver (Adult)	Indianapolis, Indiana
Jewish Hospital	Heart (Adult)	Louisville, Kentucky
Methodist Hospital	Heart (Adult)	Indianapolis, Indiana
Methodist Hospital	Lung (Adult, single or double)	Indianapolis, Indiana
St. Louis Children's Hospital	Heart (Pediatric)	St. Louis, Missouri
St. Louis Children's Hospital	Heart – Bilat. Lung Combination (Pediatric)	St. Louis, Missouri
St. Louis Children's Hospital	Liver (Pediatric)	St. Louis, Missouri
St. Louis Children's Hospital	Lung (Pediatric)	St. Louis, Missouri
University of Michigan	Liver (Pediatric)	Ann Arbor, Michigan
University of Michigan	Lung (Adult, single or double)	Ann Arbor, Michigan
University of Michigan	Heart (Adult)	Ann Arbor, Michigan
University of Wisconsin	Pancreas/Kidney (Adult SPK-PTA-PAK***)	Madison, Wisconsin
University of Wisconsin	Liver (Adult)	Madison, Wisconsin

**Adult Simultaneous Pancreas Kidney

***Adult Simultaneous Pancreas Kidney—Pancreas Transplant Alone—Pancreas After Kidney—Kidney only (in conjunction with SPK)

Orthodontics

Benefit: Orthodontic prostheses and related services and supplies are not in benefit, with certain exceptions. A PCP referral is necessary for all items.

Interpretation: Orthodontic prostheses and related services and supplies are covered under the following limited circumstances:

- Treatment of teeth that have been injured in an accident. The tooth had to have had an intact root or been part of a permanent bridge, prior to the injury. Only the portion of the orthodontic prosthesis directly supporting the affected tooth is covered.
- Treatment that is an integral part of the surgical correction of congenital deformities or conditions resulting from tumors or cysts, disease, or previous therapeutic processes.
- Repair or replacement of damaged orthodontic prostheses which were originally covered. Repair and/or replacement necessitated by abuse or neglect on the part of the member is not covered.

Exclusions:

- Treatment of developmental conditions, such as developmental tooth malalignment or temporomandibular joint disorder (TMD).
- With the exception of accidental injury of the teeth, services for conditions that are of dental origin. Conditions of dental origin include, but are not limited to, those resulting from tooth decay or inflammation of the gums.
- Services for conditions resulting from misadventures while eating (i.e. tooth breaks while biting into a hard substance).
- Services for conditions resulting from injuries that are not substantiated with concurrent medical or dental records.
- Treatment for cosmetic purposes. This does not include reconstructive treatment. (See benefit interpretation on Cosmetic/Reconstructive Surgery.)
- Services for conditions resultant from atrophy of the jaw or maxilla.
- Dentures and related services.

Treatment for any conditions not listed as covered above.

Paid by:

Covered services:	
Professional Charges:	IPA
Facility charges:	HMO
Outpatient facility charges:	See Outpatient Surgery
Anesthesia (IV sedation or general) when determined to be medically necessary	HMO
 Non-covered services:	
All charges:	Member

Orthognathic Surgery

Benefit: Orthognathic surgery addresses mandibular and maxillary deformities or defects that prevent effective functional relationships between osseous, muscular, dental and contiguous structures. Such surgery may be covered if the member's general health is affected, if he/she has difficulty living normally because of the orofacial condition, or if he/she needs to take medication frequently to treat pain related to the deformity.

Interpretation: Gross defects in the facial skeleton may cause disharmony in jaw relationships. These deformities may be genetic or acquired. Abnormalities of jaw-to-face size and shape may include excessive or deficient bone-to-bone, tooth-to-bone and bone-to-soft tissue relations. These may include but are not limited to:

- Prognathia, retrognathia, micrognathia, apertognathia;
- Retrusion of maxilla, protrusion of mandible;
- Hypoplasia, hyperplasia or asymmetry of the maxilla and/or mandible or parts thereof;
- Agenesis or ankylosis of the temporomandibular joint, as well as condylar abnormalities and aberrations of the coronoid process;
- Paget's disease, acromegaly.

The treatment plan usually includes the following steps:

1. Consultation - The Primary Care Physician (PCP) refers for consultative and diagnostic services. The PCP should document the member's chief complaint and any comorbidity to support medical necessity. The PCP should refer the member to a general dentist, an oral maxillofacial surgeon, an orthodontist, and/or other physician as appropriate.
2. Diagnostic Work-up - Facial skeletal deformities may be identified and measured by:
 - Clinical examination
 - Intraoral plaster study casts
 - Cephalometric radiographs & analysis
 - Oral and facial photographs
3. Absolute medical criteria justifying surgical intervention include but may not be limited to, one or more of the following:
 - Significant symptoms refractory to conservative treatment
 - Serious comorbidity which can only be resolved surgically
 - Chronic severe pain requiring frequent medication.
 - Documented speech or occupational dysfunction
 - Documented psychological impairment.
 - Documented serious nutritional deficiencies as a result of the deformity.
4. Second Opinion: If there are questions about the course of treatment, or use of one surgical procedure over another, a second opinion from another oral maxillofacial surgeon and/or appropriate health professional should be obtained. The opinion of a Board Certified Orthodontic specialist may be particularly useful.
5. If the PCP and consultant(s) agree that orthognathic surgery is clinically indicated, the surgery should be authorized.
6. Exclusions: Orthodontic and/or prosthodontic services of a dentist are excluded, including pre-surgical services.

