



**BlueCross BlueShield
of Illinois**

Blue Cross and Blue Shield of Illinois Provider Manual

HMO Scope of Benefits Section 2020

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

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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.

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 HMO Illinois[®], Blue Advantage HMOSM, Blue Precision HMOSM, BlueCare DirectSM and Blue FocusCareSM enrollees, but benefits do vary from one benefit plan to another. Coverage Variations are noted as applicable on the following guidelines. Additional information can also be found in the Benefit Matrix. It has accurate details for each benefit plan including, but not limited to copayments, rehabilitation benefits, DME benefits and behavioral health benefits. The Benefit Matrix is located on the BCBSIL IPA Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx in the Provider Network Management – HMO Resources folder. If you do not have access to the website complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf).

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 prospectively request an exception to this. Requests related to a Durable Medical Equipment or Orthotic/Prosthetic provider would be requested from the HMO Customer Assistance Unit. There is a form located on the BCBSIL IPA Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx – in the Provider Network Management – HMO Report Templates folder. If you do not have access to the website complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf).

For other types of services, the Nurse Liaison or Provider Network Consultant should be contacted.

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. Additional information regarding benefits and/or financial responsibility can be found in the Medical Service Agreement. The IPA may contact the Customer Assistance Unit Staff at 312-653-6600 for more help with benefits interpretation.

Abortion

Benefit: Coverage for Pregnancy termination (Abortion) is a covered benefit if referred by the Primary Care Physician (PCP) Women's Principal Health Care Provider (WPHCP). In the case of IPAs that do not retain the responsibility for abortion referrals the HMO must refer for the procedure.

Effective June 13, 2019, for policies that are newly issued, or upon those that are revised, renewed or amended the lifetime limit will be removed upon that event.

Effective June 13, 2019, Group Blue Precision HMO members (Group # starting with an R) and BlueCare Direct members (Group # starting with an A): elective abortions are in benefit upon the new issue, revision, renewal or amendment.

Effective Jan. 1, 2020, elective abortions are in benefit for Individual Blue Precision HMO, BlueCare Direct and Blue FocusCare members (Group #s starting with an I).

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 website: www.fda.gov).

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

Coverage and IPA Variations:

Blue Precision HMO, BlueCare Direct and Blue FocusCare members – Elective abortions were not a covered benefit. An abortion was only covered in cases of rape, incest or endangerment to mother. (See above reference regarding coverage change).

Effective July 1, 2017, elective and Therapeutic abortions are not in benefit for members of the Archdiocese of Chicago Employer Group. The group numbers are: H00120, H00119, B00599, and B00598.

Effective Jan. 1, 2020, Abortion services are not in benefit for members of the Wheaton College Employer Group. The group number is B93046. The Abortion pill (Plan B/RU 486), is also not in benefit.

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

IPAs vary in retention 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: Acupuncture is in benefit if determined medically necessary by the Primary Care Physician (PCP) for the following HMO products: HMO Illinois and Blue Advantage HMO. Acupuncture is not in benefit for the following HMO products: Blue Precision HMO, BlueCare Direct and Blue FocusCare.

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)

Coverage Variation:
Blue Precision HMO, BlueCare Direct and Blue FocusCare members – Acupuncture is not a covered benefit.

Allergy Testing/Desensitization

Benefit: Allergy testing and allergy immunotherapy (desensitization injections) are in benefit if determined to be medically necessary by the Primary Care Physician (PCP).

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.

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 (except as outlined in the Nutritional Supplement/Enteral Nutrition Guideline found in this section of the Provider Manual), weight-loss supplements and over-the-counter food substitutes are not in benefit.

Paid by: Professional Charges: **IPA**
Testing supplies: **IPA**
Antigens: **IPA**

Ambulance Services

Benefit: Ambulance service is covered under emergency conditions and under non-emergency conditions that are specified below.

Interpretation: Benefits for ambulance transportation are available in emergency situations when:

- Such transportation is ordered by the primary care physician; or
- Such transportation is rendered outside the IPA's treatment area (beyond 30 miles from IPA); 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 any of the following situations, the PCP and IPA have given prior approval:

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

Exclusions:

- Transportation from home or a custodial nursing home to a doctor's office, hospital, or another facility for outpatient services.
- Medi-cars.

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.

The IPA may use the ambulance company of its choice.

Paid by:

Professional 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) to Forty-Eight (48) hour non-invasive continuous ambulatory blood pressure monitors are in benefit if determined to be medically necessary by the PCP/WPHCP.

Interpretation: **Non-invasive continuous** ambulatory blood pressure monitors are portable devices that record blood pressure while the member is involved in daily activities.

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

Coverage Variation: Benefit Plan DIRPI- Equipment charges excluded.

Confidential and Proprietary

Amniocentesis

Benefit: Amniocentesis is covered 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:

Professional Charges:	IPA
Inpatient and/or Outpatient	HMO
Surgical Facility Charges:	
Outpatient Facility Charges:	IPA

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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 Charges: **HMO**
Professional Charges: **IPA**

Coverage Variation: Benefit Plan DIRPI- 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: Professional charges: **IPA**

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Autism Spectrum Disorder (ASD)

Benefit: ASD related services are in benefit when provided for the treatment of any autism or other related diagnoses. 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 Dec. 12, 2008, for new groups and upon renewal for existing groups. The law mandates coverage for members up to age 21. In addition, Pervasive Developmental Disorders are considered Serious Mental Illness (SMI) under Public Acts (PA) 094-0906 and PA 094-0921.

Interpretation: ASD includes, but may not be limited to the following diagnosis:

- Autistic disorder – childhood autism, infantile psychosis, Kanner's syndrome
- Childhood disintegrative disorder – Heller's syndrome
- Other specified pervasive developmental disorders – Asperger syndrome, atypical childhood psychosis, borderline psychosis of childhood
- Pervasive developmental disorder – not otherwise specified (PDD-NOS) Childhood psychosis Not Otherwise Specified (NOS), childhood type schizophrenia NOS, schizophrenic syndrome of childhood NOS
- Rett's syndrome

Services are subject to medical necessity/maintenance, determination to be consistent with the manner used for other diseases or illnesses. 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.

In addition to benefits already in place, the Illinois Public Act (PA) 95 -1005 provided additional benefits for treatment of ASD, including Applied Behavioral Analysis (ABA), psychiatric, psychological, habilitative, rehabilitative and therapeutic care. From the effective date through the calendar year 2009, there was a maximum of \$36,000.00 additional benefit. In calendar year 2010, the maximum additional benefit was \$37,260.00. The limit was removed as of Jan. 1, 2011.

Applied Behavioral Analysis (ABA)

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 spectrum disorders 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."

Autism Spectrum Disorder (ASD) (cont.)

ABA is predominantly performed in the home, although if these services are performed in a clinical facility they would remain the IPA risk. Services that may be included and covered under the benefit:

- An in-home ABA evaluation
- 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 benefits for treatment of ASD were also affected by the passage of the Emergency Economic Stabilization Act of 2008 included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 in the following manner:

- There was no coverage if the member self directs to an out of network provider for SMI Diagnosis except in emergency conditions.
- Previous day/visit limits no longer apply once the employer group implemented the ACT.
- There were 20 additional speech therapy visits after the contracted rehab benefit limit is reached for members with a ASD diagnosis
- Mental Health benefits could not be used for rehab visits.

Benefits were applied in the following manner:

- If a member was seeing a rehab therapist for rehab services, they use their contracted rehab limit, then the additional 20 speech therapy, then the additional Illinois Mandated Coverage for Autism Spectrum Disorders annual benefit.
- If member is seeing a Mental Health specialist, for mental health services, they have unlimited services if they meet medical necessity criteria.
- If member is receiving “ABA therapy” by an ABA provider, it is deducted from the Illinois Mandated Coverage for Autism Spectrum Disorders annual benefit only.

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

Autism Spectrum Disorder (ASD) (cont.)

Note: See related benefits interpretation on Mental Health Care (Inpatient), Mental Health Care (Outpatient), Dental and Durable Medical Equipment

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803

Note: Members who have an Autism Spectrum Disorder will have additional occupational, physical, and speech therapy for the treatment of ASD after the purchased benefits are exhausted by accessing the Illinois Mandated Coverage for Autism Spectrum Disorders Annual Benefit.

Coverage Variation: Benefit Plan DIRPI:

Durable Medical Equipment (DME) is normally excluded from the DIRPI benefit package, however, with the Illinois Mandated Coverage for Autism Spectrum Disorders (ASD) Annual Benefits - DME would be covered for the DIRPI members for the treatment of ASD. The normal process regarding use of a contracted DME provider must be followed.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

Automatic External Defibrillator

Benefit: The Automatic External Defibrillator is in benefit if determined medically necessary by the Primary Care Physician.

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.

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

Confidential and Proprietary

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:

Equipment Charges:	HMO
Inpatient and/or Outpatient	HMO
Surgical Facility charges:	
Professional Charges:	IPA

Autopsy Examination

Benefit: Autopsy is not a covered benefit.

Paid by: **Member**

Confidential and Proprietary

BRCA (Breast Cancer Susceptibility) Testing and Related Genetic Counseling

Benefit: BRCA (Breast Cancer Susceptibility Gene 1, Gene 2) testing, related to breast and ovarian cancer, and related genetic counseling, is a covered benefit, when referred by the PCP or WPHCP.

- Interpretation:**
- For a woman who has had a prior BRCA-positive breast or ovarian tumor, BRCA testing is covered. The member's copayment, coinsurance and/or deductible would apply (as applicable).
 - The Affordable Care Act and related laws mandate that BRCA testing and related genetic counseling be provided, at no cost to the member, under the following circumstances:
 - The woman has personal history of non-BRCA related breast or ovarian cancer OR
 - The woman has a family history of breast, ovarian, tubal or peritoneal cancer

The woman should be tested with one of several screening tools designed to identify a personal and/or family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA 1 or BRCA 2)

Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical Facility charges:	HMO
	Outpatient Lab/Diagnostic Charges:	IPA

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: Professional Charges: **IPA**
Equipment Charges: **HMO**
Facility Charges: **IPA**

Coverage Variation: Benefit plan DIRPI: Equipment charges excluded.

Blood and Blood Derivatives

- Benefit:** Blood related services are covered, which includes the following:
- 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:	Professional Charges:	IPA
	Inpatient Facility and/or Outpatient Surgical 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 DIRPI: All charges excluded from coverage except dispensing fee

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: Professional Charges: **IPA**
Inpatient Facility Charges: **HMO**

Confidential and Proprietary

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.

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 determined by the Primary Care Physician (PCP) as medical necessary. It may be utilized to treat the following medical conditions (this is not an all-inclusive list):

- 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.

- **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 cosmetics.

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**
Inpatient and/or Outpatient Surgical Facility Charges: **HMO**
Drug Charges: **IPA**

Breast Screening

Benefit: "Diagnostic mammogram" means a mammogram obtained using diagnostic mammography. "Diagnostic mammography" means a mammogram that is performed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

"Screening mammography" means a mammogram that is performed in the absence of symptoms, subjective or objective abnormalities or other conditions (such as a positive family history of breast cancer at a young age).

Comprehensive ultrasounds and breast MRIs are also in benefit when determined medically necessary by the PCP, WPHCP, Physician Assistant or Advanced Nurse Practitioner.

Interpretation: A diagnostic mammogram is covered when determined to be medically necessary by Physician, Physician Assistant or an Advanced Nurse Practitioner.

A comprehensive ultrasound and MRI of the breast is covered when medically necessary as determined by a Physician, Physician Assistant or an Advanced Nurse Practitioner. This expands the coverage to include those situations where it is determined medically necessary regardless of a mammogram demonstrating the presence of heterogeneous or dense breast tissue.

The diagnostic mammogram, screening mammogram, breast ultrasound and breast MRI services are to be provided without member cost-sharing.

Paid by: Professional Charges: IPA
Outpatient Facility 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

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 prosthetic devices. Post-mastectomy breast prostheses are also covered (See Prosthetic Devices).

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Prosthetic Charges (from a contracted provider):	HMO
	Prosthetic Charges (from a non-contracted provider):	IPA
	Medical Supply Charges:	HMO

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

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

Cardiac Rehabilitation

Benefit: Phase One and Phase Two Cardiac rehabilitation therapies are covered benefits under the conditions outlined below. Phase Three is not in benefit.

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.

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Outpatient Facility Charges:	IPA
	Phase Three rehabilitation:	Member

Note: Cardiac Rehabilitation services do not count towards the PT/ST/OT benefit limit.

CAR-T Therapy

Benefit: CAR-T therapy is in benefit when ordered by the Primary Care Physician and when performed at an HMO contracted facility that has been approved by the CAR-T manufacturer.

CAR-T is in benefit if the therapeutic CAR-T agent is FDA approved and is being administered for the treatment of a condition, for which CAR-T has been proven to be effective. CAR-T is not considered a transplant related service. The FDA has approved the CAR-T agent as a drug. CAR-T is not in benefit as part of a Clinical Trial (see Investigational Procedures, Drugs, Devices, Services, and/or Supplies guideline)

The PCP must send a referral to the contracting transplant facility to initiate evaluation of the member. If the PCP determines medical appropriateness, a member may be referred to multiple Blue Cross and Blue Shield of Illinois HMO contracted centers that can perform the CAR-T administration.

Notification Process:

1. The IPA will initiate the notification process by contacting the HMO Nurse Liaison. The IPA will submit the following information via fax or email:
 - Member name, Group and ID numbers
 - Member's contact telephone number
 - Copy of the referral to the CAR-T facility
 - Member's diagnosis, type of CAR-T, medical history
 - Letter from PCP indicating approval and that the Car-T is a curative treatment for the member's condition.
 - Letter from the CAR-T facility and statement from Referring Physician confirming the member's CAR-T candidate status and that the CAR-T is a curative treatment for the member's condition.
2. Once the HMO Nurse Liaison receives the documentation, it will be reviewed with the HMO Medical Director. The HMO Nurse Liaison will generate a letter to the IPA notifying them of the determination with a copy to the Provider Network Consultant and the Customer Advocate Specialist(s) in the Service Centers (FSUs). The IPA is responsible for notifying the member as per the IPA's member notification process.

Note: If a member changes IPAs during the workup or follow up care period, the new IPA must send a new notification to the HMO and issue a new referral.

Note: If a member needs a second CAR-T treatment, a new authorization request will need to be submitted to the HMO.

CAR-T Therapy (cont.)

Interpretation:

The IPA is expected to continue to perform Utilization/Referral and Case Management for both CAR-T 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 CAR-T treatment. Examples include, but are not limited to, ongoing testing and treatment for the cancer that has led to the CAR-T evaluation and ambulatory services related to CAR-T that occur post-hospitalization.

Once the HMO has sent the notification letter to the IPA, confirming that these services are in benefit for the member, the following CAR-T services become the financial responsibility of the HMO:

- Preparation of CAR-T.
- All inpatient and outpatient surgical facility covered services related to the CAR-T administration
- After the member has received the CAR-T treatment, benefits will be provided for transportation and lodging for the member and a companion for the 90-day post-hospitalization period after the CAR-T administration. If the recipient of the treatment is a dependent child, benefits for transportation and, lodging will be provided for the CAR-T recipient and two companions.

For lodging benefits to be available, the member's place of residency must be more than a 30-minute transit radius from the Hospital where the CAR-T will be administered. Lodging is limited to \$50.00 for each night, per person. Transportation costs are also covered and must be primarily for and essential to medical care. Benefits for transportation and lodging are limited to a maximum of \$10,000 per episode of treatment.

