TABLE OF CONTENTS

Introduction and Guidelines for Benefits Interpretation .............................................................. 3
National Coverage Determinations (NCDs) ............................................................................. 3
Local Coverage Determinations (LCDs) .................................................................................. 4
Medicare Coverage Database ................................................................................................. 4
Abortion (Elective) ................................................................................................................... 5
Allergy Testing/Desensitization ............................................................................................... 6
Ambulance Services .................................................................................................................. 7
Ambulatory Blood Pressure Monitoring .................................................................................. 8
Amniocentesis ............................................................................................................................ 9
Apnea Monitors ....................................................................................................................... 10
Assistant Surgeon ................................................................................................................... 11
Automatic External Defibrillator ............................................................................................. 12
Automatic Implantable Cardioverter Defibrillator (AICD) ......................................................... 13
Autopsy Examination .............................................................................................................. 14
Biofeedback Therapy ............................................................................................................. 15
Blood and Blood Derivatives ................................................................................................. 16
Botulinum Toxin ..................................................................................................................... 17
Breast Surgery ......................................................................................................................... 18
Cardiac Rehabilitation ............................................................................................................ 20
Chemical Dependency Services ............................................................................................. 21
Chemotherapy .......................................................................................................................... 22
Chiropractic Services ............................................................................................................. 23
Cochlear Implantation ............................................................................................................ 24
Collagen Implant ..................................................................................................................... 25
Computerized Knee Evaluation ............................................................................................... 26
Contact Lenses/Eyeglasses ..................................................................................................... 27
Cosmetic/Reconstructive Surgery ......................................................................................... 28
Custodial Care ......................................................................................................................... 30
Day Rehabilitation Program .................................................................................................. 31
Dental ..................................................................................................................................... 32
Diabetes Self-Management ..................................................................................................... 34
Durable Medical Equipment (DME) ..................................................................................... 35
Earplugs ................................................................................................................................... 37
Electrical Bone Growth Stimulation ..................................................................................... 38
Emergency Communication Devices .................................................................................... 39
Emergency Services ............................................................................................................. 40
Epidural Anesthesia ............................................................................................................... 41
Family Planning ...................................................................................................................... 42
Health Examinations................................................................................................................ 43
Hearing Screening.................................................................................................................... 44
Hematopoietic Growth Factors (HGF) ..................................................................................... 45
Hemodialysis and Peritoneal Dialysis...................................................................................... 46
Home Health Care Services .................................................................................................... 47
Hospice Care........................................................................................................................... 49
Hospital Beds ......................................................................................................................... 51
Hyperalimentation (TPN) ....................................................................................................... 52
Hyperthermia Therapy ............................................................................................................ 53
Hypnosis.................................................................................................................................. 54
In-Vitro Chemotherapeutic Drug Assays .................................................................................. 55
Infusion Pumps (Implanted-Permanent) .................................................................................. 56
Intravenous Immunoglobulin (IVIG) ...................................................................................... 58
Lithotripsy (Percutaneous and Extracorporeal) ..................................................................... 59
Mammography ......................................................................................................................... 60
Maternity/Obstetrical Care ...................................................................................................... 61
Mental Health Care (Inpatient) ............................................................................................... 62
Mental Health Care (Outpatient) ............................................................................................ 63
Neuromuscular Stimulation for Scoliosis ................................................................................. 65
Nutritional Services (Dietary Counseling) .............................................................................. 66
Obesity ................................................................................................................................... 67
Obstructive Sleep Apnea (OSA) Syndrome ............................................................................. 68
Occupational Therapy ............................................................................................................. 70
Organ and Tissue Transplantation ......................................................................................... 71
Outpatient Drugs ..................................................................................................................... 75
Outpatient Surgery .................................................................................................................. 84
Pain Management Programs ................................................................................................... 85
Physical Therapy ....................................................................................................................... 86
Positron Emission Tomography (PET Scan) .......................................................................... 87
Podiatry/Pediatric Services ..................................................................................................... 88
Private Duty Nursing ............................................................................................................... 89
Prostate Procedures ................................................................................................................ 90
Prosthetic Devices .................................................................................................................. 91
Respiratory Therapy (Inhalation Therapy) ............................................................................... 93
Second Opinions ..................................................................................................................... 94
Sensory Evoked Potentials (SEP) ........................................................................................... 95
Skilled Nursing Facility (SNF) ............................................................................................... 96
Speech Therapy ....................................................................................................................... 97
Topographic Brain Mapping (TBM) ......................................................................................... 98
Ultrasonic Bone Stimulation ................................................................................................... 99
Ultraviolet (UV) Light Treatment for Psoriasis................................................................. 100
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 Evidence of Coverage upon enrollment with the HMO.

To be eligible for the benefits of the policy, the services must be provided or ordered by the Primary Care Physician (PCP).

All plans must be offered uniformly to all enrollees residing in the service area of the HMO and must be offered at uniform premium, with uniform benefits and cost sharing throughout the plan's service area. Refer to the Benefit Matrix for accurate details for each benefit plan regarding copayments, rehabilitation benefits, Durable Medical Equipment (DME) benefits and behavioral health (BH) and chemical dependency (CD) benefits.

The IPA is responsible for providing, or arranging for, all covered physician services, IPA-approved inpatient and outpatient hospital services, ancillary services and non-hospital-based emergency services within the scope of benefits of the evidence of coverage.

All inpatient hospital admissions (except those which occur out of area), Skilled Nursing Facility (SNF) days and home health visits must be approved by the IPA to be covered by the HMO. For inpatient stays during which enrollment ends, the HMO and IPAs must continue to cover inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of an inpatient stay.

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

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

This section is intended to provide a quick reference of covered and non-covered services. It includes frequently asked benefit issues and some issues that may be misinterpreted based upon past experience. However, it is not possible to include everything. The IPA may contact the Customer Service at 877-774-8592 for more help with benefits interpretation.

Providers participating in the HMO network should refer directly to Medicare coverage policies when making coverage decisions. There are two types of Medicare coverage policies that apply:
- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)

As a Medicare Advantage plan, Blue Medicare Advantage HMO must cover all services and benefits covered by Medicare. Coverage information that you receive concerning original Medicare also applies to Blue Medicare Advantage HMO.