Orthognathic Surgery (cont.)

Paid by:	Professional Charges (including oral surgery):	IPA
	Anesthesia Services:	IPA
	Facility Charges:	HMO
	Orthodontic and/or prosthodontic services	Member

Note: See related benefits interpretations on Dental, Oral Surgery, Temporomandibular Joint Disorder, Orthodontics

Orthotic Devices

Benefit: Prescription orthotic devices used to alleviate or correct a condition arising from illness or injury are covered. Adjustments and repair of the device(s) are covered.

Interpretation: An orthotic device is a rigid or semi-rigid supportive device that assists body function by restricting or eliminating motion of a weak or diseased body member.

The following orthotic devices are covered when medically necessary and prescribed by an IPA physician:

- Braces (leg, arm, neck, back, and shoulder)
- Corsets (back and special surgical corsets)
- Splints (extremity)
- Trusses (including Sykes hernia control device)
- Prescription, custom foot orthotics (see below)
- Oral orthotics (see benefits interpretation on Temporomandibular Disorder)
- Prescription helmets following cranial surgery

Foot orthotics are in a special category, and include orthopedic foot appliances, inlays, or transferable shoe inserts. Wedges, elevations, pockets and other corrections can be incorporated into the orthotic to treat many foot ailments. Prescription foot orthotics or splints are those which are custom-made for the member. Custom-made prescription foot orthotics are covered if determined to be medically necessary by an IPA physician.

Stock foot orthotics which are pre-formed, available in standard sizes and not custom made for the member are not in benefit. These include arch supports, orthotic splints, shoe inserts and other foot support devices. Regular orthopedic and diabetic shoes (including custom made) are not in benefit. Orthopedic shoes that are an integral part of a leg brace are in benefit.

Coverage for prescription orthotics includes the following services:

- Orthopedic, podiatric, or other professional examinations
- Impressions, casts and imprints
- Models
- Range of motion studies
- Visits for casting (impressions), dispensing and "checkup" after the orthotic is dispensed
- Use of Electrodynogram (EDG) to evaluate orthotic

If the IPA uses a non-contracting provider, the member can not be held responsible for the cost of the equipment. The HMO will reject the claim and the IPA is liable for the cost of the equipment.

Paid by:	Physician/professional/supply charges including "L" code list on next page:	IPA
	Equipment charges (from a contracted provider):	HMO
	Equipment charges (from a non-contracting provider):	IPA

Coverage Variation: Benefit Plan DIRPY: All EXCLUDED

Note: See related benefits interpretations on DME, Medical Supplies, and Prosthetics

Orthotic Devices (cont.)

The following codes are examples of those that are considered off the shelf and do not require the skills of an orthotist or prosthetist to fit. Professional Claims that contain L codes will be the responsibility of the IPA; IPA providers should not bill L codes except for off the shelf items. The IPA may not send split risk claims to the HMO to pay for services billed by IPA physicians.

Code	Description
L0120	Cervical, flexible, nonadjustable (foam collar)
L1830	KO, immobilizer, canvas longitudinal prefabricated, includes fitting & adjustment
L1902	AFO, ankle gauntlet, prefabricated, includes fitting & adjustment
L1906	AFO, multiligamentous ankle support, prefabricated, includes fitting & adjustment
L3000	Foot insert, removable, molded to patient model, UCB type, Berkeley Shell, each
L3001	Foot insert, removable, molded to patient model, Spenco, each
L3003	Foot insert, removable, molded to patient model, silicone gel, each
L3010	Foot insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each
L3030	Foot insert, removable, formed to patient foot, each
L3040	Foot, arch support, removable, premolded, longitudinal, each
L3050	Foot, arch support, removable, premolded, metatarsal, each
L3060	Foot, arch support, removable, premolded, longitudinal/metatarsal, each
L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur
L3660	SO, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting & adjustment
L3670	SO, acromio/clavicular (canvas & webbing type), prefabricated, includes fitting & adjustment
L3908	WHO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting & adjustment
L4350	Ankle Control Orthosis, Stirrup Style, Rigid, Includes Any Type Interface(E.G., Pneumatic, Gel), Prefabricated, Includes fitting & adjustment
L4360	Walking boot (e.g. air cast), pneumatic, with or without joints; includes fitting & Adjustment
L4386	Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting & adjustment
L4396	Static or dynamic AFO, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, includes fitting & adjustment

2010 Deleted Codes previously on list:

Code	Description
L0210	Thoracic, rib belt
L1825	KO, elastic knee cap, prefabricated, includes fitting and adjustment
L3700	EO, elastic with stays, prefabricated, includes fitting and adjustment
L3701	Elbow orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)
L3909	WO, elastic, prefabricated, includes fitting and adjustment
L3911	Wrist hand finger orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

Outpatient Surgery

Benefit: Outpatient surgery is covered in full if it is medically necessary and an IPA physician refers the member for surgery.

Interpretation: IPA physicians should perform necessary surgery on an outpatient basis whenever possible. Many minor procedures can be done in the office setting.

The HMO will pay group-approved hospital or ambulatory surgical facility fees.

The anesthesiologist or anesthesiologist's charges are the responsibility of the IPA.

If the hospital or ambulatory surgical facility bills preoperative ancillary services, (such as x-ray and laboratory procedures) as part of the facility charges, the HMO will pay for these services.

If the laboratory or x-ray procedures are performed on an outpatient basis, as part of, or in anticipation of an outpatient surgical procedure, these services are the capitated responsibility of the IPA. However, under the Pre-Admission Testing Arrangement, an IPA may be reimbursed for these. Refer to the Medical Service Agreement.