These services are not in benefit:

- Drugs which are Investigational
- Storage fees
- Services provided to any individual who is not the recipient unless otherwise specified in this provision.
- Travel time or related expenses incurred by a Provider

Paid by:

Diagnostic Work-up charges (regardless if Member is accepted as a CAR-T candidate or actually has CAR-T treatment):

IPA

Professional Charges:

IPA

Drug Charges (inpatient admission):

HMO

Inpatient Facility and Outpatient Surgical Facility Charges:

HMO

Note: BlueCare DirectSM: The physician signing the referral and submitting the approval letter may be the PCP, a treating provider or a physician advisor.

Note: At this time, Kymriah has been approved for treatment in members up to and including 25 years of age. Yescarta has been approved for treatment in members 18 and above.

Chemical Dependency/Substance Use Disorder (SUD) Services

Benefit: Chemical Dependency/SUD 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/SUD. These are considered mental illness.

Benefits are available for the treatment and rehabilitation of chemical dependency/SUD. The benefits for chemical dependency/SUD treatment may include outpatient, inpatient, partial hospitalization, intensive outpatient and residential programs.

Effective Jan. 1, 2019, Public Act (PA)100-1024 created a new definition as follows: "Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. In addition, the Public Act deleted the definition of "serious mental illness."

Effective Jan. 1, 2020, telepsychiatry will be a covered benefit for Blue Precision HMO, Blue FocusCare and BlueCare Direct. Telepsychiatry refers to behavioral health services rendered by a Psychiatrist via a simultaneous audio and video telehealth setting permitting 2-way, live interactive communication between the patient and the distant site health care provider. Telepsychiatry can also be offered by licensed Nurse Practitioners and Physician Assistants operating within the scope of their license. Telepsychiatry may include a range of services, such as medication management, psychiatric evaluations, therapy (individual therapy, group therapy, family therapy) and patient education.

Interpretation: (Included for historical reference) The Emergency Economic Stabilization Act of 2008 included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (The MHPAEA or ACT). The ACT does not require coverage of mental health (MH) or substance use (SU) benefits but if plans do cover such benefits, it required that group health plans and group health insurers apply the same treatment and financial limits to medical-surgical and mental health and substance use disorders. Under this law, all previous day/limits were removed for a member being treated by a mental health provider.

The requirements of the new law were effective for plan years beginning on or after one year from the date the legislation was signed into law. (Oct. 3, 2008). As a result, the provisions applied to new contracts and renewals on or after Oct. 3, 2009, but not before Nov. 1, 2009.

From Nov. 1, 2009, through July 1, 2010, a copay was charged based upon provider type (e.g. a specialist visit would have the specialist copay charged). Starting July 1, 2010, upon employer group renewal; the copay policy is:

- If a member is treated by their PCP, the PCP co-pay is applied.
- If a member is treated by any MH/SU professional, the PCP co-pay is applied.

Chemical Dependency/Substance Use Disorder (SUD) Services (cont.)

Prior to Jan. 1, 2014, chemical dependency/SUD services were managed by the HMO's contracted vendor. All services authorized by the vendor, were the financial responsibility of the HMO. If the member was referred to a non-contracted provider by the IPA, the IPA was responsible for the professional charges, and applicable units were applied towards the Utilization Management (UM) Fund. No units were charged to the UM Fund if provided at a contracted Chemical Dependency/SUD Facility.

If the member had dual mental health and chemical dependency/SUD diagnoses, the primary diagnosis determined authorization procedures. If the mental health diagnosis was primary, the IPA would authorize treatment. If the chemical dependency/SUD diagnosis is primary, the contracted vendor authorized treatment. Upon notification, the IPA remained 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, in a partial hospitalization program (PHP), intensive outpatient program (IOP) or residential program.

Effective Jan. 1, 2014, the IPA is responsible for management of chemical dependency/SUD services. Illinois Compiled Statutes (245 ILCS 5/370c and 370c.1) requires the American Society of Addiction Medicine's (ASAM) utilization management (UM) criteria to be used when making medical necessity determinations. This law also mandates residential programs are in benefit for chemical dependency/SUD treatment.

Non-medical (usually community-based) ancillary services (i.e., Alcoholics Anonymous) and/or educational programs are generally not covered. Any charges incurred for these types of services are the financial responsibility of the member.

TELEPSYCHIATRY GUIDELINES

Providers Rendering Telepsychiatry: Psychiatrists contracted with HMO IPAs must be credentialed and do not require additional licensing to perform telepsychiatry. Psychiatrists, Nurse Practitioners and Physician Assistants are the only type of providers who should be performing telepsychiatry.

Advanced Nurse Practitioners and Physician Assistants may render Telepsychiatry services provided they are operating within the scope of their license.

Psychiatrists, Nurse Practitioners and/or Physician Assistants who perform telepsychiatry must use internet software that is HIPAA compliant.

Chemical Dependency/Substance Use Disorder (SUD) Services (cont.)

Paid by:	Maintenance Medications: Methadone /Vivitrol /Naltrexone	HMO
	Maintenance Medications: Suboxone /Subutex /Buprenorphine /Naloxone:	IPA
	Group Approved In area Professional Charges (related to outpatient, inpatient, residential, PHP and IOP Settings):	IPA
	Non-Group Approved In Area Non-Emergency Professional Charges (related to outpatient, inpatient, residential, PHP and IOP settings): -	HMO 50% paid to the provider if accepts benefit assignment, to the member if not
	Professional Charges (Non-Group Approved -out of area emergency – regardless of diagnosis):	HMO
	Group Approved Facility Charges (related to inpatient, residential, PHP and IOP Settings)	HMO
	Outpatient Treatment/Diagnostic Facility Charges (in area - non SMI/SMI/Substance Use – non-emergency - NGA):	HMO – 50% paid to the facility
	Facility Charges (Non-Group Approved - out of area emergency – regardless of diagnosis):	HMO

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:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical 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 a PCP or WPHCP determines medical necessity for the services, the services are covered.

Paid by: Professional Charges: **IPA**

Coverage Variation:

Blue Precision HMO, BlueCare Direct and Blue FocusCare members – Chiropractic and Osteopathic manipulations have a 25-visit limit per calendar year.

Note: See related benefits interpretation on Speech Therapy

Cochlear Implantation

Benefit: Cochlear implants are in benefit if determined by the Primary Care Physician (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:	Professional Charges:	IPA
	Equipment Charges:	HMO
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Aural Therapy:	IPA

Cognitive Therapy

Benefit: Cognitive therapy is in benefit if determined by the Primary Care Physician (PCP) to be medically necessary.

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.

Paid by: Professional Charges: **IPA**

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: Professional 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**

Confidential and Proprietary

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): **IPA/HMO/Member (as described in the Vision Care benefits interpretation)**

Lens charges: **Member (as described in the Vision Care Benefits.)**

Paid by: **For Medical treatment of certain diseases of the eye:**

Professional Charges: **IPA**
Lens charges: **HMO**

Coverage Variation: Benefit Plan DIRPI- 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 contracted Provider. The IPA may refer the member to a supplier of their 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
- Or such other procedures as determined by the Primary Care Physician (PCP)

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.)

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient	HMO
	Surgical Facility Charges:	

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

Confidential and Proprietary

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.

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: Professional Charges: **IPA**
Facility charges: **IPA**

Confidential and Proprietary

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 the treatment mentioned above continues to be in benefit, even if the injury becomes apparent several months later. Only directly injured teeth are covered.

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.

Anesthesia for non-covered dental procedures performed in a dental or oral surgeon’s office:

Anesthesia is a covered benefit if the member meets the following:

- Less than 19 years old
- Has been diagnosed with an autism spectrum disorder or a developmental disability

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 includes, but is not limited to Cerebral Palsy, Epilepsy, Autism Spectrum Disorder and/or a Developmental 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
Inpatient and/or Outpatient Surgical Facility Charges:	HMO
Outpatient Facility Charges:	See Outpatient Surgery Benefit

Routine dental care

Professional Charges:	Member
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Hospitalization/Ambulatory Surgical Facility use for Non-Covered Dental Procedures

Professional Charges for dental procedures:	Member
Anesthesia Charges (If member does not meet above criteria:	Member
Anesthesia Charges (If member does meet above criteria:	IPA
Professional Charges for treatment of medical condition:	IPA
Inpatient and/or Outpatient Surgical Facility Charges:	HMO

Anesthesia for non-covered dental procedures performed in a dental or oral surgeon's office

Professional Charges for dental procedures:	Member
Anesthesia Charges (If member does not meet above criteria:	Member
Anesthesia Charges (If member does meet above criteria:	IPA

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 Charges:	IPA
	DME (from contracted provider):	HMO
	DME (from non-contracted provider):	IPA
	Prescription Drugs:	HMO (through prescription benefit)

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

Diabetes Self-Management (cont.)

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

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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. The HMO Drug Formulary is available on the BCBSIL website.

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.

Interpretation: Drugs administered during an inpatient admission or during surgical 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 and nonsurgical procedures in an ambulatory facility. 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 these drugs to the member at no additional cost. Such drugs include but are not limited to:

- All intravenous injectables including chemotherapy and antibiotics, **except for** heparin preparations and anithemophelic factors
- All biologicals
- 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. Additional information can be found in this section on the Hyaluronan guide line. The brand names include, but are not limited to:

- 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 DIRPI- no prescription drug benefit.

Some employer groups have limitations on their prescription benefits. Such limitations may include self-injectable or contraceptive drugs.

A small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors and coverage may vary.

Effective July 1, 2017, Contraceptive Drugs are not in benefit for members of the Archdiocese of Chicago Employer Group. The group numbers are: H00120, H00119, B00599 and B00598.

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 canes, 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 normally not in benefit. For example, separate pieces of DME would not be provided for use at home and at school. However, there are certain life-sustaining DME items whereas back-up equipment may be indicated and covered. The list of these items may be found at the end of this benefit Guideline. If the Primary Care Physician determines that there is medical necessity for the back-up equipment, the IPA should submit a benefit determination to the Customer Assistance Unit (CAU) for authorization and to ensure appropriate claim adjudication.

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, except for HMO authorized life-sustaining equipment as described above;
- 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:	Professional Charges:	IPA
	Equipment Charges (from a contracted provider):	HMO
	Equipment Charges (from a non-contracted provider):	IPA

Coverage Variation: Benefit Plan DIRPI

Durable Medical Equipment (DME) is normally excluded from the DIRPI benefit package, however, with the additional ASD benefit - DME would be covered for the DIRPI members for the treatment of ASD. The normal process regarding use of a contracted DME provider must be followed.

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

Durable Medical Equipment (DME) (cont.)

Note: Life-Sustaining DME List:

HCPCS Code	Life Sustaining DME
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0425	Stationary compressed gas system
E0430	Portable gaseous oxygen system
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0434	Portable liquid oxygen system
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0440	Stationary liquid oxygen system
E0450	Volume ventilator, stationary or portable, w/backup rate feature, used w/invasive interface
E0457	Chest shell (cuirass)
E0460	Negative pressure ventilator; portable or stationary
E0608	Apnea monitor
E1353	Oxygen Equipment, regulator
E1377	Oxygen concentrator, high humidity system equivalent to 244 cu. ft.
E1378	Oxygen concentrator, high humidity system equivalent to 488 cu. ft.
E1379	Oxygen concentrator, high humidity system equivalent to 732 cu. ft.
E1380	Oxygen concentrator, high humidity system equivalent to 976 cu. ft.
E1381	Oxygen concentrator, high humidity system equivalent to 1220 cu. ft.
E1382	Oxygen concentrator, high humidity system equivalent to 1464 cu. ft.
E1383	Oxygen concentrator, high humidity system equivalent to 1708 cu. ft.
E1384	Oxygen concentrator, high humidity system equivalent to 1952 cu. ft.
E1385	Oxygen concentrator, high humidity system equivalent to over 1952 cu. ft.
E1390	Oxygen Concentrator, Capable Of Delivering 85 Percent Or Greater Oxygen
K0533	Respiratory Assist Device, Bi-Level Pressure Capability, With Backup Rate
K0534	Respiratory Assist Device, Bi-Level Pressure Capacity, With Back Up Rate

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**

Confidential and Proprietary

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 three months 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

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Equipment Charges: (rental or purchase)	HMO

Coverage Variation: Benefit Plan DIRPI: 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**

Confidential and Proprietary

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

Note: 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: Professional Charges: **IPA**
Inpatient and/or Outpatient Surgical **HMO**
Facility Charges:

Confidential and Proprietary

Erythropoietin (EPO)

Benefit: Erythropoietin (EPO) is in benefit.

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 DIRPI- Excluded

Note: See related benefits interpretation on Drugs

Family Planning

Benefit: Family planning services are generally in benefit including family planning counseling, prescribing of contraceptive drugs, contraceptive devices, injectable contraceptives and sterilization. Oral contraceptives, NuvaRing 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
- Depo-Provera
- FDA Approved Implants

Paid by:

Professional Charges:	IPA
Device Charges (except Diaphragms):	IPA
Depo-Provera:	IPA
FDA Approved Implants:	IPA
Diaphragms (member must submit bills to HMO for reimbursement with)	HMO

- 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: A small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors and coverage may vary. Any member that has Prescription Drug coverage under the HMO is eligible for the birth control patch and oral contraceptives, except as noted below.

Effective July 1, 2017, contraceptives are not in benefit for members of the Archdiocese of Chicago Employer Group. The group numbers are: H00120, H00119, B00599, and B00598.

Effective Jan. 1, 2020, Wheaton College B93046: IUDs and Contraceptive Implants are not in benefit.

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 DIRPI- No drug benefit.

Some employer groups have no, or limited, pharmacy benefits.
A small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors and coverage may vary.

Growth Hormone Therapy

Benefit: Growth hormone therapy is in benefit if determined medically necessary by the Primary Care Physician (PCP).

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.

Growth hormone replacement may be useful in, but is not limited to, the 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.

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

Benefit Variation: Benefit plan DIRPI- Excluded.

Members without prescription drug benefit—self-injectable excluded.

Some employer groups have no, or limited, pharmacy benefits.

A small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors and coverage may vary.

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: Professional Charges: **IPA**
Outpatient Test Charges: **IPA**
Non-covered examinations: **Member**

Hearing Aids

Benefit: Hearing aids are in benefit as noted below. A “hearing aid” is defined as a hearing instrument that is any wearable non-disposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold. "Related services" means those services necessary to assess, select, and adjust or fit the hearing instrument to ensure optimal performance, including, but not limited to: audiological exams, replacement ear molds, and repairs to the hearing instrument.

The IPA may refer the member to a supplier of its choice. The HMO members have a discount available through the TruHearing Program. The discount can be utilized in conjunction with their medical coverage. TruHearing's contact number is 866-687-2020.

Effective Oct. 1, 2010, Bone Anchored Hearing Aids (BAHA) will be considered an exception to hearing benefits. The BAHA codes (L8690 and L8691) are usually billed as part of a facility claim, but can be billed as a professional claim as well. Being that these are considered prosthetic codes, the IPA will need to contact the CAU for an exception (prospectively) to use a non-contracted provider if the BAHA will be billed as a professional claim. If the claim will be billed as part of a surgical facility claim that is the HMO's financial risk, no exception will be needed. Please note, these are being considered in benefit as an exception to hearing benefits, therefore, all HMO members have this benefit, if the PCP has determined medical necessity.