National Coverage Determinations (NCDs)
The Centers for Medicare & Medicaid Services (CMS) explains NCDs through program manuals, which are found at [http://cms.hhs.gov/manuals/](http://cms.hhs.gov/manuals/). Key manuals for coverage include:
- Medicare National Coverage Determinations Manual
- Medicare Program Integrity Manual
- Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network. These articles can be found at [www.cms.hhs.gov/MLNMattersArticles/](http://www.cms.hhs.gov/MLNMattersArticles/).
Local Coverage Determinations (LCDs)
CMS contractors (e.g., carriers and fiscal intermediaries) develop and issue local coverage determinations (LCDs) to provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NDC or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

Provider may access our region’s LCDs at the following website addresses:

- Medicare Part B: www.wpsmedicare.com
- Medicare Part A: www.wpsmedicare.com

Providers are encouraged to join mailing lists at the above Medicare contractors’ websites for LCD policy publications and at CMS’s website for NCD policy publications. The can be done by going to each contractor’s website (and CMS’s website) and subscribing to their mailing lists.

Medicare Coverage Database

The following areas may be searched:
- National Coverage Determinations (NCDs)
- National Coverage Analyses (NCAs) – These documents support the NCD process.

Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is normally updated on a monthly basis. Therefore, the most current information on LCDs should be accessed through the local websites listed in the box above.
Abortion (Elective)

Benefit: Coverage for elective pregnancy termination (abortion) is not a covered Medicare procedure except:

- If the pregnancy is the result of an act of rape or incest; or
- In the case where a woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

No limits apply to medically necessary abortions. The IPA physician must refer the member for the procedure. In the case of IPAs that do not retain the responsibility for abortion referrals, the HMO must refer for the procedure.

Paid By:

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

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

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

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

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

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

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

Paid By:

| Partial MSA: | Physician Charges: | IPA |
| Testing Supplies: | IPA |
| Antigens: | IPA |

| Global MSA: | Physician Charges | IPA |
| Testing Supplies: | IPA |
| Antigens: | IPA |
Ambulance Services

Benefit: Ground and air ambulance service is covered under emergency conditions and also 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

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

The IPA may use the ambulance company of its choice.

Paid By:

Partial MSA: HMO
Global MSA: IPA
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 only covered for those patients with suspected white coat hypertension. Suspected white coat hypertension is defined as meeting all criteria below:

- Office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit;
- At least two documented blood pressure measurements taken outside the office which are <140/90 mm Hg; and
- No evidence of end-organ damage.

24-hour non-invasive continuous ambulatory blood pressure monitors are in benefit if determined to be medically necessary by the PCP.

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

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

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

Paid By:
Partial MSA:  
Physician Charges: IPA  
Monitor/Equipment Charges: HMO

Global MSA:  
Physician Charges: IPA  
Monitor/Equipment Charges: IPA
Amniocentesis

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

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

Paid By:

Partial MSA:
- Physician Charges: IPA
- Inpatient Facility Charges: HMO
- Outpatient Facility Charges: HMO

Global MSA:
- Physician Charges: IPA
- Inpatient Facility Charges: IPA
- Outpatient Facility Charges: IPA
Apnea Monitors

Benefit: Apnea monitors are a covered benefit for members diagnosed with obstructive sleep apnea (OSA).

Interpretation: The benefits coverage of the sleep testing devices are specifically: Type 1 PSG when the test is attended in a sleep lab facility, Type II or Type III if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility, or Type IV measuring three or more channels, one of which is airflow, if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

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.
- Other diagnostic sleep tests for the diagnosis of OSA other than those listed above.

Paid By:

Partial MSA: Equipment Costs: HMO
Professional Charges: IPA

Global MSA: Equipment Costs: IPA
Professional Costs: IPA
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.

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<td>Global MSA</td>
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<td>Charges: IPA</td>
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Automatic External Defibrillator

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

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

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

**Paid By:**
- **Partial Risk:** HMO (if referred by the PCP)
  Member (if not referred by the PCP)
- **Global Risk:** IPA (if referred by the PCP)
  Member (if not referred by the PCP)
Automatic Implantable Cardioverter Defibrillator (AICD)

Benefit: Automatic implantable defibrillators are in benefit.

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

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

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

Paid By:

Partial MSA:  
Device: HMO  
Facility Charges: HMO  
Professional Fees: IPA

Global MSA:  
Device: IPA  
Facility Charges: IPA  
Professional Fees: IPA
Autopsy Examination

Benefit: Autopsy is not a covered benefit.

Paid By: Member
Biofeedback Therapy

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

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

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

Using the above criteria, biofeedback would rarely be expected to provide added therapeutic benefit for the following conditions:
- Anxiety Disorders
- Asthma
- Hypertension
- Headaches
- Insomnia
- Raynaud’s Syndrome

**Paid By:**

- **Partial MSA:**
  - Physician Charges: IPA
  - Device Charges: HMO
  - Facility Charges: IPA
- **Global MSA:**
  - Physician Charges: IPA
  - Device Charges: IPA
  - Facility Charges: IPA
Blood and Blood Derivatives

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

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

Blood derivatives extracted from whole blood or manufactured are utilized as drugs to treat specific conditions. Blood derivatives are covered as injectable drugs (see separate benefits interpretation on Outpatient 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:
Partial MSA:
- Physician Charges: IPA
- Inpatient Facility Charges for Administration of Blood Derivatives or Blood Components: HMO
- Outpatient Facility and Other Outpatient Charges for Administration of Blood Derivatives or Blood Components: IPA
- Autologous Blood Donation and Storage Charges, when elective surgery is scheduled: HMO
- Autologous Blood Donation and Storage Charges, when elective surgery is NOT scheduled: Member
- Home Health Charges (from contracted provider): HMO
- Home Health Charges (from non-contracted provider): IPA