The Medical Service Agreement should be consulted for chargebacks to the Utilization Management Fund.

Paid by: Physician/Professional Charges: **IPA**
Hospital/Ambulatory Facility Charges: **HMO (see above)**

Oxygen

Benefit: Oxygen and oxygen supplies are covered in full when the member has a medical condition for which an IPA physician recommends and orders oxygen.

Interpretation: Oxygen and oxygen supplies furnished to a member in the home setting are covered as Durable Medical Equipment.

Receipts for the oxygen and equipment should be accompanied by a statement by the IPA physician as to the diagnosis, oxygen flow rate, frequency of use, method of delivery and duration of use.

Covered oxygen and supplies include:

- Portable oxygen and systems
- Mask or nasal cannula
- Nebulizer (ultrasonic)
- Oxygen gauge
- Oxygen humidifier
- Oxygen tent
- Oxygen tubing
- Oxygen tanks
- Oxygen stands

Benefits are **not** available for:

- Topical oxygen therapy to treat decubitus ulcers
- Installation of respiratory support systems
- Back-up respirators or ventilators

Paid by: HMO, which reimburses the member

Coverage Variation: Benefit Plan DIRPY: Excluded

Note: See related benefits interpretation on Durable Medical Equipment

Pain Management Programs

Benefit: A formal pain management program is in benefit if the PCP refers the member for this service.

Interpretation: Chronic pain syndromes can be refractory to standard management. Such pain can be addressed in a coordinated, multidisciplinary pain management program that may be either inpatient or outpatient.

Inpatient: A short hospital (or institutional) stay may be required for a member needing an intense pain rehabilitation program that includes a multidisciplinary coordinated team approach. Such a member typically will have failed all attempts at treatment with less intense modalities.

Outpatient: Coordinated, multi-disciplinary outpatient pain rehabilitation programs may be appropriate for members with chronic pain. Outpatient therapy visits in such a program are charged against the cumulative outpatient physical therapy benefit.

Day hospital programs for pain management are addressed in the section on Day Rehabilitation Programs

Paid by: Inpatient facility charges: **HMO**
Outpatient charges: **IPA**
Professional fees: **IPA**

Note: See related benefits interpretation on Day Rehabilitation Programs

Physical Therapy

Benefit: Physical therapy is covered when an IPA physician determines that such therapy is expected to result in significant improvement within two months in the condition for which it is rendered. Anticipation of significant improvement, not necessarily complete recovery, meets the criteria.

Interpretation: Physical therapy is the treatment of disease or injury by physical means, thermal modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part. The therapy must be performed by a physician or by a licensed registered physical therapist upon a physician's order.

Sometimes, a trial of therapy is helpful in determining whether or not ongoing physical therapy is appropriate.

The IPA physician's expectation that a member will improve within 60 days is the key to determining whether or not services are in benefit. Referrals for therapy service should not be denied unless there is documentation that the PCP does not anticipate significant improvement within 60 days.

Physical therapy not expected to result in significant improvement within two months is not in benefit. Range of motion and passive exercises used for paralyzed extremities are not in benefit. General exercise programs, work hardening programs, functional capacity assessment or other therapy services recommended by an employer are not considered in benefit even when recommended by a physician.

In accordance with Illinois State Bill 2917, there is coverage for medically necessary preventative physical therapy for members diagnosed with multiple sclerosis. Coverage must be the same as coverage for any other therapies under the policy. Preventative physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. The coverage is subject to the same copayments and calendar year maximum as provided for other physical therapy benefits covered under the policy.

Most benefit plans have a maximum number of treatments that are in benefit for outpatient rehabilitation therapies (Speech Therapy, Physical Therapy and Occupational Therapy). See HMO Benefit Matrix to confirm the extent of therapy benefits.

Outpatient rehabilitative therapy visits should be counted as follows: A single date of service by the same provider will be counted as one treatment/visit for the calculation of the outpatient therapy maximum. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided.

Paid by:	Professional charges (inpatient/outpatient):	IPA
	Inpatient facility charges:	HMO
	Outpatient facility charges:	IPA
	Home Health charges (for homebound member when provided by a contracted provider):	HMO
	Home Health charges (for ambulatory member or from a non-contracted provider):	IPA

Note: See related benefits interpretation on Day Rehabilitation

Positron Emission Tomography (PET Scan)

Benefit: PET Scans are in benefit for the indications listed below.

Interpretation: Positron Emission Tomography (PET SCAN) is a three-dimensional medical imaging technique that noninvasively measures the concentration of radiopharmaceuticals in the body that are labeled with positron emitters. PET can measure metabolism, blood flow, or other physiological values in vivo. Modern PET systems provide three-dimensional images of the brain, heart, and other organs. PET provides diagnostic information that is not available from any other imaging modality.

Positron Emission Tomography may be an appropriate diagnostic modality for evaluation of the following:

- Epilepsy: To assess patients with seizures who are candidates for surgery.
- Lung cancer: To distinguish between benign and malignant nature of a solitary pulmonary nodule when CT scan and chest x-ray are inconclusive or discordant. Also, as a staging technique for patients in whom a diagnosis of lung cancer is established.
- Melanoma: To assess extranodal spread of melanoma at initial staging or during follow up treatment.
- Lymphomas (all): To stage lymphoma either initially or at follow up.
- Colorectal Cancer: To assess resectability of hepatic or extrahepatic metastatic colorectal cancer.
- Head and Neck Cancer: To identify an unknown primary tumor suspected to be head and neck cancer. Also, to stage cervical lymph nodes to assess resectability of tumor. Also, to detect residual or recurrent disease followed after treatment of head and neck cancer.
- Cardiac: To assess myocardial perfusion/ diagnosis of CAHD. Also, to assess myocardial viability in a patient with severe left ventricular dysfunction in order to determine candidacy for a revascularization procedure.