Pediatric Hearing aid benefits vary as follows:

Effective Aug. 23, 2018: for policies that are newly issued, or upon those that are revised, renewed or amended on or after this date:

- Blue Precision, Blue CareDirect and BlueFocus Care members are covered up to the age of 19.
- HMO Illinois and Blue Advantage HMO members are covered up to the age of 18.
 - The following is in benefit:
 - One hearing aid/instrument per ear every 36 months, to include parts, attachments or accessories, including an ear mold,
 - Related services such as audiological exams and selections, fitting and adjustment of ear molds
 - Hearing instrument repairs

Adult Hearing aid benefits vary as follows:

Effective January 2, 2020: for policies that are newly issued, or upon those that are revised, renewed or amended on or after this date:

- Blue Precision, Blue CareDirect and BlueFocus Care members 19 and over have benefits as listed below.
- HMO Illinois and Blue Advantage HMO members 18 and over have benefits as listed below .
 - The following is in benefit (unless otherwise described in the chart on the following pages):

One hearing aid/instrument for each ear up to \$2500.00 every 24 months, to include parts, attachments or accessories, including ear mold,

- Related services such as audiological exams and selections, fitting and adjustment of ear molds
- Hearing instrument repairs

Hearing Aids (cont.)

Paid by:	Member with benefits for hearing aid:	
	Professional fees:	IPA
	Hearing aid:	HMO
	BAHA device:	HMO
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Member without benefits for hearing aid:	
	Professional fees (related to hearing aid):	Member
	Professional Charges (related to audiometry):	IPA
	Hearing aid:	Member
	BAHA device:	HMO
	Inpatient and/or Outpatient Surgical	
	Facility Charges (related to BAHA device):	HMO

Note: See related benefits interpretation on Hearing Screening

Hearing Aids (cont.)

Employer Group	Group Number	Hearing Aid Benefit	Benefit Plan Number	Benefit Plan Name	Cancel Date
American Academy of Pediatrics	H64598	1 hearing aid covered every 36 months from date of purchase	H61	GF520	
American Medical Association	H36750	1 Pair Covered Every 36 Months From Date of Purchase	V50	TLG25	1/1/2018
American Medical Association	H36750	1 Pair Covered Every 36 Months benefit period	K09	X8M40	
Associated Banc Corp.	B00002	1 Pair Covered Every 36 Months From Date of Purchase	689	X1G20	1/1/2014
Baxter International	B50101	Hearing aid per impaired ear; replacement; Limited to every 2 years includes hearing aid; batteries; fittings; exams	Y66	YL620	
Bloom Township High School District # 206	B01028,B228388 B228372,	2 devices per 36 months	S21	GWH30	
CATERPILLAR AURORA ACTIVE/COBRA	B51315	1 pair of hearing aids once every 36 months.	S51	VJG20	1/1/2015
CATERPILLAR JOLIET IAM ACTIVE/COBRA	B51316	1 pair of hearing aids once every 36 months.	U50	TKQ40	1/1/2015
CATERPILLAR SALARIED ACTIVE/COBRA	B51314	1 pair of hearing aids once every 36 months.	S51	VJG20	1/1/2015
Christian Elim Services Foundation	H29763/B29763	1 hearing aid per ear every 36 months	M21	GRH25	
Concept Schools, NFP	B01624	100% after deductible, limit to \$2,500 every 36 months	F17	CFH20	
Elmhurst College	H63088/B63088	1 Pair Covered Every 36 Months From Date of Purchase	C70	CQG15	1/1/2013
Elmhurst College	H63088/B63088	1 Pair Covered Every 36 Months From Date of Purchase	R72	RS715	1/1/2014
Elmhurst College	H63088/B63088	1 Pair Covered Every 36 Months From Date of Purchase	G53	WZG15	7/1/2014
Elmhurst College	H02548/B05990	1 Pair Covered Every 36 Months From Date of Purchase	G53/K03	WZG15/RKM30	
Fermi Research Alliance, LLC	B51346	1 pair covered at 100% after \$200 copay every 36 months	A93	D9820	
FORD HOURLY ACTIVES	B50897	1 Pair Covered Every 36 Months From Date of Purchase	701	BYG25	
Generation Brands	H24459 & B24459	\$150 For Exam(s) and up to \$600 for hearing aids every 3 years	E57	BCH20	1/1/2013
Gerresheimer Glass Policy	H94876, H94877	1 Pair Covered Every 36 Months From Date of Purchase	V54	YRE05	
HEALTH CARE SERVICE CORP	H19847, H19848 & B19847	\$5,000 maximum per lifetime coverage	L66	LL720	1/1/2013
HEALTH CARE SERVICE CORP	H81027 & B81026	\$5,000 maximum per lifetime coverage	M66	ML725	1/1/2013
HEALTH CARE SERVICE CORPORATION	H81027 & B81026	1 Pair Covered Every 36 Months From Date of Purchase	D76	DWM25	
Ispen International, Inc.	B15862	\$450 maximum per year	L46	MZE10	4/1/2014
Ispen International, Inc.	B15862	\$450 allowance per ear every 36 months	Y49	SCE20	6/1/2015
Ispen International, Inc.	B15862	\$450 allowance per ear every 36 months	R52	WJG20	
Latin School of Chicago	H00202	1 hearing aid per ear every 36 months	L17	CMF20	
Lending Solutions, Inc	B02040	1 Pair Covered Every 36 Months From Date of Purchase	P50	TDF30	
Lincolnway Area Affiliation of Participating School Districts	B01776	Two every 6 months for children or bone anchored	J12	F6V35	
Rush Street Corporation	B01384	1 hearing aid per ear every 36 months	P21	GTQ20	
Schaumburg Township-IPBC	H01475	Age 19 and under. 1 Pair Covered every 36 months from date of purchase. Over Age 19 \$2500 per year and are limited to a single purchase per hearing impaired ear every 36 months.	P79	PZM20	7/1/2018
STANDARD BAHMO ACTIVE	H19848, B19847	1 Pair Covered Every 36 Months From Date of Purchase	L66	LL720	

State of Illinois	H06800 & B06800	\$150 For Exam(s) and up to \$600 for hearing aids every 3 years	P78	PYX20	
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Confidential and Proprietary

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

Confidential and Proprietary

Hematopoietic Growth Factors (HGF)

Benefit: Hematopoietic growth factors are in benefit if determined medically necessary by the Primary Care Physician (PCP).

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.

These factors may be useful in the, but are not limited to, 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.

This is not an all-inclusive listing.

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

Benefit Benefit Plan DIRPI—self-injectable excluded

Variations: Some employer groups have limited or no self-injectable drug benefits.
A small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors and coverage may vary.

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.

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:	Professional 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 related Ancillary Charges:	HMO

Note: Blue FocusCare has a separate contracted provider list for Dialysis Providers

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 that may be ordered multiple times per day or week at a specified interval. Visits of longer duration are considered private duty nursing. Outpatient private duty nursing may not be 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 to the Utilization Management Fund as cited in the Medical Service Agreement.

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

Note: Benefit Plan NGM20 - State of Illinois - College Insurance Program (Employer Group # H06803 and B06803 has a \$30.00 copay per home health visit.)

Note: Effective July 1, 2020, Benefit Plan KPM25 - State of Illinois Actives, State of Illinois - Retirees (Employer Group # H06800 and B06800) has a \$35.00 copay per home health visit.)

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 generally not covered under the Hospice Care Program, but may remain a covered benefit – see note below.

- 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:	Professional Charges:	IPA
	Facility Charges:	HMO

Confidential and Proprietary

Hospital Beds

Benefit: Hospital beds are covered as durable medical equipment for bed-confined members if determined medically necessary by the Primary Care Physician (PCP).

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.

Paid by: HMO

Coverage Variation: Benefit Plan DIRPI- Excluded

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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 (Durolane, Orthovisc, Monovisc, Euflexxa, Supartz, Hymovis, Gel-ONE, GelSyn-3, GenVisc 850, Hyalgan, Visco-3, Synvisc/Synvisc-One and TriVisc)+

Benefit: Treatment with Hyaluronan (including, but not limited to: Durolane, Orthovisc, Monovisc, Euflexxa, Supartz, Hymovis, Gel-ONE, GelSyn-3, GenVisc 850, Hyalgan, Visco-3, Synvisc/Synvisc-One and TriVisc) is in benefit for members if determined medically necessary by the Primary Care Physician (PCP)

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 Charges: **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 (Durolane, Orthovisc, Monovisc, Euflexxa, Supartz, Hymovis, Gel-ONE, GelSyn-3, GenVisc 850, Hyalgan, Visco-3, Synvisc/Synvisc-One and TriVisc) claim.

Note: Autologous Cultured Chondrocytes, implant (J7330) has been classified as a drug, not a device. Therefore, the financial liability is:

Professional and Drug Charges: IPA (Administered in an outpatient setting)
Outpatient Surgical and Inpatient Facility Charges: HMO

Hyperthermia Therapy

Benefit: Hyperthermia Therapy is in benefit if determined medically necessary by the Primary Care Physician.

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. Local hyperthermia is usually used (but is not limited to) 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 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:

Professional Charges:	IPA
Inpatient and/or Outpatient Surgical Facility Charges:	HMO

Hypnotherapy (Hypnosis)

Benefit: Hypnotherapy is a covered benefit, when administered by a licensed Clinical Psychologist or Physician.

Interpretation: Hypnotherapy, for the purpose of HMO benefits, is defined as the use of hypnosis in the practice of clinical psychology or psychiatry services is a covered benefit. Additional information can be found in the Section 225 Illinois Compiled Statutes 15/3 (h).

Paid by:

Professional Outpatient Charges:	IPA
Professional Inpatient Charges:	IPA
Outpatient Treatment Room Charges:	IPA
Inpatient and/or Outpatient Surgical Facility Charges:	HMO
Hypnosis – administered by a non-licensed professional – all Charges:	Member

Exclusion: Hypnosis performed by a non-licensed professional

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.

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

Note: See Benefits Interpretation on Hepatitis B Vaccine

Infertility

Benefit:

Blue Cross and Blue Shield of Illinois (BCBSIL) contracts with a network of infertility practitioners to provide services to eligible members within the HMO network. Currently, WINFERTILITY INC., a division of Women's Integrated Network (WIN), serves as the central point of contact for physicians, patients and pharmacies involved with infertility services. WIN will notify HMO when a member has reached their maximum benefit or if services are requested for a member who doesn't qualify for infertility treatment. Infertility providers will also verbally notify the Member of the exhaustion of benefits if applicable.

The Infertility provider directory is listed on the IPA access portal at Provider Network Management > HMO > HMO Resources > HMO Infertility Network. Provider updates are disseminated to the IPA network as needed, via the monthly Informational Document.

Oocyte (egg) Retrievals: A member is allowed four completed oocyte (egg) retrievals per calendar year except that if a live birth follows a completed oocyte retrieval, then two more completed oocyte retrievals shall be covered (per calendar year). The Winfertility Reproductive Endocrinologist determines medical necessity for oocyte retrievals.

Note: If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count toward the insured or the member's covered completed oocyte retrievals.

Semen (sperm): Semen analysis is a covered service. This is usually done during the diagnostic work up and the IPA's financial liability.

Donor Benefits: Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures utilized to retrieve oocytes or sperm, and the subsequent procedure used to transfer the oocytes or sperm to member. Associated donor medical expenses are also covered, including but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The evaluation and treatment of infertility is in benefit to the extent described below. There are some employer groups with limited infertility benefits included at the bottom of the scope.

Note: The exclusions listed at the end of this scope also apply to donor services.

Surrogacy:

- a. **Surrogate is the HMO Member:** All infertility services provided to the surrogate are not covered. Obstetrical care is covered for the surrogate once pregnancy is established.
- b. **Surrogate is not the HMO Member:** There is no coverage for infertility or obstetrical care rendered to the surrogate.

Medication:

All drugs (injectables, oral, patches, suppositories, etc.) required in the evaluation and treatment of infertility are a covered benefit subject to the member copay. Members that do not have the HMO prescription drug benefit or an equivalent are entitled by law to

Infertility (cont.)

receive infertility medication. Infertility medication must be obtained through a WIN contracted mail order pharmacy vendor, therefore, the infertility provider and/or member must contact WIN for authorization for their medication and/or applicable member reimbursement.

Medication for an egg donor is covered.

Advanced Reproductive Technology including:

- infertility treatment with ovulation induction agents,
- uterine embryo lavage,
- embryo transfer,
- artificial insemination,
- oocyte retrievals,
- Gamete Intrafallopian Transfer (GIFT),
- Zygote Intrafallopian Transfer (ZIFT),
- low tubal ovum transfer,
- epididymal sperm aspiration, and
- intracytoplasmic sperm injection (CSI).
- In vitro fertilization.

Pre-implantation Genetic Diagnosis (PGD) – (Infertility Related)

PGD can be performed in situations where the suspected chromosomal abnormality is believed to be a cause of infertility. See Pre-implantation Genetic Diagnosis (PGD) in this section of the provider manual– Infertility Related Guideline for details of coverage.

PGD requires in vitro fertilization (IVF). It is covered if the member has not exhausted their IVF benefit. If a member has exhausted benefits for complete oocyte retrievals per calendar year and is a candidate for an approved Pre-implantation Genetic Diagnosis (PGD), since PGD requires oocyte retrievals, PGD is not in benefit during the same calendar year unless related to the one of the approved oocyte retrieval. (See PGD Guidelines in this section of the provider manual).

Interpretation: In accordance with applicable law, coverage is provided for the treatment of infertility. The law does not apply to self-insured employers or to trusts or insurance policies written outside of Illinois. To receive infertility coverage, the member must meet the definition of infertility and not be sterile as a result of a voluntary sterilization procedure.

If infertility is due to an underlying medical condition, the member will return to the IPA Primary Care Physician (PCP) or Women's Principal Health Care Provider (WPHCP) for the treatment of that condition. (i.e., pituitary adenoma, thyroid disease, etc). If the initial history and exam suggest any underlying medical condition, this condition should be ruled out or treated before the member is referred for primary infertility treatment.

Diagnosis: A diagnosis of infertility is established when a male or female meets any one of the four definitions described below. The PCP/WPHCP is responsible for diagnosing the member as infertile. This includes:

1. Inability to conceive after one year of unprotected sexual intercourse. Unprotected sexual intercourse means sexual union between a male and female, without the use of any process, device, or method that prevents conception, including but not limited to oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence, or voluntary permanent surgical procedures. Such union should include appropriate measures to ensure the health and safety of sexual partners.

Infertility (cont.)

The one-year time frame should be applied to women younger than 35 when establishing a primary diagnosis of infertility. However, a shorter time frame of six (6) months should be used in the following circumstances:

- Women 35 and older
- Women having unprotected intercourse with a male and who are not menstruating and/or have a cycle length of equal to or greater than 35 days
- Women with a physician's diagnosis of Bilateral Tubal Occlusions, based on hysterosalpingogram (HSG) or prior surgery, which was not caused by a voluntary sterilization procedure
- Suspected Male factor infertility with either azoospermia or no motile sperm

The presence of voluntary sterilization (such as vasectomy or tubal ligation) is considered 'protection' for sexual intercourse, and thus does not meet the definition of infertility. 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 is determined by the following:

- Female: Evidence of dye penetrating at least one fallopian tube on a, hysterosalpingogram
- Male: Sperm Concentration $>$ or $=$ 15 million per ml and motility $>$ or $=$ 40% and strict morphology $>$ or $=$ 4%.

2. A woman is unable to sustain a successful pregnancy. 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.
3. Either the man or woman has been diagnosed by a physician as having a medical condition that renders conception impossible through unprotected sexual intercourse.
4. The woman has undergone one year of medically based and medically supervised methods of conception, including artificial insemination, which a physician has determined to have failed and if continued, would not be likely to lead to a successful pregnancy.

Diagnosis should also include but not limited to:

- history and physical
- semen analysis
- pap smear
- cervical cultures
- medical endocrine workup (such as thyroid functions and protection)
- Chlamydia cultures

Note: A copy of the test results must be attached to the referral or given to the member. Infertility Providers will not see members without these test results.

Referrals:

Once a diagnosis of infertility is established, the following policies and procedures apply to the referral of HMO members to network infertility providers. Benefits must be verified prior to issuing a global referral for services.

Infertility (cont.)