Global MSA:
- Physician Charges: IPA
- Inpatient Facility Charges for Administration of Blood Derivatives or Blood Components: IPA
- 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: IPA
- Autologous Blood donation and Storage Charges, when elective surgery is NOT scheduled: Member
- Home Health charges (from contracted provider): IPA
- Home Health charges (from non-contracted provider): IPA
Botulinum Toxin

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

Other Medical Uses: The Primary Care Physician, not the IPA, determines medical necessity for this service. If the PCP recommends the service, it is in benefit. However, the PCP might wish to consider that the Blue Cross and Blue Shield Association Technology Evaluation Center has determined that there is inadequate evidence to conclude that this service improves clinical outcomes for the following conditions:
- Oromandibular dystonia, other than jaw closing type
- Stuttering
- Vocal akathesia and other tremors
- Urinary or anal sphincter dysfunction

Cosmetic Uses: Botulinum toxin is not in benefit when used for cosmetic services unrelated to restoration of bodily function, correction of congenital deformities, or for conditions resulting from accidental injuries, tumors, disease or previous therapeutic processes. Such cosmetic services may include, but are not limited to, denervation for elimination of laugh lines, worry lines, crows’ feet, dynamic wrinkles, or other cosmesis.

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

Paid By:
Partial MSA: Professional Charges: IPA
Facility Charges: HMO
Drug Charges: IPA

Global MSA: Professional Charges: IPA
Facility Charges: IPA
Drug Charges: IPA
Breast Surgery

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

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

**Interpretation:** *Breast Reduction*

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

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

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

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

**Prophylactic Mastectomy With Reconstruction**

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

**Breast Reconstruction**

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

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

**Breast 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.
Breast Surgery (cont.)

**Bras and Prostheses**

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

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

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

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:

Partial MSA:
- Professional Charges: IPA
- Inpatient Facility Charges: HMO
- Outpatient Facility Charges: IPA
- Phase Three Rehabilitation: Member

Global MSA:
- Professional Charges: IPA
- Inpatient Facility Charges: IPA
- Outpatient Facility Charges: IPA
- Phase Three Rehabilitation: Member
Chemical Dependency Services

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

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

Interpretation: If the member has dual mental health and chemical dependency diagnoses, the primary diagnosis determines authorization procedures. The IPA remains responsible for the coordination of care and payment for associated medical or psychiatric problems that arose either prior to admission or while the member is hospitalized, in a partial hospitalization program (PHP), intensive outpatient program (IOP) or residential program. Please call the HMO Behavioral Health Liaison with any questions.

Many facilities provide specialized programs for the treatment of chemical dependency that may include a period of detoxification (usually 2-5 days).

Paid By:
Partial MSA: Professional Charges: IPA
Inpatient and Outpatient Facility Charges: HMO

Global MSA: Professional Charges: IPA
Inpatient and Outpatient Facility: IPA
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:**
- **Partial MSA:**
  - Physician Charges: IPA
  - Inpatient Drug Charges: HMO
  - Inpatient Facility Charges: HMO
  - Outpatient Drug Charges: IPA
  - Outpatient Facility 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

- **Global MSA:**
  - Physician Charges: IPA
  - Inpatient Drug Charges: IPA
  - Inpatient Facility Charges: IPA
  - Outpatient Drug Charges: IPA
  - Outpatient Facility Charges: IPA
  - Home Health Care Charges (for homebound-contracted): IPA
  - Home Health Care Charges (for ambulatory or non-contracted): IPA

**Note:** Therapy should be provided in the most clinically appropriate and cost-effective setting.
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 feels that chiropractic services will benefit the member and refers the member to a chiropractor, the services are covered. As with all clinical services, referral to a chiropractor should be based on the clinical judgment of the PCP, not the insistence of the member.

**Paid By:**
- **Partial MSA:** Professional Charges: IPA
- **Global MSA:** Professional Charges: IPA
Cochlear Implantation

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

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

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

An intensive pre-surgical evaluation is usually performed. This evaluation may include:
- Auditory brainstem response studies
- Stapedial reflex testing
- Otoacoustic emission testing
- Auditory behavioral response evaluation
- MRI or CT Scans

Patient eligibility criteria for any of the above device types include individuals who meet all of these five selection criteria:
- Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit from appropriate hearing (or vibrotactile) aids;
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
- No contraindications to surgery; and
- The device must be used in accordance with Food and Drug Administration (FDA)-approved labeling

Post-implant aural therapy is important for adults 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.

Paid By:
Partial MSA:  
   Physician Charges: IPA
   Device Costs: HMO
   Facility Charges: HMO
   Aural Therapy: IPA

Global MSA:  
   Physician Charges: IPA
   Device Costs: IPA
   Facility Charges: IPA
   Aural Therapy: IPA

Note: See related benefits interpretation on Speech Therapy.
Collagen Implant

**Benefit:** Collagen implanted by injection is limited to the following types of patients with stress urinary incontinence due to ISD:
- Patients with congenital sphincter weakness secondary to conditions such as myelomeningocele or epispadias;
- Patients with acquired sphincter weakness secondary to spinal cord lesions;
- Male patients following trauma, including prostatectomy and/or radiation; and
- Female patients without urethral hypermobility and with abdominal leak point pressures of 100 cm H or less.

**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:**

Partial MSA:
- Physician Charges: IPA
- Drug Charges: IPA
  - When used for treatment of corns, calluses or for cosmetic indications: Member

Global MSA:
- Physician Charges: IPA
- Drug Charges: IPA
  - When used for treatment of corns, calluses or for cosmetic indications: Member

**Note:** See related benefits interpretation on Cosmetic/Reconstructive Surgery.
Computerized Knee Evaluation

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

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

**Paid By:**
- **Partial MSA:** Outpatient Charges: IPA
- **Global MSA:** Outpatient Charges: IPA
Contact Lenses/Eyeglasses

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

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

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

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

For Correction of Vision:

Paid By:

<table>
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<td>Lens Charges:</td>
<td>Member (as described in the Vision Care Benefits)</td>
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For Medical Treatment of Certain Diseases of the Eye

Paid By:

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<td>Lens Charges:</td>
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Note: See related benefits interpretation on Vision Care on Vision Screening/Routine Vision Care and Prosthetic Devices.