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes.

Paid by:	Out-patient facility charges:	IPA
	Professional charges:	IPA
	Inpatient Facility charges:	HMO

Podiatry/Podiatric Services

Benefit: Podiatric surgical and non-surgical services are covered benefits if the PCP refers the member for these services. However, routine foot care (such as treatment or removal of corns and calluses) is not covered.

Interpretation: Non-routine foot care, such as diabetic foot care or treatment of infections, is covered. The Primary Care Physician determines whether the member should be seen by a podiatrist or by another specialist, such as an orthopedist or sports medicine physician.

Examples of covered surgical podiatry services include:

- Surgical removal and care of bunions
- Surgical removal of foreign bodies of the foot
- Repair of fractures
- Amputation of digits
- Surgical repair of ingrown toenails

Paid by: Professional charges: **IPA**
Facility charges: **HMO**

Note: See related benefits interpretation on Orthotics

Private Duty Nursing

Benefit: Inpatient and Outpatient Private Duty Nursing service is not covered.

Interpretation: Skilled nursing care in the home setting is covered only under the Home Health Care benefit.

Paid by: Inpatient charges: **Member**
Outpatient charges: **Member**

Prostate Procedures

Benefit: The following prostate procedures are usually undertaken in members with benign prostatic hypertrophy (BPH) or prostate cancer. Transurethral prostate resection (TURP) and various transabdominal prostate resections are long-established procedures. Many other prostate procedures have evolved in recent years.

Interpretation: Balloon dilatation of the prostatic urethra is in benefit for selected members with BPH. It is especially useful if the member has a small but obstructive prostate, is not a candidate for other procedures, and if retrograde ejaculation is particularly undesirable.

Cryosurgery consists of the administration of liquid nitrogen into diseased tissue under ultrasound guidance. It is in benefit for selected members with prostate cancer.

Laser prostatectomy is in benefit as an alternative to TURP for members with any disease for which TURP is indicated.

Transurethral Radiofrequency Needle Ablation (RFNA) via TUNA[®] RFNA device is in benefit for men with BPH, as an alternative to TURP.

Brachytherapy, which is the implantation of radioactive seeds for the treatment of prostate cancer, is in benefit. Seeds are placed under ultrasound, fluoroscopic, and/or computed tomographic guidance.

Transrectal ultrasound is in benefit for a number of indications, including but not limited to screening, diagnosis, cancer staging, and guidance of biopsy sampling and radioactive seed implantation.

Paid by:	Professional Charges:	IPA
	Outpatient Radiation Therapy Charges:	IPA
	Inpatient Facility Charges:	HMO
	Outpatient Surgery Facility Charges	HMO

Prosthetic Devices

Benefit: Prosthetic devices necessary for the alleviation or correction of conditions arising out of illness or injury are covered.

Interpretation: Prosthetic devices are those items used as a replacement or substitute for a missing body part.

Benefits are available for, but not limited to the following devices and appliances:

- Artificial eyes
- Artificial limbs (including harnesses, stump socks, etc.)
- Breast prosthesis (regardless of mastectomy date).
- Mastectomy bras
- Cardiac pacemakers
- Cleft palate devices
- Colostomy and other ostomy accoutrements directly related to ostomy care
- Electronic speech aids (in post-laryngectomy situations)
- Extraocular and intraocular lenses - Extraocular lenses means contact lenses and eyeglass lenses (frames not included). These are in benefit for aphakic post-surgery members (when an intraocular lens is not implanted during surgery). These are also in benefit for members with keratoconus. Intraocular lenses are covered only when replacing the original lens in the eye. For extraocular lenses for these specific conditions – the IPA may refer to provider of their choice. The use of a contracted provider is not required. The member pays for any refraction services.
- Maxillofacial prosthetic devices
- Penile implants and prostheses (for organic causes only)
- Prosthetic ears
- Prosthetic nose
- Shoe(s) **only** when either one or both shoes are an integral part of artificial limb(s)
- Space shoes (used as a substitute device when all of a substantial portion of the forefoot is absent)
- Testicular prosthesis
- Urethral sphincters
- Batteries used to operate eligible artificial devices

Functional adjustments and repair of prosthetics are covered when necessary as long as the device is medically required and meets the stated criteria of eligibility.

Replacement of prosthetic devices is covered when the replacement is necessitated by surgery (such as a pacemaker replacement), growth of the member, accidental destruction of the device, or wear.

Benefits will not be provided for dental appliances or hearing aids, or for replacement of covered cataract lenses unless a prescription change is required. Wigs are not in benefit.

Prosthetic Devices (cont.)

If the IPA uses a non-contracting provider, the member can not be held responsible for the cost of the equipment. The HMO will reject the claim and the IPA is liable for the cost of the equipment.

Paid by:	Physician/professional charges:	IPA
	Device charges (from a contracted provider):	HMO
	Device charges (from a non-contracted provider):	IPA
	Facility charges (if applicable):	HMO

Exclusions: Benefit Plan DIRPY: Orthopedic or external devices such as artificial limbs are excluded.