- Members should be given a global referral with a primary diagnosis of infertility. It should be open ended, and should not limit the services that are being recommended.
- HMO members with global referrals requesting to change WIN providers or who want a second opinion will not have to obtain a new referral as long as they remain within the current IPA. To facilitate the transition, the member should obtain their medical records from their current provider prior to seeking services with a new provider.
- A new global referral is required if a HMO member selects a new IPA.
- IPAs that do not refer for infertility services need to direct HMO members to the Customer Assistance Unit (CAU) at 312-653-6600 for a referral to a contracted provider in the WIN network.
- Global referrals remain in effect for the duration of a member's existing insurance coverage or until the member has a live birth.
- Women who have experienced repeated spontaneous abortions will be referred back to their regular obstetricians, but will also be followed by Winfertility providers until the time of threatened abortion is past.
- Once pregnancy is established and fetal heart tones are detected by ultrasound (approximately six weeks), the infertility services are complete and the member will be referred back to her PCP or WPHCP for prenatal care.

Exclusions:

1. Services provided to a non HMO insured surrogate.
2. Non-medical services of an egg, sperm, or embryo-donor including but not limited to transportation fees, shipping and handling fees and donation fees.
3. Reversal of voluntary sterilization (tubal ligation or vasectomy).
4. Cryopreservation (freezing) and storage of sperm, eggs or embryos.
5. Selective termination of embryo (in cases where the person's life is not in danger).
6. All investigational infertility procedures, tests, treatments or drugs.
7. Procedures which violate the religious and moral teachings or beliefs of the employer group. See Employer Groups with Limited Infertility Benefits below.
8. Predetermination Screening Counseling (PSC)
9. Preimplantation Genetic Screening (PGS)

Paid by:

Professional Charges prior to global referral issued	IPA
Professional Charges if referred by an IPA physician to a contracted infertility provider	WIN
Professional Charges if referred by an IPA physician to a non-contracted infertility provider	IPA

Infertility (cont.)

Semen Analysis done by IPA before global referral is issued	IPA
Semen Analysis done by contracted infertility provider after global referral is issued	WIN
Diagnostic tests done by IPA before global referral is issued	IPA
Diagnostic tests done by contracted infertility provider after global referral is issued	WIN
Obstetrical care once pregnancy is established	IPA
Inpatient and/or Outpatient Surgical Facility Charges	HMO
Infertility related medication ordered by the HMO Infertility provider (minus applicable copays)	WIN
All charges related to medically supervised Artificial Insemination prior to the diagnosis of infertility	Member

Note: No units will be charged towards the IPA's Utilization Management Fund for Infertility services managed by the contracted infertility provider.

Coverage Variation:

Benefit Plan DIRPI—excluded.

Employer Groups with Limited Infertility Benefits:

The mandated infertility coverage may be excluded from an employee's benefit plan if it is in violation of a religious organization's moral teachings and beliefs. Below is a list of the groups who are exempt from the infertility legislation. This list may not be all inclusive. Benefits should be verified prior to referring a member for infertility services.

See Also:

IPA Infertility Guidelines (ADM -56) in the HMO Policy section on the BCBSIL website.
Pre-implantation Genetic Diagnosis (PGD) – (Infertility Related) in this section.

Infertility (cont.)

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. This list may not be all-inclusive

HMO Group Number	Group Name	Services Covered*
H00097	Specialty Physicians of Illinois, LLC	1 only (effective 01/01/07)
H01445	Presence Fox Knoll	1 only
H01446	Presence Mcauley Manor	1 only
H01447	Presence Health Corporate	1 only
H01448	Presence Service Corp	1 only
H01449	Presence Villa Franciscan	1 only
H01450	Presence St. Anne	1 only
H01451	Presence Cor Mariae	1 only
H01452	Presence St. Joseph	1 only
H01453	Presence Senior Services	1 only
H01455	Presence Home Care	1 only
H01456	Presence Geneva Care	1 only
H01457	Presence Pineview Care	1 only
H18189	Alverno Clinical Laboratories	1, 2, 3 (IVFGI only) 4 (IVFDG only)
H00120	Archdiocese of Chicago	1 only
H00119	Archdiocese of Chicago	1 only
H55970	Catholic Cemeteries	1 only
H57208	St. Coletta's of Illinois	1,2,3(IVFGI only), 4(IVFDG only)
H59010	Presence Health Preferred	1 only
H59051	Presence St. Francis Hospital	1 only
H59060	Presence Behavioral Health	1 only
H59075	Presence Home Health	1 only
H59076	Presence Ambulatory	1 only
H59081	Presence Resurrection System Service	1 only
H59082	Presence Holy Family	1 only
H59083	Presence St. Joseph Hospital	1 only
H59084	Presence St. Mary and Elizabeth Hospital	1 only
H59085	Presence Ambulatory	1 only
H59316	Presence Our Lady of Resurrection	1 only
H59999	Presence Senior Services Resurrection Nursing Home	1 only
H64536	St. James Hospital	1 only
H64593	Presence Health	1 only

Infertility (cont.)

Blue Advantage Group Number	Group Name	Services Covered*
B00843	Presence Health Network	1 only
B00097	Specialty Physicians of Illinois, LLC	1 only (effective 01/01/07)
B02647	Presence Home Care	1 only
B02649	Presence St. Joseph Hospital	1 only
B02650	Presence Geneva Care	1 only
B02651	Presence Pineview Care	1 only
B06245	St. Coletta's of Illinois	1, 2, 3(IVFGI only), 4(IVFDG only)
B00599	Archdiocese of Chicago	1 only
B00598	Archdiocese of Chicago	1 only
B59010	Presence Health Preferred	1 only
B59051	Presence St Francis Hospital	1 only
B59060	Presence Behavioral Health	1 only
B59075	Presence Home Health	1 only
B59076	Presence Ambulatory	1 only
B59081	Presence Resurrection Systems Services	1 only
B59082	Presence Holy Family	1 only
B59083	Presence St. Joseph Hospital	1 only
B59084	Presence St. Mary and Elizabeth Hospital	1 only
B59085	Presence Ambulatory	1 only
B59316	Presence Our Lady of the Resurrection	1 only
B59999	Presence Senior Services	1 only
B64528	Wheaton Franciscan Service	1,2,3,4, 5 (standard)
B64536	St. James Hospital	1 only
B64593	Presence Resurrection Medical Center	1 only
B64594	Presence Fox Knoll	1 only
B64596	Presence Health Corporate	1 only
B64597	Presence Service Corp	1 only
B64598	Presence Villa Franciscan	1 only
B64599	Presence St. Anne	1 only
B64601	Presence Cor Mariae	1 only
B64602	Presence St. Joseph	1 only
B64603	Presence Senior Services	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: Professional Charges: **IPA**
Inpatient and/or Outpatient Surgical Facility Charges: **HMO**
Equipment Charges: **HMO**

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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 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:	Professional 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 DIRPI-Excluded

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

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

Intravenous Immunoglobulin (IVIG)

Benefit: Intravenous immunoglobulin is in benefit if determined medically necessary by the Primary Care Physician. .

Interpretation: Immunoglobulins are protein antibodies produced by plasma cells.. Mechanisms of action vary from simple replacement, such as in primary hypogammaglobulinemia to complex antibody-antigen interactions, such as in idiopathic thrombocytopenic purpura.

Intravenous immunoglobulin may be used 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 leukemia
- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS)
- Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS)
- Or such other condition determined by the PCP

This is not an all-inclusive listing.

Paid by:	Administration in physician office:	IPA
	Inpatient and/or Outpatient Surgical 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

Investigational Procedures, Drugs, Devices, Services, and/or Supplies

Benefit: Procedures, drugs, devices, services and/or supplies which are investigational are generally excluded from coverage by the Certificate of Coverage. However, certain of these services, are in benefit, reflecting provisions of Federal (Patient Protection and Affordable Care Act (PPACA) – Section 2709) and Illinois state (Public Act 097-0091) law. This benefit includes clinical trials in Phase I, II, III or IV.

Interpretation: A procedure, drug, device, service and/or supply (referred to as a service in the following document) are defined as investigational if it meets the following criteria:

1. It is provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or
2. It is awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to the member, and
3. Specifically with respect to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to the member.

There are certain services that are in benefit:

1. Applied behavior analysis used for the treatment of Autism Spectrum Disorder(s)
2. Services provided within the context of a clinical trial

Clinical trial services are in benefit if all of the following are met:

1. The PCP has determined medical necessity and has referred the member to the clinical trial that is designed to address a potentially life-threatening condition. This is not limited to a cancer diagnosis, AND
2. It is a qualified clinical trial - determined by meeting at least one of the following criteria:
 - a. The trial is approved or funded by one or more of the following:
 - i. The National Institutes of Health
 - ii. The Centers for Disease Control and Prevention
 - iii. The Agency for Health Care Research and Quality
 - iv. The Centers for Medicare & Medicaid Services
 - v. A cooperative group or center of any of the entities described in clauses (i) through (iv) above or the Department of Defense or the Department of Veterans Affairs
 - vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - vii. The Department of Veterans Affairs
 - viii. The Department of Defense
 - ix. The Department of Energy
 - b. OR it is conducted under an investigational new drug application reviewed by the Food and Drug Administration
 - c. OR it is a drug trial that is exempt from having such an investigational new

Investigational Procedures, Drugs, Devices, Services, and/or Supplies (cont.)

- drug application
3. AND, the services would normally be covered for members who are not enrolled in a clinical trial.

The clinical trial can be Phase I, II, III or IV.

Coverage of routine care for members in a qualified clinical trial is subject to the same requirements, such as authorization and utilization management. An IPA can require the member to use an in-network provider if one is available to provide routine care in connection with the clinical trial.

There are certain services that are not in benefit. These include:

- Services which are experimental, investigational, or of unproven efficacy and which do not meet the definitions of coverage as described above
- Out-of-network services, that are not approved by the PCP
- A service provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the member
- A non-health care service that the member is required to receive as a result of participation in the clinical trial
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- An investigational drug or device that has not been approved for market by the United States Food and Drug Administration
- Services provided to members of an employer group that meets the grandfathered status under the Affordable Care Act (ACA)

Paid by:

Professional Charges (not covered by clinical trial):
Inpatient and/or Outpatient Surgical Facility Charges (not covered by clinical trial):

**IPA
HMO**

Note: It is strongly recommended that the IPA contact the clinical trial/research facility in advance, to establish the coverage for any anticipated services.

See related benefits interpretations: ASD

Laboratory Tests

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

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. If the IPA refers a member for laboratory or pathology services, and the lab/pathology provider sends a portion of the processing and/or reading to another lab/pathology vendor, the IPA remains responsible for all services performed.

Paid by: Outpatient Laboratory and Pathology Services

Facility Charges: **IPA**

Professional **IPA**

Charges:

Inpatient Facility and/or Outpatient Surgical Facility Laboratory and Pathology Services

Facility Charges: **HMO**

Professional **IPA**

Charges:

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 and/or Outpatient **HMO**
Surgical facility Charges:
Professional 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 DIRPI- Excluded

Note: A small percentage of HMO members receive pharmacy benefits from non-BCBSIL vendors and coverage may vary. 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/WHCP 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. Lactation Counseling is also a covered service. This is considered preventive care, therefore, no copayment should be collected.

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 a member in the second or third trimester joins the HMO, she may have a Transition of Care (TOC). To determine if there is a TOC – contact the HMO customer service department. If the member does not have a TOC, the IPA retains the responsibility for the obstetrical services. The IPA physician may be reluctant to assume responsibility of a new member in her third trimester. 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, 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
	Inpatient and/or Outpatient Surgical 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 located on the BCBSIL website.

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 medical supply. If the IPA receives a bill, the IPA would follow the normal group approval process. If the member pays up front for the medical supply, 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.

Effective Jan. 1, 2019, Public Act (PA)100-1024 created a new definition as follows: "Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. In addition, the Public Act deleted the definition of "serious mental illness."

(Included for historical purposes) In June 2006, the law Public Act (PA) 094-0906 and PA 094-0921 was signed impacting the existing Illinois Compiled Statutes (215 ILCS 5/370c). This law required all HMOs to comply with all provisions of the SMI statute effective Jan. 1, 2007.

SMI includes psychiatric illnesses of:

- 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) – see Autism scope for additional information
- Obsessive-compulsive disorders
- Depression in childhood and adolescence
- Panic disorder
- Post-traumatic stress disorders (acute, chronic, or with delayed onset)
- Anorexia Nervosa (effective Jan. 1, 2008)
- Bulimia Nervosa (effective Jan. 1, 2008)
- Eating disorders, including but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specific feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (effective Aug. 24, 2017)

Refer to the note at the end of this section for 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, 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.

Mental Health Care (Inpatient) (cont.)

A mental health inpatient admission is not in benefit (without a mental health diagnosis) 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, intensive outpatient psychiatric programs and residential programs are included in the member's inpatient mental health benefit.

Members admitted to BCBSIL contracted psychiatric partial hospitalization programs or intensive outpatient programs will have every one day in the program charged as 0.25 units towards the IPA's Utilization Management (UM) Fund. Every one day in a residential facility will be charged as 0.5 unit towards the IPA's UM Fund.

Serious Mental Illness (SMI)

Policies issued or renewed after Jan. 1, 2007, are subject to the provisions of (215 ILCS 5/370c). This law provided additional coverage for inpatient and outpatient services:

- Increased inpatient mental health benefits to 45 days in addition to the purchased benefits
- Increased outpatient mental health benefits to include 60 visits in addition to the purchased benefits
- Twenty additional speech therapy visits for members with a PDD diagnosis
- Allowed members to self-refer to any mental health provider (regardless of contracted status) for a non-SMI diagnosis and receive 50 percent coverage. The benefits are described in the paid by section of this scope. The IPA should stamp any self-directed claims as NGA OON (out of network) and submit them to the HMO.
- No impact on coverage for chemical dependency

Effective Aug. 1, 2012, the HMOs have made an administrative decision to cover diagnosis code 311 for members under 18 years of age as a non-SMI diagnosis.

Effective Aug. 24, 2017, the Public Act 100-0305 updated the definition of a SMI to include : eating disorders, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Mental Health Parity

Mental Health Parity and Addiction Equity Act of 2008

The Emergency Economic Stabilization Act of 2008 included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (The MHPAEA or ACT). The ACT does not require coverage of mental health (MH) or substance use (SU) benefits but if plans do cover such benefits, it required that group health plans and group health insurers apply the same treatment and financial limits to medical-surgical and mental health and substance use disorders. Under this law, all previous day/visit limits were removed for a member being treated by a mental health provider.

The requirements of the new law were effective for plan years beginning on or after one year from the date the legislation was signed into law. (Oct. 3, 2008). As a result, the provisions applied to new contracts and renewals on or after Oct. 3, 2009, but not before Nov. 1, 2009.

Mental Health Care (Inpatient) (cont.)

From Nov. 1, 2009, through July 1, 2010, a copay was charged based upon provider type (e.g. a specialist visit would have the specialist copay charged). Starting July 1, 2010, upon employer group renewal; the copay policy is:

- If a member is treated by their PCP, the PCP co-pay is applied.
- If a member is treated by any MH/SU professional, the PCP co-pay is applied.
- If member is seeing a rehab therapist, the rehab co-pay applies.

The co-pay is applied as above whether it's SMI or Non-SMI or Substance Use Disorder.