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

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

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

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

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

- 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 septrhinoform 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; and
- Laser treatment of rosacea.

Not in Benefit: Benefits are not provided for purely cosmetic procedures, unless there is documentation that the surgery/treatment is being performed for correction of congenital deformities or for conditions resulting from accidental injuries, tumors or disease. The Etiology of the underlying condition for which the surgery/treatment is performed, rather than the type of procedure, is the factor which determines benefit eligibility. In the absence of appropriate documentation, the following procedures are considered cosmetic and not in benefit:

- Revision or treatment of complications, procedures or conditions that were originally considered cosmetic and revision is performed for purely aesthetic purposes;
- Excision or treatment of decorative or self-induced tattoos;
- Chemical peel or dermabrasion of face or other areas for wrinkling or pigmentation;
- Rhytidectomy solely for aging skin; buttock and thigh lifts; neck tucks;
- Excision or correction of glabellar frown lines;
- Revision of vaccination scars;
- Insertion or injection of prosthetic material to replace absent adipose tissue;
- Hairplasty (any type) for male pattern alopecia (male or female member);
- Electrolysis for hirsutism;
- Augmentation of otherwise normal breasts, regardless of size;
- Reduction or repositioning mammoplasty when asymptomatic;
- Liposuction 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); and
- Condition of "moon face" developed as a side effect of cortisone therapy;

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

Paid By:

Partial MSA:  
Physician Charges:  IPA  
Facility Charges:  HMO

Global MSA:  
Physician Charges:  IPA  
Facility Charges:  IPA

Note: See related benefits interpretations on Breast Surgery and Orthognathic Surgery.
Custodial Care

Benefit: Custodial care services are not in benefit.

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

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

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

Paid By: Member

Note: See related benefits interpretations on Skilled Nursing Facility and Home Health Care.
Day Rehabilitation Program

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

Interpretation: A day rehabilitation program is a non-residential planned rehabilitative program of speech therapy (ST), occupational therapy (OT) and/or physical therapy (PT). 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:

Partial MSA:
- Physician Charges: IPA
- Facility Charges: IPA

Global MSA:
- Physician Charges: IPA
- Facility Charges: IPA
Dental

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

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

Certain oral surgical procedures are covered for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Coverage for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances.

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 exam
- Cleaning
- Filling
- Orthodontics (braces)
- Endodontic
- Prosthodontic
- Periodontal services; and
- Restorative or prosthetic services that alter jaw or teeth relationships.

Injury to Sound Natural Teeth

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

Injury to the tooth may not be obvious. All of the treatment mentioned above continues to be in benefit, even if the injury becomes apparent several months later. Only directly injured teeth are covered.

Hospitalization/Ambulatory Surgical Facility Use for Non-covered Dental Procedures

An admission (or use of an ambulatory surgical facility) for non-covered dental services is a covered benefit when one or more of the following conditions exist:
- A non-dental physical condition makes hospitalization or use of an ambulatory surgical facility medically necessary to safeguard the health of the member.
- The member requires medical management during a dental procedure because of serious systemic disease.
- The member needs anesthesia because of inability to cooperate with extensive dental procedures while conscious. Examples include, but are not limited to, members who are mentally or physically handicapped, or young children.
- The surgical procedures are complex and carry a high probability of life-threatening complications.
Dental (cont.)

When a hospital or ambulatory surgical facility is used for non-covered dental surgery, the HMO or IPA will pay the facility charges based upon a partial or global contract. 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:

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

Paid By:

Partial MSA:

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

**Routine Dental Care:**
- Professional Charges: Member

**Hospitalization/Ambulatory Surgical Facility Use for Non-covered Dental Procedures:**
- Professional fees for dental procedures: Member
- Anesthesia charges (If member does not meet above criteria): Member
- Anesthesia Charges (If member does meet above criteria): IPA
- Professional fees for treatment of medical condition: IPA
- Facility Charges: HMO

Global MSA:

**Injury to Sound Natural Teeth:**
- Professional Charges: IPA
- Hospital Charges: IPA
- Outpatient Facility Charges: IPA

**Routine Dental Care:**
- Professional Charges: IPA

**Hospitalization/Ambulatory Surgical Facility Use for Non-covered Dental Procedures:**
- Professional fees for dental procedures: Member
- Anesthesia charges (If member does not meet above criteria): Member
- Anesthesia Charges (If member does meet above criteria): IPA
- Professional Fees for Treatment of Medical Condition: IPA
- Facility Charges: 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 250mg/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 through the member’s pharmacy benefits.

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:
Partial MSA: Professional Fees: IPA
DME (from contracted provider): HMO
DME (from non-contracted provider): IPA
Prescription Drugs: IPA (through prescription benefit)

Global MSA: Professional Fees: IPA
DME: IPA
Prescription Drugs: HMO (through prescription benefit)

Note: See related benefits interpretations on Outpatient Drugs, DME and Infusion Pumps.
**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; and
- Are ordered and/or prescribed by an IPA Physician.

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

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

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

If DME can be rented for a cost less than purchase, payment for the rental will be made. Once purchase price is reached, no more benefits will be available for that piece of equipment. Purchase will be covered only if:
- The item of equipment is unavailable on a rental basis; or
- The member will use the item of equipment for a long enough period of time to make its purchase more economical than continuing rental fees.

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

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; and
- 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.
Durable Medical Equipment (DME) (cont.)

Paid By:

Partial MSA:
- Physician Charges: IPA
- Equipment Charges (from a contracted provider): HMO
- Equipment Charges (from a non-contracted provider): IPA

Global MSA:
- Physician Charges: IPA
- Equipment Charges (from a contracted provider): IPA
- Equipment Charges (from a non-contracted provider): IPA
Earplugs

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

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

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

Paid By: Equipment Charges: Member
Electrical Bone Growth Stimulation

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

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

The non-invasive method is accepted medical practice for the treatment of long bone, pelvis and shoulder girdle non-union secondary to trauma meeting the following criteria:
- At least 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:**
- **Partial MSA:**
  - Physician Charges: IPA
  - Facility Charges: HMO
  - Device Charges: HMO

- **Global MSA:**
  - Physician Charges: IPA
  - Facility Charges: IPA
  - Device Charges: IPA

**Note:** See related benefits interpretation on Ultrasonic Bone Stimulation.
Emergency Communication Devices

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

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

Paid By: Device Charges: Member
Emergency Services

Benefit: Emergency services are covered.