Note: Eyeglass lenses and contact lenses do not require use of a non-contracted Provider. The IPA may refer the member to a supplier of its choice.

Note: See related benefits interpretation on Vision Screening/Routine Vision Care and Contact Lenses/Eyeglasses for additional information.

Refractive Keratoplasty

Benefit: Refractive Keratoplasty is a generic term encompassing a variety of surgical procedures performed on the cornea to improve vision by changing the refractive capability of the eye.

Interpretation: Radial Keratotomy (RK) or Photorefractive Keratectomy (PRK) is in benefit only for selected members with myopia (nearsightedness). These members have **all** of the following:

- Correction of less than 7.0 diopters for RK or 12.0 diopters for PRK
- Less than 0.5 diopter change within the last year
- Some clinical condition that precludes the use of eyeglasses and contact lenses

Keratomilusis, keratophakia, or epikeratoplasty are in benefit for members:

- Who are aphakic and
- Who cannot have an intraocular lens implant and
- Who are intolerant to contact lenses

These procedures are not in benefit for correction of refractive problems.

The Blue Cross and Blue Shield Association Technology Evaluation Center has determined that all other refractive keratoplasty have no evidence of improved clinical outcomes. **These include but are not limited to laser in-situ keratomileusis (LASIK) and minimally invasive radial keratotomy (mini RK).** The PCP might wish to consider this when deciding whether or not to refer for refractive keratoplasty procedures other than those listed above.

Paid by: Professional charges: **IPA**
Facility charges: **HMO**

Respiratory Therapy (Inhalation Therapy)

Benefit: Respiratory therapy is a covered benefit.

Interpretation: This process consists of treatment of a disease, injury or condition by means of respiratory therapy by or under the supervision of a qualified Respiratory Therapist. It can be provided on an inpatient or outpatient basis.

Respiratory therapy provided by the member or the member's family in the member's home or place of work is excluded.

Some equipment and supplies are covered see Benefits Interpretation for Durable Medical Equipment).

Paid by:	Outpatient charges:	IPA
	Inpatient charges:	HMO

Seat Lift

Benefit: A seat lift for home use is covered as durable medical equipment for selected members.

Interpretation: The seat lift must be medically necessary. Criteria for medical necessity include:

- Device prescribed as part of a physician's course of treatment that is designed to show improvement or retard deterioration.
- Member has diagnosed condition that prohibits the member from assuming the upright position on his or her own effort.
- Member bed-ridden or chair-confined without device.
- Once in the standing position, member able to ambulate with an assistive device or stand-by assistance.

A basic non-recliner chair is covered and only the electrical components are considered as the medical device. Exceptions require documentation of unique medical necessity, and require approval of the HMO Medical Department. Chair lifts (i.e., stairway elevator-like devices) and/or modifications to vehicles are not in benefit.

Paid by: HMO

Coverage Variation: Benefit Plan DIRPY: Excluded

Second Opinions

Benefit: Second opinions are covered as physician services if the Primary Care Physician recommends this service.

Interpretation: Members who call the HMO and request information regarding second opinions will be referred to their PCP. If the PCP agrees to refer the member for a second opinion, they are not required to refer the member (a) outside of their IPA, or (b) to a specialist practicing in a group different from that in which the first specialist practices.

If there is a substantive disagreement between the first and second opinion, the Primary Care Physician and the IPA retain the responsibility of determining the need for a third opinion or for selecting the appropriate course of action.

Paid by: Professional fees: **IPA**

Sensory Evoked Potentials (SEP)

Benefit: Evoked potentials are in benefit in a limited number of situations.

Interpretation: Sensory Evoked Potentials (SEP) are electrical waves generated by sensory neurons in response to stimuli. Changes in the electrical waves are averaged by a computer and then interpreted by a physician to assist the diagnosis of certain neuropathic states or to provide information for treatment management.

Sensory evoked potentials are detected by superficial electrodes attached to the skin or needle electrodes placed into the skin. Various means of stimulation are used:

- Auditory evoked potentials - Clicks or tones delivered through headphones.
- Somatosensory evoked potentials - transcutaneous stimulation of nerve trunks in arms or legs.
- Visual evoked potentials - Flashes of light or alternating checkerboard patterns.

Sensory evoked potentials are in benefit for evaluation of these symptoms or diagnoses:

1. Auditory

- Evaluation of brainstem functions (e.g., hypoxic encephalopathy).
- As a second line test to identify presence of brainstem tumors (e.g., acoustic neuromas) (May be a first line test if CT or MRI scanning is not available).
- To supplement EEG findings in evaluating irreversibility of coma or brain death.
- To evaluate hearing impairment in young children or mentally handicapped members of any age.

2. Somatosensory

- Evaluation of spinal cord injury in unconscious trauma members.
- To diagnose or manage somatosensory deficits (e.g., multiple sclerosis).

3. Visual

- To diagnose or manage multiple sclerosis both in the acute phase and the chronic phase.
- To localize visual field defects occurring in the absence of structural lesions (e.g., metabolic or infectious diseases).

Paid by: Professional Charges: **IPA**
Facility Charges: **HMO**

Skilled Nursing Facility (SNF)

Benefit: Care of a member in a Skilled Nursing Facility (SNF) is a covered benefit for selected members.

Interpretation: Skilled nursing facility care is in benefit if the member has a documented need for skilled care and the PCP refers for the service.