Paid by:	GA Professional Charges:	IPA
	Professional Charges (in area - non SMI/SMI/Substance Use – non emergency - NGA)	HMO – 50% paid to the provider if accepts benefit assignment, to the member if does not
	Professional Charges (out of area emergency – regardless of diagnosis)	HMO
	Outpatient lab services billed independently of a group approved residential program services	IPA
	GA Facility Charges:	HMO
	Facility Charges (in area - non SMI/SMI/Substance Use – non-emergency - NGA)	HMO - 50% paid to provider
	Facility Charges (out of area emergency – regardless of diagnosis)	HMO

Special Coverage Note—Electroconvulsive Therapy (ECT)

Inpatient ECT services are in benefit. These services are considered to be medical services. ECT is subject to usual Utilization Management Fund chargeback.

Mental Health Care (Inpatient) (cont.)

List of Serious Mental Illness (SMI) – ICD-10

Diagnosis Code	DESCRIPTION
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.8	Other Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, unspecified
F28	Other Psychotic Disorder not due to a Substance or known physiologic condition
F29	Unspecified Psychosis not due to a substance or known physiological condition
F30.1	Manic Episode without Psychotic Symptoms
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic Episode, severe with Psychotic Symptoms
F30.3	Manic Episode in partial remission
F30.4	Manic Episode in Full remission
F30.8	Other manic Episodes
F30.9	Manic Episode, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32	Major Depressive Disorder, single episode
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode
F32.4	Major depressive disorder, single episode, in partial; remission
F32.5	Major depressive disorder, single episode, in full remission
F32.8	Other depressive episodes
	Atypical Depression

Mental Health Care (Inpatient) (cont.)

	Post-schizophrenic depression
	Single episode of "masked" depression NOS
F32.9	Major depressive disorder, single episode, unspecified
	Depression NOS
	Depressive disorder NOS
	Major depression NOS
F33	Major depressive disorder, recurrent
	Includes: recurrent episodes of depressive reaction
	recurrent episodes of endogenous depression
	recurrent episodes of major depression
	recurrent episodes of psychogenic depression
	recurrent episodes of reactive depression
	recurrent episodes of seasonal depressive disorder
	recurrent episodes of vital depression
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent severe with psychotic features
	Endogenous depression with psychotic features
	Recurrent severe episodes of major depression with mood-congruent psychotic symptoms
	Recurrent severe episodes of major depression with mood-incongruent psychotic symptoms
	Recurrent severe episodes of major depression with psychotic symptoms
	Recurrent severe episodes of psychogenic depressive psychosis
	Recurrent severe episodes of psychotic depression
	Recurrent severe episodes of reactive depressive psychosis
F33.4	Major depressive disorder, recurrent, in remission
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
	Recurrent brief depressive episodes
F33.9	Major depressive disorder, recurrent, unspecified
	Monopolar depression NOS
F31	Bipolar Disorder
F31.0	Bipolar disorder, current episode hypomanic
F31.1	Bipolar disorder, current episode manic without psychotic features
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate

Mental Health Care (Inpatient) (cont.)

F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar Disorder, current episode manic severe with psychotic features
F31.3	Bipolar Disorder, current episode depressed, mild or moderate severity
F31.30	Bipolar Disorder, current episode depressed, mild or moderate severity unspecified
F31.31	Bipolar Disorder, current episode depressed, mild
F31.32	Bipolar Disorder, current episode depressed, moderate
F31.4	Bipolar Disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar Disorder, current episode depressed, severe with psychotic features
F31.6	Bipolar Disorder, current episode mixed
F31.60	Bipolar Disorder, current episode mixed, unspecified
F31.61	Bipolar Disorder, current episode mixed, mild
F31.62	Bipolar Disorder, current episode mixed, moderate
F31.63	Bipolar Disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar Disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar Disorder, currently in remission, most recent episode unspecified
F31.7	Bipolar Disorder, currently in remission
F31.71	Bipolar Disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar Disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar Disorder, in partial remission, most recent episode manic
F31.74	Bipolar Disorder, in full remission, most recent episode manic
F31.75	Bipolar Disorder, in partial remission, most recent episode depressed
F31.76	Bipolar Disorder, in full remission, most recent episode depressed
F31.77	Bipolar Disorder, in partial remission, most recent episode mixed
F31.78	Bipolar Disorder, in full remission, most recent episode mixed
F31.8	Other Bipolar Disorders
F31.81	Bipolar II disorder
	affective disorders
F34.0	Cyclothymic disorder
	Affective personality disorder
	Cycloid personality
	Cyclothymia
	Cyclothymic personality
F34.1	Dysthymic disorder
	Depressive neurosis
	Depressive personality disorder
	Dysthymia
	Neurotic depression
	Persistent anxiety depression
F34.8	Other persistent mood (affective) disorders

Mental Health Care (Inpatient) (cont.)

F34.9	Persistent mood (affective) disorder, unspecified
F39	Unspecified mood (affective) disorder
F41.0	Panic disorder (episodic paroxysmal anxiety) without agoraphobia
	Panic attack
	Panic state
F42	Obsessive-compulsive disorder
F42.8	Other Obsessive – Compulsive Disorder (includes rumination)
F43.1	Post-traumatic stress disorder (PTSD)
	Traumatic neurosis
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/ purging type
F50.2	Bulimia nervosa
	Bulimia NOS
	Hyperorexia nervosa
F50.81	Binge Eating Disorder
F50.82	Avoidant/Restrictive Food Intake Disorder
F50.89	Other Specified Eating Disorder
F50.9	Eating Disorder Unspecified
	Anancastic neurosis
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.5	Asperger's syndrome
	Asperger's Disorder
	Schizoid disorder of childhood
	Autistic psychopathy
F84.8	Other pervasive developmental disorders
	Overactive disorder associated with intellectual disabilities and stereotyped movements
F84.9	Pervasive developmental disorder, unspecified
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Childhood
F98.3	Pica of Infancy and Childhood

Mental Health Care (Inpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis – ICD-9 Version

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 CURRENT DEPRESSED MILD
29652	BIPOLAR I MOST RECENT EPISODE OR CURRENT DEPRESSED MODERATE
29653	BIPOLAR I DISORD MOST REC EPI OR CURRENT DEPRESSED SEVERE W/O MENTION PSYCHOTIC BEHAVIOR
29654	BIPOLAR I DISORD MOST REC EPI OR CURRENT DEPRESSED SEVERE AS WITH PSYCHOTIC BEHAVIOR
29655	BIPOLAR I DISORD MOST REC EPI OR CURRENT DEPRESSED IN PARTIAL OR UNSPECIFIED 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 CURRENT MIXED SEVERE W/O MENT PSYCHOTIC BEHAVIOR
29664	BIPOLAR I DISORD MOST REC EPI OR CURRENT MIXED SEVERE SPEC AS WITH PSYCHOTIC BEHAVIOR
29665	BIPOLAR I DISORD MOST REC EPI OR CURRENT MIXED IN PARTIAL 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.

Effective Jan. 1, 2019, Public Act (PA)100-1024 created a new definition as follows:

"Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. In addition, the Public Act deleted the definition of "serious mental illness."

Effective Jan. 1, 2020, telepsychiatry will be a covered benefit for Blue Precision HMO, Blue FocusCare and BlueCare Direct. Telepsychiatry refers to behavioral health services rendered by a Psychiatrist via a simultaneous audio and video telehealth setting permitting 2-way, live interactive communication between the patient and the distant site health care provider. Telepsychiatry can also be offered by licensed Nurse Practitioners and Physician Assistants operating within the scope of their license. Telepsychiatry may include a range of services, such as medication management, psychiatric evaluations, therapy (individual therapy, group therapy, family therapy) and patient education.

(Information included for historical reference) In June 2006, the law Public Act (PA) 094-0906 and PA 094-0921 was signed impacting the existing Illinois Compiled Statutes (215 ILCS 5/370c). This law required all HMOs to comply with all provisions of the SMI statute effective Jan. 1, 2007.

SMI includes psychiatric illnesses of:

- 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) – see Autism scope for additional information
- Obsessive-compulsive disorders
- Depression in childhood and adolescence
- Panic disorder
- Post-traumatic stress disorders (acute, chronic, or with delayed onset)
- Anorexia Nervosa (effective Jan. 1, 2008)
- Bulimia Nervosa (effective Jan. 1, 2008)
- Eating disorders, including but not limited to, anorexia nervosa, bulimia nervosa , pica, rumination disorder, avoidant/restrictive food intake disorder, other specific feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (effective Aug. 24, 2017)

Refer to the note at the end of this section for 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.

Mental Health Care (Outpatient) (cont.)

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; this does not exclude members with mental retardation. 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, psychological testing, transcranial magnetic stimulation (TMS), biofeedback and neurofeedback. Marriage counseling for those members in a qualified Domestic Partnership, Civil Union or marriage is also a covered service.

Mental Health Care (Outpatient) (cont.)

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.

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. 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.

TELEPSYCHIATRY GUIDELINES

Providers Rendering Telepsychiatry: Psychiatrists contracted with HMO IPAs must be credentialed and do not require additional licensing to perform telepsychiatry. Psychiatrists, Nurse Practitioners and Physician Assistants are the only type of providers who should be performing telepsychiatry.

Advanced Nurse Practitioners and Physician Assistants may render Telepsychiatry services provided they are operating within the scope of their license.

Psychiatrists, Nurse Practitioners and/or Physician Assistants who perform telepsychiatry must use internet software that is HIPAA compliant.

Serious Mental Illness (SMI)

Policies issued or renewed after Jan. 1, 2007, are subject to the provisions of (215 ILCS 5/370c). This law provided additional coverage for inpatient and outpatient services:

- Increased inpatient mental health benefits to 45 days in addition to the purchased benefits
- Increased outpatient mental health benefits to include 60 visits in addition to the purchased benefits
- Twenty additional speech therapy visits for members with a PDD diagnosis
- Allowed members to self-refer to any mental health provider (regardless of contracted status) for a non-SMI diagnosis and receive 50 percent coverage. The benefits are described in the paid by section of this scope. The IPA should stamp any self-directed claims as NGA OON (out of network) and submit them to the HMO
- No impact on coverage for chemical dependency

Effective Aug. 1, 2012, the HMOs have made an administrative decision to cover diagnosis code 311 for members under 18 years of age as a non-SMI diagnosis.

Effective Aug. 24, 2017, the Public Act 100-0305 updated the definition of a SMI to include: eating disorders, including, but not limited to, anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Mental Health Care (Outpatient) (cont.)

Mental Health Parity

Mental Health Parity and Addiction Equity Act of 2008

The Emergency Economic Stabilization Act of 2008 included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (The MHPAEA or ACT). The ACT does not require coverage of mental health (MH) or substance use (SU) benefits but if plans do cover such benefits, it required that group health plans and group health insurers apply the same treatment and financial limits to medical-surgical and mental health and substance use disorders. Under this law, all previous day/visit limits were removed for a member being treated by a mental health provider.

The requirements of the new law were effective for plan years beginning on or after one year from the date the legislation was signed into law. (Oct. 3, 2008). As a result, the provisions applied to new contracts and renewals on or after Oct. 3, 2009, but not before Nov. 1, 2009.

From Nov. 1, 2009, through July 1, 2010, a copay was charged based upon provider type (e.g. a specialist visit would have the specialist copay charged). Starting July 1, 2010, upon employer group renewal; the copay policy is:

- If a member is treated by their PCP, the PCP co-pay is applied.
- If a member is treated by any MH/SU professional, the PCP co-pay is applied.
- If member is seeing a rehab therapist, the rehab co-pay applies.

The co-pay is applied as above whether it's SMI or Non-SMI or Substance Use Disorder.

Benefits are NOT available for:

- Services directed toward making one's personality more forceful or dynamic.
- Consciousness raising.
- Vocational or religious counseling.
- Group socialization (except in the treatment of ASD)
- Educational activities (i.e., smoking cessation classes)
- Simple lifestyle dissatisfactions which are a reaction to common life stresses
- 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).

Special Coverage Notes **Electroconvulsive Therapy (ECT)**

Outpatient ECT services are in benefit. These services are considered to be medical services. ECT is subject to usual utilization management fund unit charge.

Mental Health Care (Outpatient) (cont.)

Paid by:	GA Professional Charges:	IPA
	Professional Charges (in area - non SMI/SMI/Substance Use –non-emergency - NGA)	HMO – 50% paid to the provider if accepts benefit assignment, to the member if not
	Professional Charges (out of area emergency – regardless of diagnosis)	HMO
	GA Outpatient Treatment/ Diagnostic Facility Charges:	IPA
	Outpatient Treatment/Diagnostic Facility Charges (in area - non SMI/SMI/Substance Use – non-emergency - NGA)	HMO – 50% paid to the facility
	Facility Charges (out of area emergency – regardless of diagnosis)	HMO

Note: refer to ASD Guideline for additional information.

Mental Health Care (Outpatient) (cont.)

List of Serious Mental Illness (SMI) – ICD-10

Diagnosis Code	DESCRIPTION
F20.0	Paranoid Schizophrenia
F20.1	Disorganized Schizophrenia
F20.2	Catatonic Schizophrenia
F20.3	Undifferentiated Schizophrenia
F20.5	Residual Schizophrenia
F20.8	Other Schizophrenia
F20.81	Schizophreniform Disorder
F20.89	Other Schizophrenia
F25.0	Schizoaffective Disorder, Bipolar Type
F25.1	Schizoaffective Disorder, Depressive Type
F25.8	Other Schizoaffective Disorders
F25.9	Schizoaffective Disorder, unspecified
F28	Other Psychotic Disorder not due to a Substance or known physiologic condition
F29	Unspecified Psychosis not due to a substance or known physiological condition
F30.1	Manic Episode without Psychotic Symptoms
F30.10	Manic episode without psychotic symptoms, unspecified
F30.11	Manic episode without psychotic symptoms, mild
F30.12	Manic episode without psychotic symptoms, moderate
F30.13	Manic episode, severe, without psychotic symptoms
F30.2	Manic Episode, severe with Psychotic Symptoms
F30.3	Manic Episode in partial remission
F30.4	Manic Episode in Full remission
F30.8	Other manic Episodes
F30.9	Manic Episode, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32	Major Depressive Disorder, single episode
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single
F32.4	Major depressive disorder, single episode, in partial; remission
F32.5	Major depressive disorder, single episode, in full remission
F32.8	Other depressive episodes
	Atypical Depression

Mental Health Care (Outpatient) (cont.)

	Post-schizophrenic depression
	Single episode of “masked” depression NOS
F32.9	Major depressive disorder, single episode, unspecified
	Depression NOS
	Depressive disorder NOS
	Major depression NOS
F33	Major depressive disorder, recurrent
	Includes: recurrent episodes of depressive reaction
	recurrent episodes of endogenous depression
	recurrent episodes of major depression
	recurrent episodes of psychogenic depression
	recurrent episodes of reactive depression
	recurrent episodes of seasonal depressive disorder
	recurrent episodes of vital depression
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent severe with psychotic features
	Endogenous depression with psychotic features
	Recurrent severe episodes of major depression with mood-congruent psychotic symptoms
	Recurrent severe episodes of major depression with mood-incongruent psychotic symptoms
	Recurrent severe episodes of major depression with psychotic symptoms
	Recurrent severe episodes of psychogenic depressive psychosis
	Recurrent severe episodes of psychotic depression
	Recurrent severe episodes of reactive depressive psychosis
F33.4	Major depressive disorder, recurrent, in remission
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
	Recurrent brief depressive episodes
F33.9	Major depressive disorder, recurrent, unspecified
	Monopolar depression NOS
F31	Bipolar Disorder
F31.0	Bipolar disorder, current episode hypomanic
F31.1	Bipolar disorder, current episode manic without psychotic features
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate

Mental Health Care (Outpatient) (cont.)