Interpretation: The IPA is responsible for paying for facility and professional charges for all services for Emergency Medical Conditions provided to a Member within the geographical area of Cook, DuPage, Kane, Kendall, Lake, McHenry and Will counties. The HMO pays for facility, physician and ancillary charges for all services for Emergency Medical Conditions provided to a Member outside of the geographical area of Cook, DuPage, Kane, Kendall, Lake, McHenry and Will Counties. Prior authorization or approval by the IPA is not required for payment of hospital-based emergency services.

Paid By:

- Professional Charges In-area: IPA
- Facility Charges In-area: IPA
- Professional Charges Out-of-area: HMO
- Facility Charges Out-of-area: HMO

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

**Benefit:** Epidural anesthesia is a covered benefit.

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

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Family Planning

Benefit: Family planning services, including family planning counseling, prescribing of contraceptive drugs, fitting of contraceptive devices and sterilization is not in benefit.

Note: See related benefits interpretations on Abortion, Outpatient Drugs and Sterilization.
Health Examinations

Benefit: **Initial Health Risk Assessment**
CMS requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact an enrollee. The Original Medicare initial preventive visit (i.e., “Welcome to Medicare” preventive visit), an Annual Wellness Visit, or a recent previous physical examination in a commercial plan (to which the Medicare Advantage Organization (MAO) has access) would fulfill this obligation.

**Routine Health Exams**
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 an agency or organization, but not by statute, are not covered.

**Annual Health Assessment**
The Blue Medicare Advantage HMO’s Annual Health Assessment (AHA) serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits.

The components of the AHA include the member’s past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings and chronic disease monitoring. These assessments can occur in the provider’s office or member’s home to remove barriers to completion.

**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. The HMO preventive care guidelines provide evidence-based guidance to preventive care services.

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.

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Hearing Screening

**Benefit:**  Routine hearing screening is not a covered benefit. Diagnostic audiometry is covered if ordered by the PCP for injury or disease.

**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, if medically necessary.

**Paid By:**
- **Partial MSA:** Physician/Professional Charges: IPA
- **Global MSA:** Physician/Professional Charges: IPA

**Note:** See related benefits interpretation on Hearing Aids.
Hematopoietic Growth Factors (HGF)

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

**Interpretation:** Hematopoietic growth factors are naturally occurring substances produced by all humans. They modulate the development and maturation of white blood cells. A variety of such substances, including those listed below, have been identified:
- Granulocyte Colony Stimulating Factor (G-CSF)
- Granulocyte-Macrophage Colony Stimulating Factor (GM-CSF)
- Macrophage Stimulating Factor (M-CSF)
- Interleukin-3 (IL-3)

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

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

**Paid By:**
- Partial MSA: HMO (through the pharmacy program-as a self-injectable)
  IPA (if administered in physician office)
- Global MSA: HMO (through the pharmacy program-as a self-injectable)
  IPA (if administered in physician office)

**Note:** See related policies on Erythropoietin, Outpatient 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 Dialysis Facility Program or Home Health Care Program is covered.

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

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

Benefits apply to equipment, supplies and physician services.

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

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

Global MSA: Physician Charges: IPA
Outpatient Facility and related pharmaceutical changes (from a contracted provider): IPA
Outpatient Facility and related pharmaceutical changes (from a non-contracted provider): IPA
Outpatient lab services billed independently of the Dialysis Facility: IPA
Home Health Charges (from a Contracted provider): IPA
Home Health Care Services

Benefit: Home health care is a covered benefit when services are obtained from a Medicare-certified and contracted home health care provider. In addition, the IPA is financially responsible for one hundred percent of covered charges for home health care services ordered for ambulatory patients for whom care could have been provided in the office or an outpatient setting.

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

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

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

Comprehensive coverage includes:

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

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 and licensed by the state
- Maintains clinical records on all members served
### Home Health Care Services (cont.)

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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
- Dietary counseling

The following services are not covered under the Hospice Care Program:
- Durable medical equipment
- Home delivered meals
- Homemaker service
- Traditional medical services provided for the direct care of the terminal illness, disease or condition
- Transportation including, but not limited to Ambulance Transportation

Note: 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.
Hospice Care (Cont.)

Paid By:

Partial MSA:
- Professional Charges for Hospice: CMS
- Facility Charges for Hospice: CMS
- All other Professional Charges: IPA
- All other Facility Charges: HMO

Global MSA:
- Professional Charges for Hospice: CMS
- Facility Charges for Hospice: CMS
- All other Professional Charges: IPA
- All other Facility Charges: IPA
Hospital Beds

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

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

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

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

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

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

**Paid By:**
- Partial MSA: HMO
- Global MSA: IPA
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:
Partial MSA: Home Health, nutrients/solutions, supplies and equipment: HMO
Professional Charges: IPA

Global MSA: Home Health, nutrients/solutions, supplies and equipment: IPA
Professional Charges: IPA

Note: See related benefits interpretation on Nutritional Supplements/Enteral Nutrition.
Hyperthermia Therapy

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

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

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

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

Paid By:
Partial MSA: Physician Charges: IPA
Facility Charges: HMO

Physician Charges: IPA
Facility Charges: IPA
Hypnosis

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

Paid By: Member
In-Vitro Chemotherapeutic Drug Assays

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

Paid By: Member
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.