Skilled care is care that requires the services of a trained medical professional, and cannot reasonably be taught to a person without specialized skill and professional training. Examples of skilled care are:

- frequent extensive, sterile dressing changes
- infusions of IV medications
- daily physical therapy with documentation of continuing objective improvement
- frequent non-self-injectable medications

It is the IPA's responsibility that one or more IPA physicians maintain privileges with at least one HMO-contracted SNF. The IPA (especially the physician) must regularly assess the level of care required by any member in a SNF. In particular, the physician should assess the member's need for skilled services. Care should not be custodial (see separate benefits interpretation on Custodial Care). Ongoing eligibility for benefit coverage depends on the member's continuing need for skilled care. The nature of the care provided, rather than the setting of care, determines whether or not the care is skilled.

Skilled Nursing facility means an institution or a distinct part of institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

There is no benefit coverage for holding a skilled nursing bed during the time that a SNF member is hospitalized.

SNF days are charged against the Utilization Management Fund at a rate of 0.50 units per day if an HMO contracting facility is used, or at a rate of 1.50 units per day if a non-contracting facility is used.

Paid by: Physician charges: **IPA**
Facility charges: **HMO**

Note: See related benefits interpretation on Custodial Care

Smoking Cessation

Benefit: Medical treatment for smoking cessation is in benefit.

Interpretation: Examples of medical treatments include, but are not limited to, laser treatment, counseling, behavioral therapy, biofeedback and acupuncture.

Non-medical (usually community-based) ancillary services and/or educational programs (i.e., smoking cessation classes) are not covered; however, these services may be valuable, and their recommendation is encouraged. Any charges incurred for non-medical services are the financial responsibility of the member.

Over the counter medications/products (such as nicotine gum and patches) are not in benefit.

Paid by:

Professional charges for medical treatment:	IPA
Charges for non-medical treatment:	Member
Over the counter medications/products:	Member

Speech Therapy

Benefit: Speech therapy is covered when an IPA physician determines that such therapy is expected to result in significant improvement within two months in the condition for which it is rendered. Significant member improvement, not necessarily complete recovery, meets the criteria.

Interpretation: Speech therapy must be prescribed by a licensed physician and provided by, or under the supervision of, a Registered Speech Therapist to be in benefit. Speech therapists guide the improvement of speech and also help diagnose and treat infants and adults with swallowing disorders.

Results of a trial of therapy may help an IPA physician determine whether or not ongoing speech therapy is medically necessary.

Speech therapy which maintains, rather than improves, speech communication is not covered.

Communication devices, such as computer boards, are in benefit. The instruction of sign language or lip reading is not covered.

The IPA physician's expectation that a member will improve within 60 days is the key to determining whether or not services are in benefit. Referrals for therapy service should not be denied unless the PCP does not anticipate significant improvement within 60 days.

Most benefit plans have a maximum number of treatments that are in benefit for outpatient rehabilitation therapies (Speech Therapy, Physical Therapy and Occupational Therapy.) See HMO Benefit Matrix to confirm the extent of therapy benefits.

Outpatient rehabilitative therapy visits should be counted as follows: A single date of service by the same provider will be counted as one treatment/visit for the calculation of the outpatient therapy maximum. In other words, if a member is sent for PT but at the visit the member is also provided ST, there is only one visit, regardless of the fact that more than one modality of treatment was provided.

Paid by:	Professional charges: (Inpatient/Outpatient):	IPA
	Facility charges (Inpatient):	HMO
	Outpatient facility charges:	IPA
	Device charges (from a contracted provider)	HMO
	Device charges (from a non-contracted provider)	IPA

Note: See related benefits interpretation on Day Rehabilitation

Sterilizations

Benefit: Voluntary sterilization (tubal ligations, Essure[®] vasectomies) are covered in full upon referral by an IPA physician or, in some circumstances, by the HMO.

Interpretation: All outpatient ancillary and physician services directly related to a sterilization procedure and follow-up services for a reasonable period after the surgery are covered as non-capitated services.

If a tubal ligation is performed directly following delivery, charges for the sterilization must be submitted separately from charges of prenatal and postpartum care. (Prenatal and postpartum charges are the financial responsibility of the IPA.)

Reversals of previous voluntary sterilizations are **not** covered.

Paid by:	Physician charges:	HMO
	Facility charges:	HMO
	Outpatient ancillary charges:	HMO

Coverage Variations: Certain employer groups do not provide any coverage for sterilization. Eligibility for the benefit should be predetermined in all cases.

Medical Service Agreements with IPAs vary. Some IPAs do not refer members for sterilization procedures. Members should be directed to call (312) 653-6600 for a referral if their IPA does not provide referrals for sterilization.

Note: All days are charged against the Utilization Management Fund for those IPAs who contractually are required to refer members for sterilizations.

Note: See related benefits interpretations on Family Planning, Abortion, and Infertility

Synagis®

Benefit: This immunization is in benefit for infants at high risk for developing Respiratory Syncytial Virus (RSV) infection.

Interpretation: Synagis® is administered to prevent lower respiratory infections caused by RSV in pediatric members at high risk of death or disability from RSV infection. Such members may have a history of prematurity or bronchopulmonary dysplasia. Members should receive monthly doses starting before the commencement of the RSV season, which is typically November through April.

This immunization is given intramuscularly, and is not classified as self-injectable. As with all immunizations and other non-self-injectable medications, Synagis® is the financial responsibility of the IPA.

Paid by: IPA

Note: See related benefits interpretations on Drugs, Immunizations

Temporomandibular Joint Disorder (TMD)

Benefit: A limited number of services for TMD disorders are in benefit.