F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar Disorder, current episode manic severe with psychotic features
F31.3	Bipolar Disorder, current episode depressed, mild or moderate severity
F31.30	Bipolar Disorder, current episode depressed, mild or moderate severity unspecified
F31.31	Bipolar Disorder, current episode depressed, mild
F31.32	Bipolar Disorder, current episode depressed, moderate
F31.4	Bipolar Disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar Disorder, current episode depressed, severe with psychotic features
F31.6	Bipolar Disorder, current episode mixed
F31.60	Bipolar Disorder, current episode mixed, unspecified
F31.61	Bipolar Disorder, current episode mixed, mild
F31.62	Bipolar Disorder, current episode mixed, moderate
F31.63	Bipolar Disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar Disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar Disorder, currently in remission, most recent episode unspecified
F31.7	Bipolar Disorder, currently in remission
F31.71	Bipolar Disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar Disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar Disorder, in partial remission, most recent episode manic
F31.74	Bipolar Disorder, in full remission, most recent episode manic
F31.75	Bipolar Disorder, in partial remission, most recent episode depressed
F31.76	Bipolar Disorder, in full remission, most recent episode depressed
F31.77	Bipolar Disorder, in partial remission, most recent episode mixed
F31.78	Bipolar Disorder, in full remission, most recent episode mixed
F31.8	Other Bipolar Disorders
F31.81	Bipolar II disorder
	affective disorders
F34.0	Cyclothymic disorder
	Affective personality disorder
	Cycloid personality
	Cyclothymia
	Cyclothymic personality
F34.1	Dysthymic disorder
	Depressive neurosis
	Depressive personality disorder
	Dysthymia
	Neurotic depression
	Persistent anxiety depression
F34.8	Other persistent mood (affective) disorders

Mental Health Care (Outpatient) (cont.)

F34.9	Persistent mood (affective) disorder, unspecified
F39	Unspecified mood (affective) disorder
F41.0	Panic disorder (episodic paroxysmal anxiety) without agoraphobia
	Panic attack
	Panic state
F42	Obsessive-compulsive disorder
F42.8	Other Obsessive – Compulsive Disorder (includes rumination)
F43.1	Post-traumatic stress disorder (PTSD)
	Traumatic neurosis
F43.10	Post-traumatic stress disorder, unspecified
F43.11	Post-traumatic stress disorder, acute
F43.12	Post-traumatic stress disorder, chronic
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type
F50.02	Anorexia nervosa, binge eating/ purging type
F50.2	Bulimia nervosa
	Bulimia NOS
	Hyperorexia nervosa
	Anancastic neurosis
	F50.81 Binge Eating Disorder
	F50.82 Avoidant/Restrictive Food Intake Disorder
	F50.89 Other Specified Eating Disorder
	F50.9 Eating Disorder Unspecified
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.5	Asperger's syndrome
	Asperger's Disorder
	Schizoid disorder of childhood
	Autistic psychopathy
F84.8	Other pervasive developmental disorders
	Overactive disorder associated with intellectual disabilities and stereotyped movements
F84.9	Pervasive developmental disorder, unspecified
F98.21	Rumination Disorder of Infancy
F98.29	Other Feeding Disorders of Infancy and Childhood
F98.3	Pica of Infancy and Childhood

Mental Health Care (Outpatient) (cont.)

List of Serious Mental Illness (SMI) Diagnosis – ICD-9 Version

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

Mental Health Care (Outpatient) (cont.)

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

Diagnosis Code	DESCRIPTION
29561	SCHIZOPHRENIC DISORDERS RESIDUAL TYPE SUBCHRONIC
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

Mental Health Care (Outpatient) (cont.)

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

Diagnosis Code	DESCRIPTION
29620	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29621	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
29622	INVOLUTIONAL MELANCHOLIA SINGLE EPISODE
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 CURRENT DEPRESSED MILD
29652	BIPOLAR I MOST RECENT EPISODE OR CURRENT DEPRESSED MODERATE
29653	BIPOLAR I DISORD MOST REC EPI OR CURRENT DEPRESSED SEVERE W/O MENTION PSYCHOTIC BEHAVIOR
29654	BIPOLAR I DISORD MOST REC EPI OR CURRENT DEPRESSED SEVERE AS WITH PSYCHOTIC BEHAVIOR
29655	BIPOLAR I DISORD MOST REC EPI OR CURRENT DEPRESSED IN PARTIAL OR UNSPECIFIED 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 CURRENT MIXED SEVERE W/O MENT PSYCHOTIC BEHAVIOR
29664	BIPOLAR I DISORD MOST REC EPI OR CURRENT MIXED SEVERE SPEC AS WITH PSYCHOTIC BEHAVIOR
29665	BIPOLAR I DISORD MOST REC EPI OR CURRENT MIXED IN PARTIAL 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

Mental Health Care (Outpatient) (cont.)

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

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
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. If the PCP determines medical necessity it is in benefit.

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 used in treatment of members with known or suspected recurrent colorectal carcinoma

- 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 used for the localization of primary and metastatic neuroendocrine tumors bearing somatostatin receptors (i.e. pheochromocytoma).

This is not an all-inclusive listing.

Paid by: Professional Charges: IPA

Naprapathic Services

- Benefit:** The use of naprapathic services in the treatment of an illness or injury is a covered benefit when referred by the PCP/WPHCP. Naprapathic services are considered separate from Physical Therapy (PT), Occupational Therapy (OT) and Chiropractic services. Therefore, Naprapathic services do not count towards any coverage limitations for PT, OT or Chiropractic services.
- Interpretation:** Naprapathic Medicine is a specialized system of health care that employs hands-on manual medicine, nutritional counseling, and a wide variety of therapeutic modalities. Naprapathy focuses on conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial and connective tissue. If a PCP or WPHCP determines medical necessity for the services, the services are covered.
- Paid by:** Professional Charges: IPA
- Coverage Variation:** Blue Precision HMO, BlueCare Direct and Blue FocusCare members are limited to 15 visits per calendar year for any service provided by a Naprapath.

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:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical	HMO
	Facility Charges:	
	Equipment Charges:	HMO

Coverage Variation: Benefit Plan DIRPI: (Equipment Rental and purchase) Excluded

Note All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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 DIRPI: Excluded

Confidential and Proprietary

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; members diagnosed with anorexia or bulimia.. 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: Professional Charges: **IPA**

Inpatient and/or Outpatient Surgical Facility Charges: **HMO**

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

Nutritional Supplements/Enteral Nutrition

Benefits: Nutritional items are not a covered benefit. Such items include, but are not limited to, infant formula, weight-loss supplements, over-the-counter food substitutes, and liquid nutrition or high-calorie liquid nutrition products, with or without special formulation.

Enteral Nutrition is in benefit. Supplies and equipment for proper functioning and effective use of an Enteral Nutrition system is also in benefit.

Interpretation: Nutritional supplements are dietary products that either substitute for or complement natural food.

Nutritional Supplement Exception: As of Sept. 1, 2007, a new law (PA 95-520) was passed that required coverage for amino acid –based elemental formulas, regardless of the delivery method. The law is specific to the diagnosis and treatment of (1) eosinophilic disorders and (2) short – bowel syndrome when the prescribing physician has issued a written order stating the formula is medically necessary.

Enteral Nutrition (available only by physician’s prescription) is administered via a feeding tube. Enteral Nutrition may be necessary for a member with a functioning gastrointestinal tract who cannot eat because of difficulty swallowing, or because of structural problems in the head, neck, or thorax. Examples of these conditions are head and neck cancer and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion.

Nutritional Supplements Paid by: **Member (usually)**
HMO (if the above criteria for the exceptions listed above are met)

Note: If a BCBSIL HMO Contracting Provider is used, the provider will most likely bill for the supplement. 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 nutritional supplement
- Purchase price
- Quantity
- IPA physician prescription or approval
- Diagnosis
- Receipt(s) verifying payment for supplies

Enteral Nutrition Paid By: Home Health, nutrients, supplies and equipment: **HMO**
Professional Charges: **IPA**

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: Professional Charges: **IPA**
Inpatient and/or Outpatient Surgical Facility Charges: **HMO**

Note: See related benefits interpretation on Nutritional Supplements

Coverage Variation – Effective Jan. 1, 2015, HMO Illinois members in Group number H09634 (Comcast), all surgical treatment of obesity is not a covered benefit.

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. Polysomnograms can also be done in the member's home, as deemed medically necessary by the Primary Care Physician.

A member with OSA syndrome will usually 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

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.

Obstructive Sleep Apnea (OSA) Syndrome (cont.)

- 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 may include:

- 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.

Paid by:	Professional Charges:	IPA
	Diagnostic Testing	IPA
	Facility Charges (outpatient diagnostic testing or medical treatment)	IPA
	Inpatient and/or Outpatient Surgical Facility Charges	HMO
Benefit Variation:	Equipment Charges (from contracted provider):	HMO
	Equipment Charges (from a non-contracted provider):	IPA
	Benefit Plan DIRPI- Equipment excluded	

Obstructive Sleep Apnea (OSA) Syndrome (cont.)

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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 IPA Physician 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

Notes:

- See related benefits interpretations on Day Rehabilitation, Home Health Services
- Members who have an Autism Spectrum Disorder (ASD) will have additional occupational, physical, and speech therapy for the treatment of ASD after the purchased benefits are exhausted. See the ASD Guideline for additional information.

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 Guideline on Cosmetic/Reconstructive Surgery.)

Repair or replacement of damaged removable appliances.

Services for conditions resultant from atrophy of the jaw or maxilla.

Pre-prosthetic 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
Professional Charges for covered dental implant(s):	HMO
Professional Charges for non-covered dental implant(s):	Member
Inpatient and/or Outpatient Surgical Facility Charges (related to covered dental/oral surgery services):	HMO
Outpatient Facility Charges:	See Outpatient Surgery

Extraction of completely-bony-impacted teeth:

Professional Charges:	HMO
Inpatient and/or Outpatient Surgical Facility Charges:	HMO
Outpatient Facility Charges:	HMO
Anesthesia (IV sedation or general) when determined to be medically necessary	HMO

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

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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/stem cells
- Cornea
- Heart
- Liver
- Lung
- Kidney
- Isolated pancreas and simultaneous pancreas/kidney
- Small intestine

Note: this is not an exhaustive list. Submit a Benefit Determination Request Form if there is a question regarding coverage for an organ or tissue transplant not on the list. In addition, if there is any other question related to organ and tissue transplantation benefit, the IPA should contact their Nurse Liaison to discuss the issue. The form can be found on the BCBSIL IPA Access Portal at https://bcbsilezaccess.com/ipa_portal/default.aspx. If you do not have access to the website complete and submit the form located here: https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf).

Notification and Authorization Process:

1. The IPA will initiate the approval process by contacting the Medical Management (MM) Health Coordinator 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. If the PCP determined medical appropriateness, a member may be referred to multiple transplant centers.
3. If the member is accepted as a transplant candidate, the IPA will send to the Health Coordinator the following information via fax at 312-233-6018:
 - Copy of the referral to the transplant facility
 - Member's diagnosis, type of transplant, medical history
 - A signed letter from the PCP indicating his/her approval
 - Letter from the transplant facility confirming the member's transplant candidate status

The Health Coordinator can be reached by calling 312-653-2238, if needed.

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 Health Coordinator. 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 Health Coordinator 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 email or fax. The FSU will make the appropriate notations in the BCBSIL system. 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.

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. Examples include, but are not limited to, dialysis for kidney transplant candidate and an LVAD (left ventricular assist device) for a heart transplant candidate. If the member is not accepted as a transplant candidate, the evaluation services are the financial responsibility of the IPA.

Once the HMO has approved the transplant, these services 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
- Mental Health evaluations performed and ordered by the approved organ transplant center as it relates to the transplant.
- 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.

Effective Jan. 1, 2011, and upon employer group renewal, meals are no longer considered covered under the travel expenses related to an organ transplant. Lodging is limited to \$50.00 for each night, per person. Transportation costs are also covered and must be primarily for and essential to medical care.

Organ and Tissue Transplantation (cont.)

These services are not in benefit:

- Drugs which are Investigational
- Storage fees
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
- 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)

Note: BlueCare Direct : The physician signing the referral and submitting the approval letter may be the Primary Care Physician (PCP), a treating provider or a physician advisor.

Claim Submission Notes:

- The HMO will reimburse the IPA the lesser of the amount paid by IPA or the BCBSIL PPO Schedule of Maximum Allowance. The IPA also has the option to request the HMO pay the provider directly. This will be done at the lesser of billed charges or the BCBSIL PPO Schedule of Maximum Allowance.
- 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/Stem cells, Kidney or Cornea transplants: The member may be referred to any contracted facility in the state of Illinois, or in a neighboring state, as listed on the HMO Contracted Provider List (Appendix D). The most current list is located on the [BCBSIL IPA Access Portal](#). If you do not have access to the website complete and submit the form located here:

https://www.bcbsil.com/pdf/standards/hmo/hmo_user_access_request_form.pdf.

The following facility can be used (as indicated)

Hospital Name	Location	Transplant Type
University of Wisconsin	Madison, WI	Kidney

The following is a list of Blue Distinction Centers for Transplants® that must be used for the following transplant types (as indicated)

Heart		
Hospital Name	Location	Transplant Type
Advocate Christ Hospital Medical Center	Oak Lawn, IL	Adult Heart
Aurora St. Luke's Medical Center	Milwaukee, WI	Adult Heart
Froedert Memorial Lutheran Hospital	Milwaukee, WI	Adult Heart
Henry Ford Health System	Detroit, MI	Adult Heart
Indiana University Health, Inc (Riley Hospital For Children) IN	Indianapolis, IN	Pediatric Heart
Indiana University Health, Inc.(Methodist Hospital) IN	Indianapolis, IN	Adult Heart
Jewish Hospital	Louisville, KY	Adult Heart
Loyola University Medical Center	Maywood, IL	Adult Heart
Northwestern Memorial Hospital	Chicago, IL	Adult Heart
Spectrum Health Hospitals (Fred and Lena Meijer Health Center)	Grand Rapids, Michigan	Adult Heart
SSM Cardinal Glennon Children's Hospital	St. Louis, MO	Pediatric Heart
St. Vincent Hospital and Health Service	Indianapolis, IN	Adult Heart
The Ann & Robert H. Lurie Children's Hospital of Chicago	Chicago, IL	Pediatric Heart
UK Healthcare	Lexington, KY	Adult Heart
University of Chicago Medical Center	Chicago, IL	Adult Heart
University of Iowa Hospitals and Clinics	Iowa City, IA	Adult & Pediatric Heart
University of Michigan Medical Center	Ann Arbor, MI	Adult & Pediatric Heart
University of Wisconsin Hospital and Clinics	Madison, WI	Adult Heart

Organ and Tissue Transplantation (cont.)

Heart/Lung Combination		
Hospital Name	Location	Transplant Type
Henry Ford Hospital	Detroit, MI	Adult Combination Heart - Lung (Single or Bilateral)
Loyola University Medical Center	Maywood, IL	Adult Combination Heart-Lung (Single or Bilateral)
Spectrum Health Hospitals (Fred and Lena Meijer Health Center)	Grand Rapids, MI	Adult Combination Heart - Lung (Single or Bilateral)
UK Healthcare	Louisville, KY	Adult Combination Heart - Lung (Single or Bilateral)
University of Michigan Medical Center	Ann Arbor, MI	Adult Combination Heart-Lung (Single or Bilateral)
University of Wisconsin Hospitals and Clinics	Madison, WI	Adult Combination Heart - Lung (Single or Bilateral)

Liver		
Hospital Name	Location	Transplant Type
Aurora St. Luke's Medical Center	Milwaukee, WI	Adult Liver Deceased Donor ONLY
Henry Ford Health System	Detroit, MI	Adult Liver Deceased and Living Donor
Indiana University Health Inc. (Riley Hospital for Children)	Indianapolis, IN	Pediatric Liver Deceased and Living Donor
Indiana University Health, Inc. (University Hospital)	Indianapolis, IN	Adult Liver Deceased Donor ONLY
Jewish Hospital	Louisville, KY	Adult Liver
Loyola University Medical Center	Maywood, IL	Adult Liver
Northwestern Memorial Hospital	Chicago, IL	Adult Liver Deceased Donor ONLY
Rush University Medical Center	Chicago, IL	Adult Liver Deceased Donor ONLY
St. Louis University Hospital	St. Louis, MO	Adult Liver
UK Healthcare	Lexington, KY	Adult Liver Deceased Donor ONLY
University of Chicago Medical Center	Chicago, IL	Adult Liver Deceased Donor ONLY
University of Illinois Medical Center	Chicago, IL	Adult Liver Deceased and Living Donor
University of Iowa Hospitals and Clinics	Iowa City, IA	Adult Liver Deceased Donor ONLY
University of Michigan Medical Center	Ann Arbor, MI	Adult Liver Deceased and Living Donor
University of Wisconsin Hospital and Clinics	Madison, WI	Adult Liver Deceased Donor ONLY

Organ and Tissue Transplantation (cont.)