*Examples of Covered Services*

1. Implantable Infusion Pumps
   a) **Chemotherapy for Liver Cancer**
      The implantable infusion pump is covered for intra-arterial infusion of 5-FU dR for the treatment of liver cancer for patients with primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in whom the metastases are limited to the liver, and where: (1) the disease is unresectable, or (2) the patient refuses surgical excision of the tumor.

   b) **Anti-Spasmodic Drugs for Severe Spasticity**
      An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

      As indicated by at least a 6 week trial, the patient cannot be maintained on noninvasive methods of spasm control, such as oral anti-spasmodic drugs, either because these methods fail to control adequately the spasticity or produce intolerable side effects, and prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

   c) **Opioid Drugs for Treatment of Chronic Intractable Pain**
      An implantable infusion pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for treatment of severe chronic intractable pain of malignant or nonmalignant origin in patients who have a life expectancy of at least 3 months, and who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

      The patient's history must indicate that he/she would not respond adequately to noninvasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain); and a preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and degree of side effects (including effects on the activities of daily living) and patient acceptance.
**Infusion Pumps (Implanted-Permanent) (cont.)**

**d) Coverage of Other Uses of Implanted Infusion Pumps**
Determinations may be made on coverage of other uses of implanted infusion pumps if the physician verifies that:

- The drug is reasonable and necessary for the treatment of the individual patient;
- It is medically necessary that the drug be administered by an implanted infusion pump; and,
- The FDA-approved labeling for the pump must specify that the drug being administered and the purpose for which it is administered is an indicated use for the pump.

**e) Implantation of Infusion Pump is Contraindicated**
The implantation of an infusion pump is contraindicated in the following patients:

- With a known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.)
- Who have an infection
- Whose body size is insufficient to support the weight and bulk of the device
- With other implanted programmable devices since crosstalk between devices may inadvertently change the prescription.

*Note:* Payment may also be made for drugs necessary for the effective use of an implantable infusion pump as long as the drug being used with the pump is itself reasonable and necessary for the patient's treatment.

**Nationally Non-Covered Indications**
The following indications for treatment using infusion pumps are not covered under Medicare:

1. Implantable Infusion Pump

   **a) Thromboembolic Disease**
   According to the Public Health Service, there is insufficient published clinical data to support the safety and effectiveness of the heparin implantable pump. Therefore, the use of an implantable infusion pump for infusion of heparin in the treatment of recurrent thromboembolic disease is not covered.

   **b) Diabetes**
   An implanted infusion pump for the infusion of insulin to treat diabetes is not covered. The data does not demonstrate that the pump provides effective administration of insulin.

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Intravenous Immunoglobulin (IVIG)

**Benefit:**  Intravenous immunoglobulin is in benefit for selected members.

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

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

This is not an all-inclusive listing and the Primary Care Physician (PCP), not the IPA, determines medical necessity for this service. If the PCP recommends the service, it is in benefit.

**Paid By:**

**Partial MSA:**
- Administration in Physician Office: IPA
- Inpatient Facility Charges: HMO
- Outpatient Facility Charges: IPA
- Administration in home health setting (for homebound member and from contracted provider): HMO
- Administration in home health setting (for ambulatory member or when services are provided by a non-contracted provider): IPA

**Global MSA:**
- Administration in Physician Office: IPA
- Inpatient Facility Charges: IPA
- Outpatient Facility Charges: IPA
- Administration in home health setting (for homebound member and from contracted provider): IPA
- Administration in home health setting (for ambulatory member or when services are provided by a non-contracted provider): IPA
Lithotripsy (Percutaneous and Extracorporeal)

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

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

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

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

**Paid By:**

| Partial MSA | Inpatient Facility Charges: | HMO |
| Outpatient Facility Charges: | HMO |
| Physician Charges: | IPA |

| Global MSA | Inpatient Facility Charges: | IPA |
| Outpatient Facility Charges: | IPA |
| Physician Charges: | IPA |
Mammography

**Benefit:** Mammography is a covered benefit.

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

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

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

**Paid By:**

**Partial MSA:**

- Outpatient Facility Charges: IPA
- Professional Charges: IPA

**Global MSA:**

- Outpatient Facility Charges: IPA
- Professional Charges: IPA
Maternity/Obstetrical Care

Benefit: Maternal/obstetrical care is a covered benefit.

Interpretation: 80 - Health Care Associated With Pregnancy
(Rev. 1, 10-01-03) A3-3101.12, HO-210.13
Reasonable and necessary services associated with pregnancy are covered and reimbursable under the Medicare program. Because pregnancy is a condition sufficiently at variance with the usual state of health, it is appropriate for a pregnant woman to seek medical care. The increased possibility of illness or injury accompanying this condition is well recognized, and medical supervision is required throughout pregnancy and for a brief period beyond. Skilled medical management is appropriate throughout the events of pregnancy, beginning with diagnosis of the condition, continuing through delivery and ending after the necessary postnatal care. Similarly, if the pregnancy terminates, whether spontaneously or for therapeutic reasons (i.e., where the life of the mother would be endangered if the fetus were brought to term), the need for skilled medical management and/or medical services is equally as important as in those cases carried to full term. After the infant is delivered, items and services furnished to the infant cannot be covered and reimbursed under the program on the basis of the mother’s eligibility. 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.

Paid By:
Partial MSA:
  Professional Charges: IPA
  Facility Charges: HMO
  Ancillary Charges: IPA

Global MSA:
  Professional Charges: IPA
  Facility Charges: IPA
  Ancillary Charges: IPA
Mental Health Care (Inpatient)

**Benefit:** Mental health services are in benefit when provided for the treatment of mental illness.

**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 and electroconvulsive therapy.

Justice 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, de-personalization or confusion;
- Homicidal or suicidal acts or significant threats; uncontrolled destructive behavior towards self, others, or personal property;
- Child and adolescent behavioral disorder that reflects a recent onset or exacerbation (usually with a precipitating event) with the capacity to establish a therapeutic alliance and a reasonable expectation for a positive response to treatment.

A mental health inpatient admission is not in benefit (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.

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**Special Coverage Note:** Electroconvulsive Therapy (ECT) Inpatient ECT services are NOT in benefit.
Mental Health Care (Outpatient)

**Benefit:**
Mental health services are in benefit when provided for treatment of a mental illness.

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.

**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, transmagnetic stimulation (TMS), biofeedback and neurofeedback.

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

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.

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 PDD)
- 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.
Mental Health Care (Outpatient) (cont.)