Interpretation: Temporomandibular disorders (TMD) and related craniomandibular disorders contribute to a constellation of cephalic, facial or cervical pain, often associated with clicking, or abnormal or restricted movement of the jaw. There are many physical, developmental, and psychological causes. Treatment is in benefit if symptoms are due to organic joint disease or to physical trauma.

The evaluation and treatment plan may include the following steps.

1) Initial evaluation - A Primary Care Physician (PCP) should document whether the member's chief complaint suggests TMD. The PCP may request consultation from a dentist, oral surgeon, or other physician specialist. The PCP does not have to consult the member's choice of provider.

2) Diagnostic Work-up - The consultant should perform appropriate diagnostic work-up. Work up could include:

- Joint x-rays
- Transcranial x-rays
- Arthrograms
- Electromyography (EMG)
- Muscle testing
- Consultation with other medical or dental disciplines:(Psychiatry, Otolaryngology, Oral surgery, Prosthodontist)

3) Second Opinion - If there is some question about the diagnosis or a proposed course of treatment, another dentist and/or appropriate health professional could provide a second opinion.

4) Conservative Treatment - Medications, physical therapy, trigger point injections, and orthotics to reposition the joint are in benefit. TMD orthotics are **REMOVABLE** appliances that guide the mandible or maxilla in relationship to the temporal fossa.

Note that many other types of oral devices are not in benefit. Please note exclusions below.

5) TMD Surgery - Surgery, including arthroscopic surgery, should only be considered when conservative treatment fails or is considered useless, and if anticipated outcome is favorable. The physician or dentist should have reasonable expectation that surgery will relieve pain and correct TMJ dysfunction. Any splints or metal plates used to hold the jaw in place postoperatively should be included in the surgical fee.

Temporomandibular Joint Disorder (TMD) (cont.)

Excluded from benefit:

- Dental restorations
- Dental prostheses
- Night splints or mouthguards used to reduce nighttime teeth clenching.
- Any other methods utilized to alter the vertical dimensions and/or change the occlusal or jaw relationship including orthodontic services. Orthodontics are defined as the use of fixed or removable appliances used to guide the teeth in relationship to one another and in relationship to the dental arch.
- Palate expander

Paid by:	Physician charges:	IPA
	Facility charges:	HMO
	TMD Orthotics (see above):	HMO

Coverage Variation: Benefit Plan DIRPY- Orthotics excluded

Topographic Brain Mapping (TBM)

Benefit: Topographic brain mapping is in benefit for selected members.

Interpretation: Topographic Brain Mapping (TBM), sometimes referred to as Brain Electrical Activity Mapping (BEAM), is an extension of conventional electroencephalography. Clinical application of this technology continues to expand.

Topographic brain mapping is appropriate for the following:

- Preoperative evaluation of brain tumor resection
- Preoperative evaluation of seizure foci in seizure disorders poorly responsive to medical therapy
- Localization of brain centers, such as the speech center, before or during selected surgical procedures.

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes.

Paid by:	Professional fees:	IPA
	Outpatient facility fees:	IPA
	Inpatient facility charges:	HMO

Ultrasonic Bone Stimulation

Benefit: Ultrasonic bone stimulation is in benefit for selected members with fractures.

Interpretation: Ultrasonic bone stimulation refers to the administration of ultrasonic energy produced by a portable generator to a fracture through a surface transducer. Therapy is instituted when the fracture is fresh, and it is adjunctive to conventional management of the fracture. Fracture healing is promoted by one daily self-administered 20-minute application for a period of up to 90 days.

Ultrasonic bone stimulation is in benefit to treat adults with recent fractures when:

- Fracture is otherwise treated by closed reduction without surgery or other methods of fixation AND
- Reduced fracture gap is less than 0.5cm AND
- There is no underlying bone disease AND
- Member is not taking: Steroids, Anticoagulants, or Non-Steroidal Anti-inflammatory Drugs (NSAIDs)

Ultrasonic bone stimulation is also used to treat fracture non-union of bones other than skull or vertebrae.

The Primary Care Physician not the IPA determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes other than those listed above.

Paid by: Professional Fees: **IPA**
Equipment Charges or Services: **HMO**

Coverage Variation: Benefit Plan DIRPY—purchase or rental excluded.

Note: See related benefits interpretation on **Electrical Bone Growth Stimulation**

Ultraviolet Light Treatment for Psoriasis

Benefit: The diagnosis and treatment of psoriasis is covered.

Interpretation: Psoriasis with or without polyarthritis is a chronic genetically determined skin condition without specific etiology.

Ultraviolet light, either alone or as adjunctive treatment with medication, may be appropriate for psoriasis treatment. Oral psoralens combined with ultraviolet A light is called "PUVA" therapy. If the physician recommends home ultraviolet light treatment, the member may rent or purchase medical UV equipment under the Durable Medical Equipment benefit. Sunlamps or "treatments" obtained at commercial tanning spas do not qualify for coverage.

Paid by:	Professional fees:	IPA
	Equipment charges (from contracted provider):	HMO
	Equipment charges (from non-contracted provider):	IPA

Coverage Variation: Benefit Plan DIRPY: DME Excluded

Vision Screening/Routine Vision Care

Benefit: Vision screening to determine the need for eye examination, and the actual eye exam by an optometrist or ophthalmologist to determine the nature and degree of refractive error or other abnormality in the eye is a covered benefit. Orthoptic and vision training services are available through the medical plan if referred by the PCP. Evaluation and treatment of eye injuries and eye diseases are covered in the same manner as other medically necessary services.