Liver/Kidney Combination		
Hospital Name	Location	Transplant Type
Aurora St. Luke's Medical Center	Milwaukee, WI	Adult Liver/kidney
Henry Ford Hospital	Detroit, MI	Adult Liver/kidney
Indiana University Health, Inc. (University Hospital)	Indianapolis, IN	Adult Liver (deceased)/kidney
Jewish Hospital	Louisville, KY	Adult Liver/kidney
Loyola University Medical Center	Maywood, IL	Adult Liver/kidney
Northwestern Memorial Hospital	Chicago, IL	Adult Liver/kidney
St. Louis University Hospital	St. Louis, MO	Adult Liver/kidney
UK Healthcare	Lexington, KY	Adult Liver/kidney
University of Chicago Medical Center	Chicago, IL	Adult Liver/kidney
University of Illinois Medical Center	Chicago, IL	Adult Liver (deceased)/kidney
University of Iowa Hospitals and Clinics	Iowa City, IA	Adult Liver/kidney
University of Michigan Medical Center	Ann Arbor, MI	Adult Liver (deceased or living)/kidney
University of Wisconsin Hospitals and Clinics	Madison, WI	Adult Liver

Lung		
Hospital Name	Location	Transplant Type
Henry Ford Health System	Detroit, MI	Adult Single or Bilateral Lung
Indiana University Health Methodist Hospital	Indianapolis, IN	Adult Single or Bilateral Lung
Loyola University Medical Center	Maywood, IL	Adult Single or Bilateral Lung
Northwestern Memorial Hospital	Chicago, IL	Adult Single or Bilateral Lung
Spectrum Health Hospitals (Fred and Lena Meijer Health Center)	Grand Rapids, MI	Adult Single or Bilateral Lung
UK Healthcare	Louisville, KY	Adult Single or Bilateral Lung
University of Iowa Hospitals and Clinics	Iowa City, IA	Adult Single or Bilateral Lung
University of Michigan Medical Center	Ann Arbor, MI	Adult Single or Bilateral Lung
University of Wisconsin Hospital and Clinics	Madison, WI	Adult Single or Bilateral Lung

Pancreas		
Hospital Name	Location	Transplant Type
Indiana University Health Inc (University Hospital)	Indianapolis, IN	Adult Pancreas (PAK and PTA) Adult Simultaneous Pancreas-Kidney (SPK)
Rush University Medical Center	Chicago, IL	Adult Pancreas (PAK and PTA) Adult Simultaneous Pancreas-Kidney (SPK)
University of Chicago Medical Center	Chicago, IL	Adult Pancreas (PAK and PTA) Adult Simultaneous Pancreas-Kidney (SPK)
University of Illinois Medical Center	Chicago, IL	Adult Pancreas (PAK and PTA) Adult Simultaneous Pancreas - Kidney (SPK)
University of Iowa Hospitals and Clinics	Iowa City, IA	Adult Pancreas (PAK and PTA) Adult Simultaneous Pancreas - Kidney (SPK)
University of Michigan Medical Center	Ann Arbor, MI	Adult Pancreas Adult Pancreas (PAK and PTA) Adult Simultaneous Pancreas - Kidney (SPK)

Key:

SPK - Simultaneous Pancreas Kidney
 PTA - Pancreas Transplant Alone
 PAK - Pancreas after Kidney

Note: Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations.

Orthodontics

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

Interpretation: Orthodontic (braces) 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 (braces) 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 (braces) 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

Inpatient and/or Outpatient Surgical Facility

HMO

Charges:

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 Charges:	IPA
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Orthodontic and/or prosthodontic services:	Member

Note: See related benefit Guidelines on Dental, Oral Surgery, Temporomandibular Joint Disorder, Orthodontics

Confidential and Proprietary

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 cannot 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

Orthotic Devices (cont.)

Note: See related benefit Guidelines on DME, Medical Supplies, and Prosthetics

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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	Deleted/Removed Date
A4466	Garment, belt, sleeve or other covering, elastic or similar stretchable material, any type, each	Code deleted by CMS 12/31/2016
A4467	Belt, strap, sleeve, garment, or covering, any type	
L0120	Cervical, flexible, nonadjustable (foam collar)	
L0160	Cervical, semi-rigid, wire frame occipital/mandibular support, prefabricated, off-the-shelf	
L0172	Cervical, collar, semi-rigid thermoplastic foam, 2 piece, prefabricated, off-the-shelf	
L0174	Cervical, collar, semi-rigid, thermoplastic foam, 2 piece with thoracic extension, prefabricated, off-the-shelf	
L0210	Thoracic, rib belt	1/1/2010
L0450	TLSO, flexible, upper thoracic region, prefabricated, off the shelf	
L0454	TLSO, flexible, provider trunk support, prefabrication, includes fitting & adjustment	1/1/2015
L0455	TLSO, flexible, provides trunk support & extends from sacrococcygeal junction to above T-9 vertebra, prefabricated, off the shelf	
L0457	TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel & soft anterior apron, extends from sacrococcygeal junction & terminates just inferior to scapular spine, prefabricated, off the shelf	
L0467	TLSO, sagittal control, rigid posterior frame & flexible soft anterior apron with straps, closures and padding, prefabricated, off the shelf	
L0469	TLSO, sagittal-coronal control, prefabricated, off the shelf	
L0621	Sacroiliac Orthosis, flexible, provides pelvic-sacral support, prefabricated, off the shelf	
L0623	Sacroiliac orthotic, provides pelvic sacral support with rigid or semi rigid panels over sacrum & abdomen, prefabricated, off the shelf	
L0625	Lumbar Orthosis, flexible, provides lumbar support, prefabricated, off the shelf	
L0628	Lumbar Sacral Orthosis, flexible, provider lumbo sacral support, prefabricated, off the shelf	
L0641	Lumbar orthosis, sagittal control, with rigid posterior panel, posterior extends from L-1 to below L-5 vertebra, prefabricated, off the shelf	
L0642	Lumbar orthosis, sagittal control, with rigid anterior & posterior panels, posterior extends L-1 to below L-5, prefabricated, off the shelf	
L0643	Lumbar sacral orthosis, sagittal control, with rigid posterior panel, posterior extends from sacrococcygeal junction to T-9 vertebra, prefabricated, off the shelf	
L0648	Lumbar sacral orthosis, sagittal control, with rigid anterior & posterior panels, posterior extends from sacrococcygeal junction to T-9, prefabricated, off the shelf	
L0649	Lumbar sacral orthosis, sagittal coronal control, with rigid posterior frame, posterior extends from sacrococcygeal junction to T-9, lateral strength provided by rigid lateral frame, prefabricated, off the shelf	
L0650	Lumbar sacral orthosis, sagittal coronal control with rigid anterior & posterior frame, posterior extends from sacrococcygeal junction to T-9, lateral strength provided by rigid lateral frame, prefabricated, off the shelf	

Orthotic Devices (cont.)

Code	Description	Deleted/Removed Date
L0651	Lumbar sacral orthosis, sagittal coronal control, rigid shell, posterior extends from sacrococcygeal junction to T-9, anterior extends from symphysis pubis to xyphoid, prefabricated, off the shelf	
L0980	Peroneal straps, prefabricated, off-the-shelf, pair	
L0982	Stocking supporter grips, prefabricated, off-the-shelf, set of four (4)	
L0984	Protective body sock, prefabricated, off-the-shelf, each	
L1600	Hip Orthosis, adduction control of hip joints, prefabricated	1/1/2015
L1810	KO, elastic with joints, prefabricated,	1/1/2015
L1812	Knee orthosis, elastic with joints, prefabricated, off the shelf	
L1825	KO, elastic knee cap, prefabricated, includes fitting and adjustment	12/31/2010
L1830	KO, immobilizer, canvas longitudinal prefabricated, includes fitting & adjustment, off the shelf	
L1831	Knee Orthosis, locking knee joint(s), positional orthosis, prefabricated	
L1833	Knee Orthosis, adjustable knee joints, positional, rigid support, prefabricated, off the shelf	
L1836	KO, rigid, without joints, includes soft interface material, prefabricated, off the shelf	
L1848	KO, double upright with adjustable joint, with inflatable air support chambers, prefabricated, off the shelf	
L1850	KO, Swedish type, prefabricated, off the shelf	
L1902	AFO, ankle gauntlet, prefabricated, off the shelf	
L1906	AFO, multiligamentous ankle support, prefabricated, off the shelf	
L1910	AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated	
L3000	Foot insert, removable, molded to patient model, UCB type, Berkeley Shell, each	
L3001	Foot insert, removable, molded to patient model, Spenco, each	
L3002	Foot insert, removable, molded to patient model, plastazote or equal, 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	
L3031	Foot, insert/plate, removable, addition to lower extremity orthotic, high strength, lightweight material, 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	
L3070	Foot, arch support, non-removable attached to shoe, longitudinal, each	
L3080	Foot, arch support, non-removable attached to shoe, metatarsal, each	
L3090	Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each	
L3100	Hallus-vulgas night dynamic splint, prefabricated, off the shelf	
L3170	Foot, plastic, silicone or equal, heel stabilizer, prefabricated, off the shelf, each	
L3260	Surgical Boot/shoe, each	
L3265	Plastazote sandal, each	
L3480	Heel, pad and depression for spur	
L3485	Heel, pad, removable for spur	
L3500	Orthopedic shoe addition, insole, leather	
L3510	Orthopedic shoe addition, insole, rubber	
L3530	Orthopedic shoe addition, sole, half	
L3540	Orthopedic shoe addition, sole, full	
L3550	Orthopedic shoe addition, toe tap, standard	
L3560	Orthopedic shoe addition, toe tap, horseshoe	
L3650	Shoulder Orthosis, figure 8 design, abduction restrainer, prefabricated	
L3652	Shoulder Orthosis, double shoulder elastic, prefabricated, off the shelf	1/1/2015
L3660	SO, figure of eight design abduction restrainer, canvas and webbing, prefabricated, off the shelf	

Orthotic Devices (cont.)

Code	Description	Deleted/Removed Date
L3670	SO, acromio/clavicular (canvas & webbing type), prefabricated, off the shelf	
L3675	Shoulder Orthosis, vest type abduction restrainer, canvas webbing type or equal, prefabricated, off the shelf	
L3678	Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated, off the shelf	
L3700	EO, elastic with stays, prefabricated, includes fitting and adjustment	12/31/2010
L3701	Elbow orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)	12/31/2010
L3710	Elbow orthosis, elastic with metal joints, prefabricated, off-the-shelf	
L3762	Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, off the shelf	
L3809	Wrist hand finger orthosis, without joint(s), prefabricated, off-the-shelf, any type	
L3908	WHO, wrist extension control cock-up, nonmolded, prefabricated, off the shelf	
L3909	WO, elastic, prefabricated, includes fitting and adjustment	12/31/2010
L3911	Wrist hand finger orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)	12/31/2010
L3912	Hand finger orthosis, flexion glove with elastic finger control, prefabricated, off the shelf	
L3916	Wrist hand orthotic, includes one or more non-torsion joint, elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off the shelf	
L3918	Hand orthosis, metacarpal fracture orthosis, prefabricated, off the shelf	
L3924	Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off the shelf	
L3925	Finger orthosis, proximal interphalangeal/distal interphalangeal, non-torsion joint/spring, extension/flexion, may include soft interface, prefabricated, off the shelf	
L3927	Finger orthosis, proximal interphalangeal/distal interphalangeal, without joint/spring, extension/flexion, may include soft interface, prefabricated, off the shelf	
L3930	Hand finger orthosis, includes one or more non-torsion joints, turnbuckles, elastic bands/springs, may include soft interface, prefabricated, off the shelf	
L4350	Ankle Control Orthosis, Stirrup Style, Rigid, Includes Any Type Interface (E.G., Pneumatic, Gel), Prefabricated, off the shelf	
L4360	Walking boot (e.g. air cast), pneumatic, with or without joints; includes fitting & Adjustment	1/1/2015
L4361	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off the shelf	
L4370	Pneumatic full leg splint, prefabricated, off the shelf	
L4386	Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting & adjustment	1/1/2015
L4387	Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off the shelf	
L4396	Static or dynamic AFO, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, includes fitting & adjustment	1/1/2015
L4397	Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, off the shelf	
L4398	Foot drop splint recumbent positioning device, prefabricated, off the shelf	

Outpatient Surgery

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

Interpretation: 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.

The Medical Service Agreement should be consulted for unit charge towards the Utilization Management Fund.

Paid by: Professional Charges: **IPA**
Hospital/Free Standing 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.

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

Coverage Variation: Benefit Plan DIRPI: Equipment Excluded

Note: See related benefit Guidelines on Durable Medical Equipment

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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 and/or Outpatient Surgical facility Charges: **HMO**
Outpatient Charges: **IPA**
Professional Charges: **IPA**

Note: See related benefit Guidelines 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

Notes:

- See related benefit Guidelines on Day Rehabilitation
- Members who have an Autism Spectrum Disorder (ASD) will have additional occupational, physical, and speech therapy for the treatment of ASD after the purchased benefits are exhausted. See the ASD Guideline for additional information.

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**
Inpatient and/or Outpatient Surgical Facility charges: **HMO**

Note: See related benefit Guideline on Orthotics

Pre-implantation Genetic Diagnosis (PGD) – Infertility Related

Benefit: Once a member has been diagnosed with infertility, Pre-implantation Genetic Diagnosis (PGD) is in benefit for the following situations, if considered potentially causal to the infertility:

- Balanced Chromosomal Translocation Carrier
- Klinefelter's Syndrome
- Autosomal rearrangements
- Y-linked microdeletions

Note: PGD may also be in benefit for reasons not related to infertility

Interpretation: Pre-implantation Genetic Diagnosis (PGD) analyzes the genome of individual cells taken from an embryo. This technique can identify certain genetic abnormalities in the embryo at a stage before it is implanted in the uterus.

PGD can be performed in situations where the suspected chromosomal abnormality is believed to be a cause of Infertility.

Exclusions: In the absence of a demonstrated parental genetic abnormality as listed above, PGD is excluded. This includes screening of embryos for aneuploidy or other genetic abnormalities.

Paid by:	Professional Charges:	HMO
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Infertility Related In-Vitro Fertilization (IVF) Charges	WIN

Note: See related benefit Guideline on Pre-implantation Genetic Diagnosis (PGD) – (Non-Infertility Related) in this section.

Note: Refer to IPA Infertility Guidelines (ADM -56) in the HMO Policy section on the BCBSIL website

Pre-implantation Genetic Diagnosis (PGD) – Non-infertility Related

- Benefit:** PGD is in benefit for the following non-infertility related situations:
- Parental carrier of an autosomal mutation (such as Cystic Fibrosis or Marfan's Syndrome)
 - Maternal carrier of an X-linked mutation (such as Hemophilia A or Fragile X Syndrome). This would also include testing for purposes of gender selection related to the specific maternal abnormality.
 - Parental carrier of a Balanced Chromosomal Translocation or other related structural rearrangement (if not infertile).