Paid By:
Partial MSA:
  GA Professional Charges: IPA
  Professional charges (out-of-area emergency – regardless of diagnosis): HMO
  GA Outpatient Treatment/Diagnostic Facility Fees: IPA
  Facility charges (out-of-area emergency – regardless of diagnosis): HMO

Global MSA:
  GA Professional Charges: IPA
  Professional charges (out-of-area emergency – regardless of diagnosis): HMO
  GA Outpatient Treatment/Diagnostic Facility Fees: IPA
  Facility charges (out-of-area emergency – regardless of diagnosis): HMO
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:**

**Partial MSA:**
- Equipment charges: HMO
- Professional charges: IPA

**Global MSA:**
- Equipment charges: IPA
- Professional charges: IPA
Nutritional Services (Dietary Counseling)

**Benefit**

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

**Interpretation:**

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

- **Medical need** - Nutritional services for the resolution or maintenance care of a condition resulting from a disease, injury, surgery, congenital or genetic abnormality or eating disorders are covered. Examples include: special diets for hypertensive and cardiac members; newly diagnosed diabetic members; post-gastro-intestinal surgery members; individuals with celiac disease or other malabsorption syndromes; anorexics, bulimics. These members should be referred to a nutrition professional (physician, nurse or registered dietitian) at the discretion of the Primary Care Physician. The number of visits should be based on medical necessity.

- **Obesity** - Because obese members are at higher risk for other disorders (cardiovascular disease, diabetes, back problems, gynecological disorders, etc.) they are candidates for nutritional counseling. The Primary Care Physician, who determines the number of visits, should refer these members to a nutrition professional. Members may be advised to attend Weight Watchers®, TOPS, or other non-medical weight-loss programs. However, if the member is given a formal referral, the IPA becomes responsible for any charges.

- **Preventive nutritional counseling** - General nutritional counseling is normal member education, which is done as part of a physical examination or routine visit. This counseling can be done by the doctor or by nursing staff. The IPA may charge for member-driven referral to other dietary personnel if there is no special medical need, but the member must be informed prior to receiving these services.

**Paid By:**

**Partial MSA:**

- Outpatient professional charges: IPA
- Inpatient professional charges: IPA
- Inpatient facility charges: HMO

**Global MSA:**

- Outpatient professional charges: IPA
- Inpatient professional charges: IPA
- Inpatient facility 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.

The following bariatric surgery procedures are non-covered for all Medicare beneficiaries:
- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy
- Open and laparoscopic vertical banded gastroplasty
- Gastric Balloon
- Intestinal Bypass

**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:**

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<thead>
<tr>
<th>Partial MSA:</th>
<th>Global MSA:</th>
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<tbody>
<tr>
<td>Physician charges:</td>
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<tr>
<td>IPA</td>
<td>IPA</td>
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<tr>
<td>Facility charges:</td>
<td>Facility charges:</td>
</tr>
<tr>
<td>HMO</td>
<td>IPA</td>
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</table>

**Note:** See related benefits interpretation on Nutritional Supplements
Obstructive Sleep Apnea (OSA) Syndrome

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

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

Apnea is cessation of breathing and can be:

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

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

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

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

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

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

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

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

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

Surgical treatments include any procedure designed to remove or correct any identifiable airway obstruction. Such procedures can include:
- Tracheostomy – This "gold standard" treatment has poor member acceptance.
- Tonsillectomy and adenoidectomy
- Uvulopalatopharyngoplasty (UPPP) when there is clear documentation of pharyngeal narrowing.
- Mandibular and maxillary advancement procedures for members who fail to respond to UPPP.

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

Paid By:

Partial MSA:

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<tr>
<td>Diagnostic testing</td>
<td>IPA</td>
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<tr>
<td>Facility charges (outpatient diagnostic testing or medical treatment)</td>
<td>IPA</td>
</tr>
<tr>
<td>Facility charges (outpatient surgical or inpatient)</td>
<td>HMO</td>
</tr>
<tr>
<td>Device charges (from contracted provider)</td>
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<tr>
<td>Device charges (from a non-contracted provider)</td>
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Global MSA:

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<td>Diagnostic testing</td>
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<td>Device charges (from contracted provider)</td>
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<tr>
<td>Device charges (from a non-contracted provider)</td>
<td>IPA</td>
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</table>
Occupational Therapy

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

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

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

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

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

Not in benefit:

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

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

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

Paid By:

Partial MSA:

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

Global MSA:

Professional charges: IPA
Facility charges (inpatient): IPA
Home health charges (if services given to homebound member): IPA
Outpatient facility charges: IPA
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 Centers for Medicare & Medicaid Services (CMS) and Blue Cross and Blue Shield of Illinois (BCBSIL) approved transplant center.

The following organs and tissues are in benefit for transplant:
- Heart
- Liver
- Lung
- Kidney
- Isolated pancreas and simultaneous pancreas/kidney
- Small intestine

Organ and tissue transplants as listed below are in benefit when ordered by the Primary Care Physician and when performed at a BCBSIL approved transplant center.
- Bone marrow/stem cells
- Cornea

Note: this is not an exhaustive list. Contact the Health Coordinator if there is a question regarding coverage for an organ transplant. The Health Coordinator’s number for general coverage questions is 855-390-6573.

Notification and Authorization Process:

1. At the point a member is being considered for evaluation the IPA will initiate the approval process by contacting the Blue Cross Medicare Advantage HMO Provider Service department at 877-774-8592.

2. The IPA shall complete the Transition to Transplant Form, located on the Blue Cross Medicare Advantage HMO provider website under the “MA Resource Section”. The IPA shall fax the competed form to the Blue Cross Medicare Advantage HMO Health Coordinator at 505-816-3612.

Note: If a member needs a second transplant, a new Transition to Transplant Form authorization request shall be initiated.

3. If the member qualifies, the Blue Cross Medicare Advantage HMO Transplant Management team will conduct the care coordination for the member. The Blue Cross Medicare Advantage HMO Health Coordinator will communicate with both the member and the potential transplant facility within two (2) to three (3) business days following receipt of the Transition to Transplant Form. The Blue Cross Medicare Advantage HMO Health Coordinator will provide monthly status updates to the IPA Case Manager via email or telephonically.