Some employer groups offer additional vision benefits. Members may call the Participating Vision Provider to determine benefits.

Interpretation: Vision screening includes eye charts and basic screening tools and techniques. Refractive error, eye curvature, and corrective lens strength are determined by phoropter exam.

According to the American Academy of Ophthalmology, a pediatrician or family physician should evaluate infants for fixation preference, ocular alignment and ocular disease before they are six months old. By four years of age, each child should be re-examined to detect amblyopia and other ocular diseases. Adults over 35 should be screened for glaucoma as part of a routine examination.

The physician should decide when and how often to screen the member's vision. Typical recommendation is:

- Myopes under 15 years of age: every year
- Myopes 15-25 years of age: 1-3 years
- Myopes 25-40 years of age: 2-5 years
- Hyperopes under 20 years: 1-4 years
- Hyperopes 20-40 years of age: 2-5 years
- Emmetropes less than 40 years: 2-5 years
- All individuals 40-60 years: 1-3 years
- All individuals 60+ years: 1-2 years

Eyeglasses and contacts are not covered by basic vision care benefits. If the member has additional vision benefits for these, the member should contact the HMO participating Vision Care Provider to be filled. There are two medical conditions where eyeglasses and contact lenses are in benefit under the medical coverage. Refer to benefit interpretations for Contact Lenses/Eyeglasses and Prosthetic Device.

Vision Screening/Routine Vision Care (cont.)

Neither basic nor supplemental HMO vision care benefits include:

- recreational sunglasses
- subnormal vision aids, aniseikonic lenses
- additional charges for tinted, photosensitive or antireflective lenses beyond the benefit allowance for regular lenses
- replacement of lost or broken lenses, frames or contact lenses outside the benefit period limitations specified in the member's vision care plan.

Paid by:	Vision screening by PCP/IPA physician	IPA
	Eye examination (illness, injury, school eye exam mandated by law or basic refraction) performed by an IPA:	IPA
	Eye examination (basic refraction, school eye exam mandated by law) performed by HMO Participating Vision Vendor:	HMO
	Equipment charges:	HMO, Member

The HMO pays for refraction services or school eye exam mandated by law when the designated provider network provides these services. The HMO does not reimburse IPAs for these services that they may provide. The member should not be charged more than the appropriate office visit copayment if these services are provided by an IPA physician.

Note: Some members have benefits towards the cost of lenses, frames and/or contact lenses. Members may verify benefits by calling the Participating Vision Vendor. HMO Illinois and BlueAdvantage HMO Vision services provider is Davis Vision and can be reached at (877) 393-8844.

Note: Effective January 1, 2008, an amendment to the school code (Public Act 095-0671) added a requirement that proof must be provided for children entering kindergarten have obtained an eye exam by a physician licensed to practice medicine in all its branches or a licensed Optometrist. Additionally, "for purposes of this Section, an eye examination shall at a minimum include history, visual acuity, subjective refraction to best visual acuity near and far, internal and external examination, and a glaucoma evaluation, as well as any other tests or observations that in the professional judgment of the doctor are necessary vision exam."

Well Child Care

Benefit: Well child care is a covered benefit. This includes immunizations, examinations, routine tests and education or counseling as deemed necessary by an IPA Physician.

Interpretation: The frequency of examinations may be determined by an IPA physician but should meet or exceed generally accepted standards of medical practice. The HMO preventive care guidelines are one source of evidence-based guidance to well child services. The IPA should try to assure that every enrolled child receives all age-appropriate well-child care.

Tests required for participation in sports or camp activities are the responsibility of the member if such tests are not usually a part of well-child care

Paid by: Professional charges: **IPA**
Immunizations and required vaccines: **IPA**

Note: See related benefits interpretation on Immunizations

Wheelchairs

Benefit: Wheelchairs are covered as Durable Medical Equipment (DME).

Interpretation: A wheelchair is in benefit when an IPA physician prescribes one for medically necessary reasons.

Basic wheelchairs are provided. Special features will be covered only when medically necessary and so specified in the physician's prescription. Convenience items or features will not be covered.

A power-operated wheelchair is covered if the member qualifies for a wheelchair, is unable to operate manual chair, but is able to operate an electric wheelchair. The IPA must obtain prior approval from the HMO Medical department for all power-operated wheelchairs.

For all but basic manual wheelchairs, the following information should be sent to the HMO:

- A written assessment and equipment description from the DME company, including itemization of non-standard parts.
- A written physical assessment from the attending physician or physical therapist, describing the needs of the member, the setting in which the wheelchair will be used and the medical justification for each non-standard part.
- A written order (prescription) by the attending physician for the wheelchair and any medically necessary accessories.

The member certificate states that benefits are not provided for electric scooters. However, if a member (who qualifies for an electric wheelchair) requests an electric scooter, the HMO Medical Department, upon request, will review the request for a benefit determination.

The member certificate states that benefits are not provided for strollers. However, if a member qualifies for a wheelchair, the HMO medical department will review a request for a stroller upon request, on a case by case basis.

Repair and/or replacement of wheelchairs due to normal usage is a covered benefit. Generally, the less expensive option is indicated, but requests for exceptions may be submitted to the HMO for individual consideration. Repair and/or replacement necessitated by abuse or neglect on the part of the member is not covered.

Paid by: HMO

Coverage variation: Benefit Plan DIRPY: Excluded