Note: PGD may also be in benefit for reasons related to infertility.

Interpretation: Pre-implantation Genetic Diagnosis (PGD) analyzes the genome of individual cells taken from an embryo. This technique can identify certain genetic abnormalities in the embryo at a stage before it is implanted in the uterus.

- Exclusions:**
- Gender selection in the absence of maternal X-linked disorder.
 - Multi-gene mutations, such as BRCA.
 - HLA-matching an embryo to a family member for purposes of a future transplant.
 - Other situations not specifically described above as covered.
 - In the absence of infertility, all In-Vitro Fertilization (IVF) procedures are not covered.
 - Pre-implantation Genetic Screening (PGS), including screening embryos for aneuploidy or other genetic abnormalities, in the absence of a demonstrated parental genetic abnormality listed above.

Paid by: Professional Charges:
Inpatient and/or Outpatient Surgical Facility Charges:
All related In-Vitro Fertilization (IVF) Charges:

IPA
HMO
Member

Private Duty Nursing

Benefit: Inpatient Private Duty Nursing service is not covered.

Outpatient Private Duty Nursing is a covered benefit for Blue Precision HMO, BlueCare Direct and Blue FocusCare HMO programs when determined medically necessary by the Primary Care Physician (PCP) or Women's Principal Health Care Provider (WPHCP).

Definitions: **Private Duty Nursing Service** means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse. Private Duty Nursing Service does not include Custodial Care Service.

Skilled Nursing Service means those services provided by a registered nurse (R.N.) or licensed practical nurse (LPN) which require the clinical skills and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

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 your 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.)

Custodial Care Service means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of the member's 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 routine medications etc.) and are to assist with activities of daily living, (e.g. bathing, eating, dressing, etc.). Custodial Care is not a covered benefit.

Respite Care Services means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services. Respite Care is not in benefit except under a Hospice Program – refer to the Hospice Care Benefits Interpretation.

Private Duty Nursing (cont.)

Interpretation: **Private Duty Nursing Service (PDN)** is a Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (RN) or licensed practical nurse (LPN). The Skilled Nursing Services may include, but not exclusively or in all instances, the management of a tracheostomy and ventilator. The number of hours of Skilled Nursing Service required on a daily basis must exceed those which can be provided by a Coordinated Home Care Program. In addition, the nursing services involved cannot constitute Custodial or Respite Care Services.

The PCP/WPHCP's determination of the medical necessity of and number of daily hours for, PDN services must be a deliberate, comprehensive, and highly-individualized process that is based on the totality of the member's medical condition.

Because Custodial Care is not a covered benefit, an important component of PDN Service is the identification and training of caregivers, who will take over the care responsibilities when the condition stabilizes and the member no longer requires Private Duty Nursing and/or Skilled Nursing Service.

An IPA Complex Case Manager should perform periodic assessments, which should include discussions with the PCP/WPHCP. It should be confirmed that PDN is still required and at the appropriate level of service/hours, whether progress is being made in developing care givers, and that there is sufficient documentation of continued effort to move from PDN to coordinated home health care, or other recommended level of care.

A PCP/WPHCP's assessment as to whether to refer a member for PDN services may include consideration of:

- Age, Gender
- Diagnoses
- Medical history
- Recent hospitalizations
- Mental status
- Functional capacity, ADL capability, Life activities
- The totality of the member's condition, including any co-morbidities
- The member's skilled nursing/medical needs (including frequency). A comprehensive initial assessment may be conducted by the Private Duty Nursing Agency to determine the member's needs
- Other services being received or planned
- Availability of caregivers for non-skilled needs
- Level of profession needed (LPN, RN, etc.)
- Number of hours per day needing PDN coverage
- Anticipated duration of need for services
- Availability of PDN agency to provide required services
- Any other relevant documentation

Private Duty Nursing (cont.)

Exclusion: Family members, even if they are health professionals, cannot be reimbursed for services.

Coverage Variation: HMO Illinois, Blue Advantage HMO: Outpatient Private Duty Nursing is not covered

Exclusion: Inpatient Private Duty Nursing is not covered for any HMO Product

All Charges Paid by:

Outpatient Private Duty Nursing:

HMO Illinois/ Blue Advantage HMO

Blue Precision HMO, Blue FocusCare, BlueCare Direct:

Custodial Services

Respite Services (unless covered under hospice care)

Inpatient Private Duty Nursing:

Member

HMO

Member

Member

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.

Interpretation: Balloon dilatation of the prostatic urethra may be indicated 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 and/or Outpatient Surgical 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.
- 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 (cranial prosthesis) are generally not in benefit. Refer to the note on the next page.

Prosthetic Devices (cont.)

If the IPA uses a non-contracting provider, the member cannot 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:	Professional Charges:	IPA
	Equipment Charges (from a contracted provider):	HMO
	Equipment Charges (from a non-contracted provider):	IPA
	Inpatient and/or Outpatient Surgical Facility Charges (if applicable):	HMO

Exclusions:

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 Guidelines on Vision Screening/Routine Vision Care and Contact Lenses/Eyeglasses for additional information.

Note: Little Company of Mary Hospital (Employer Group # B92749) has coverage for a cranial prosthesis (wig) in relation to the medical diagnosis of cancer or alopecia for up to \$250.00 lifetime maximum per individual. A cranial prosthesis should be obtained from an HMO contracted provider. Generally, a provider who specialized in mastectomy products can also supply a cranial prosthesis.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

Pulmonary Rehabilitation

Benefit: Pulmonary rehabilitation therapy is a covered benefit.

Interpretation: Pulmonary rehabilitation programs offer a structured approach to progressive increase in exercise tolerance for members with pulmonary disease. Chronic obstructive pulmonary disease is the prototypical condition for which pulmonary rehabilitation is typically recommended, although it may be appropriate for a range of moderate to severe pulmonary conditions. A typical course of pulmonary rehabilitation consists of a single course of 36 hours of medically-supervised therapy over a period of 6 weeks, although the degree of rehabilitative services and treatment modalities do vary.

Pulmonary rehabilitation is in benefit when the PCP determines medical necessity and refers the member for the service. The PCP's expectation that the member will improve over this period is the key to determining whether or not services are in benefit.

Facilities with pulmonary rehabilitation programs may at times use ancillary services, such as psychological or dietary services. They may also provide services to members who have non-pulmonary medical conditions. Benefits for ancillary services to these members, or services given in a pulmonary rehabilitation program to members without pulmonary disease, should not be billed as pulmonary rehabilitation. Such services should be considered for benefit under whatever additional certificate provision might apply.

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Outpatient Facility Charges:	IPA

Note: Pulmonary Rehabilitation services do not count towards the PT/ST/OT benefit limit.

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) may be medically indicated for members with myopia (nearsightedness), who 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 may be medically indicated 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. Members may have additional benefits or discounts for related procedures (including LASIK) under their Vision Coverage.

Paid by:	Professional Charges:	IPA
	Inpatient and/or Outpatient Surgical 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 Benefit Guideline for Durable Medical Equipment.

Paid by: Outpatient Charges: **IPA**
Inpatient and/or Outpatient Surgical Facility Charges: **HMO**

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

Seat Lift

Benefit: A seat lift for home use is covered as durable medical equipment.

Interpretation: The seat lift must be considered medically necessary. Criteria for medical necessity may 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. Hair lifts (i.e., stairway elevator-like devices) and/or modifications to vehicles are not in benefit.

Paid by: HMO

Coverage Variation: Benefit Plan DIRPI: Excluded

Note All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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 Charges: **IPA**

Sensory Evoked Potentials (SEP)

Benefit: Evoked potentials are in benefit in a limited number of situations, if determined medically necessary by the PCP.

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
	Inpatient and/or Outpatient Surgical Facility Charges:	HMO
	Outpatient Facility Charges:	IPA

Skilled Nursing Facility (SNF)

Benefit: Care of a member in a Skilled Nursing Facility (SNF) is a covered benefit

Interpretation: Skilled nursing facility care is in benefit if the member has a documented need for skilled care and the PCP determines medical necessity 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 benefit Guideline 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 units are charged towards the Utilization Management Fund according to the terms in the Medical Service Agreement.

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

Notes:

- See related benefit Guideline on Day Rehabilitation
- Members who have an Autism Spectrum Disorder (ASD) will have additional occupational, physical, and speech therapy for the treatment of ASD after the purchased benefits are exhausted. See the ASD Guideline for additional information.

Sterilizations

Benefit: Voluntary sterilization (tubal ligations, Essure® and vasectomies) are generally in benefit 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:	Professional 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.

Effective July 1, 2017: Sterilization services are not in benefit for members of the Archdiocese of Chicago Employer Group. The group numbers are: H00120, H00119, B00599, and B00598.

Effective Jan. 1, 2020, Sterilization services are not in benefit for members of the Wheaton College Employer Group. The group number is B93046.

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 units are charged towards the Utilization Management Fund, as applicable, for those IPAs who contractually are required to refer members for sterilizations.

Note: See related benefit **Guidelines 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 benefit Guideline 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 may be tried. TMD orthotics are removable appliances that guide the mandible or maxilla in relationship to the temporal fossa, and are not themselves 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 (such as Dentures)
- Night splints or mouth guards used to reduce nighttime teeth clenching.
- Treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other method which alters vertical dimension.
- Orthodontics, used in lieu of or in conjunction with surgery for TMJ dysfunction.
- Palate expander

Paid by: Professional Charges: **IPA**
Inpatient and/or Outpatient Surgical **HMO**
Facility Charges:

Coverage Variation: Benefit Plan DIRPI – Non Custom Orthotics excluded

Note: See related benefit Guidelines on Cosmetic/Reconstructive Surgery, Dental, Oral Surgery, Orthognathic Surgery, Orthodontics.

Transgender Services

Benefit: Transgender Services are covered benefits if the Primary Care Physician determines medical necessity.

Interpretation: Most Transgender Services are non-capitated services. The IPA is expected to continue to perform Utilization Management/Referral and Case Management (if applicable) for both the Transgender related medical care and routine/unrelated medical needs. Behavioral health counseling services before the diagnosis of Gender Dysphoria and post diagnosis remain the IPA's financial liability.

Transgender Services for Gender Dysphoria consist of a series of surgical procedures and/or other services, pursued to a different extent by individuals, by which a person's physical appearance and function(s) of the existing sexual characteristics are altered or even permanently changed to resemble or conform to that of the opposite sex.

Gender Dysphoria is characterized by persistent discrepancy between a person's gender identity and that person's sex assigned at birth, often resulting in discomfort or distress.

Female-to-Male (FTM) describes individuals assigned female at birth but who identify as male, and have changed or wish to change their bodies through medical and/or surgical intervention to more closely resemble a male body.

Male-to-Female (MTF) describes individuals assigned male at birth, but who identify as female, and have changed or wish to change their bodies through medical and/or surgical intervention to more closely resemble a female body.

Behavioral Health counseling is the preferred method to address gender issues and diagnose Gender Dysphoria. The Behavioral Health professional works in conjunction with the member's PCP to determine the diagnosis. The PCP determines the medical necessity for Transgender Services.

Once the PCP has approved and the HMO has been notified; the following Transgender Services are the financial responsibility of the HMO:

- Hormonal therapy including related labs, specialist office visits and testing
- Pre-surgical evaluation
- Genital Transgender surgery - including all inpatient, outpatient and related follow up care within 90 days of the surgery
- Breast augmentation or breast reduction surgery - including all inpatient, outpatient and related follow up care within 90 days of the surgery
- Electrolysis on the affected skin in preparation for the construction of genitalia.

These services are not in benefit:

- Cosmetic surgery, including, but not limited to facial surgery, body contouring, other electrolysis services (not related to genitalia construction)
- Laryngeal or tracheal procedures, or related services which alter the voice, in the absence of a medical condition or an injury
- Speech therapy related to voice contouring in the absence of a medical condition or injury

Transgender Services (cont.)

Notification Process:

1. The IPA will initiate the notification process by contacting the HMO Nurse Liaison. The IPA will submit the following information via fax or email:
 - Documentation of the Member's diagnosis of Gender Dysphoria, from a licensed Behavioral Health Professional
 - Letter from PCP confirming the diagnosis, and the PCP's recommendation for treatment
 - The member's new name (if applicable/available)
 - Member's contact telephone number

Once the HMO Nurse Liaison receives the documentation, it will be reviewed with the Medical Director.
2. If a member changes IPAs during the transgender workup or follow up care period, the new IPA must generate a new referral for the Transgender Services.
3. The HMO Nurse Liaison will generate a letter to the IPA notifying them of the determination with a copy to the Provider Network Consultant and the Customer Advocate Specialist(s) in the Full Service Units (FSUs). The IPA is responsible for notifying the member as per the IPA's member notification process.
4. The Customer Advocate Specialist in the FSU will enter the member's information into the documentation system 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.

Paid by:	Outpatient Behavioral Health Services (Pre and Post Diagnosis)	IPA
	Professional Charges:	HMO
	Hormones (RX):	HMO
	Inpatient Facility Charges:	HMO
	Outpatient Surgical Facility Charges	HMO
	Outpatient Diagnostic Testing related to Transgender Services	HMO
	Non – Covered (excluded) Services – all Charges	Member

Note: See related benefit Guideline on Cosmetic/Reconstructive Surgery.

Transgender Services (cont.)

Claim Submission Notes:

The HMO will reimburse the IPA the lesser of the amount paid or the BCBSIL PPO Schedule of Maximum Allowance. The IPA also has the option to request the HMO pay the provider directly. This will be done at the lesser of billed charges or the BCBSIL PPO Schedule of Maximum Allowance.

- 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 "transgender services – catastrophic claim" should be indicated directly on the claim.
- Pre-transgender Surgery Evaluation related claims should be stamped group approved and "Pre-Transgender Surgery Evaluation – catastrophic claim" must be indicated directly on the claims.

Note: Per the Medical Service Agreement, IPAs vary in assignment of responsibility for Transgender Services. An IPA may not retain the responsibility for managing services other than behavioral health counseling for Transgender Services. If such an IPA has a member who is diagnosed with Gender Dysphoria who expresses a desire to proceed with Transgender Services beyond behavioral health counseling, the IPA should contact the HMO Nurse Liaison to facilitate the member's transition to another IPA. The IPA will need to submit a letter documenting the presence of Gender Dysphoria from a licensed Behavioral Health professional and a letter from the PCP confirming the diagnosis, and the PCP's recommendation for treatment.

Coverage Variation:

Effective July 1, 2017: For members diagnosed with Gender Dysphoria - services beyond Behavioral Health Therapy are not in benefit for members of the Archdiocese of Chicago Employer Group. The group numbers are: H00120, H00119, B00599, and B00598.

Effective Jan. 1, 2020: For members diagnosed with Gender Dysphoria - services beyond Behavioral Health Therapy are not in benefit for members of Wheaton College Employer Group. The group number is B93046.

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 Charges:	IPA
	Equipment Charges (from contracted provider):	HMO
	Equipment Charges (from non-contracted provider):	IPA

Coverage Variation: Benefit Plan DIRPI: Equipment Excluded

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing "Medicare Contracted Billing."

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 Guidelines 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 - Eyemed. Eyemed can be reached at 844-684-2254.

Note: Effective Jan. 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 benefit Guideline on Immunizations

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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.

Repair and/or replacement of wheelchairs due to normal usage is a covered benefit. 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 DIRPI: Equipment Excluded

Wheelchairs (cont.)

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO and BlueCare Direct have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”

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