4. If the member does not Qualify, (i.e. Uncontrolled diabetes) the member will be referred back to the IPA. Once the member becomes stabilized the IPA should initiate the request using by completing the Transition to Transplant Form.
Organ and Tissue Transplantation (cont.)

Interpretation: Organ transplantation is a non-capitated service.

Blue Cross Medicare Advantage HMO will perform Utilization/Referral and Case Management for organ transplant related care. The IPA will perform Utilization/Referral and Case Management for routine/unrelated to transplant care medical needs. The IPA also remains responsible for care and payment (according to the terms of the Medical Service Agreement) of underlying medical conditions that led to the need for the transplant – one example of this is dialysis for a kidney transplant candidate.

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

- Diagnostic workup performed by the designated transplant facility, whether or not the transplant ever takes place.
- The evaluation, preparation, removal and delivery of the donor organ, tissue, or marrow.
- (Lung) Lobar transplantation from a living related donor or a deceased matched donor is in benefit to treat a child or adolescent who has been approved for a lung transplant, but a complete lung has not become available.
- All inpatient and outpatient covered services related to the transplant surgery
- 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 for as long as the member is Medicare-eligible. Coverage for immunosuppressive drugs lasts for 36 months from Medicare Part A or Part B. After this time period, the member’s Medicare drug plan would assume responsibility for the coverage of the immunosuppressive drugs. The Drug Plan would require a pre-authorization for continued coverage.
- If a member only qualifies for Medicare due to permanent kidney failure, the entitlement for immunosuppressive drugs ends after the 36 month period.
- 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, the recipient’s insurance company or plan is responsible for covering the cost of pre-procedures donor care, organ acquisition, and post-donor care (if needed). 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 not in benefit. Benefits will not be provided for the recipient. Medicare covers medically necessary inpatient and outpatient procedures for the beneficiary, member. Being an organ donor is not a medically necessary procedure, and the costs to the donor would not be covered.
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 provisions.
- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a hospital for heart transplant surgery.
- Travel time or related expenses incurred by a provider

Paid By:
Partial and Global MSA:
HMO (When prior authorization from the HMO has been obtained)
IPA (If prior authorization from the HMO has not been obtained)

Claim Submission Notes:
- The HMO will reimburse the provider directly.
- The IPA should submit the claim and it should be stamped group approved, and "transplant – catastrophic claim" should be indicated directly on the claim
- Pre-transplant Evaluation related claims should be stamped group approved and "Pre-transplant Evaluation" should be indicated directly on the claims. These claims cannot be submitted prior to the HMO approving the transplant.
- Donor claims should be stamped NON-group approved and “Transplant Donor Claim with the HMO recipient’s name and identification number” should be indicated directly on the claim.
All transplants should occur by Medicare-eligible transplant providers. See below for Illinois approved programs. A complete list of transplant programs for all states can be found at: [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/ApprovedTransplantPrograms.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/ApprovedTransplantPrograms.pdf)

### Bone Marrow

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Location</th>
<th>Transplant Type</th>
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</thead>
<tbody>
<tr>
<td>Loyola University Medical Center</td>
<td>Maywood, IL</td>
<td>Adult</td>
</tr>
<tr>
<td>Advocate Lutheran General Medical Center</td>
<td>Park Ride, IL</td>
<td>Adult</td>
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</table>

### Heart

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Location</th>
<th>Transplant Type</th>
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<tbody>
<tr>
<td>Loyola University Medical Center</td>
<td>Maywood, IL</td>
<td>Adult Heart</td>
</tr>
<tr>
<td>University of Chicago Medical Center</td>
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<td>Adult</td>
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### Heart/Lung Combination

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<tr>
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<tbody>
<tr>
<td>University of Chicago Medical Center</td>
<td>Chicago, IL</td>
<td>Adult Combination Heart-Lung (Single or Bilateral)</td>
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### Intestinal

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<th>Hospital Name</th>
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</thead>
<tbody>
<tr>
<td>Mt. Sinai Hospital Medical Center</td>
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### Kidney

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</thead>
<tbody>
<tr>
<td>Advocate Christ Medical Center</td>
<td>Oak Lawn, IL</td>
<td>Adult</td>
</tr>
<tr>
<td>Loyola University Medical Center</td>
<td>Maywood, IL</td>
<td>Adult</td>
</tr>
<tr>
<td>University of Chicago Medical Center</td>
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<td>Adult</td>
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### Liver

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<thead>
<tr>
<th>Hospital Name</th>
<th>Location</th>
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<tbody>
<tr>
<td>Loyola University Medical Center</td>
<td>Maywood, IL</td>
<td>Adult</td>
</tr>
<tr>
<td>University of Chicago Medical Center</td>
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### Lung

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<th>Hospital Name</th>
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<tbody>
<tr>
<td>Loyola University Medical Center</td>
<td>Maywood, IL</td>
<td>Adult Single or Bilateral Lung</td>
</tr>
<tr>
<td>University of Chicago Medical Center</td>
<td>Chicago, IL</td>
<td>Adult Single or Bilateral Lung</td>
</tr>
</tbody>
</table>
Outpatient Drugs

**Benefit:**

HMO members’ drug benefit includes drugs administered in inpatient and outpatient settings.

**Part D Prescriptions:** The prescription drug program is based on a formulary. When possible, physicians should prescribe efficacious generic or brand name drugs identified in the Blue Medicare Advantage HMO Drug Formulary. The formulary is available on the Prime website at [www.myprime.com](http://www.myprime.com).

**Part B drugs covered include but are not limited to:**

**Shots (vaccinations):**

- **Flu shot:** In general, one flu shot per flu season. Flu shots are usually given before the start of the flu season, in the late summer, fall, or winter, but some people may get the shot in the spring.
- **Pneumococcal shot:** A shot to help prevent pneumococcal infections (like certain types of pneumonia)
- **Hepatitis B shots:** A series of three shots covered only for people at high or medium risk for Hepatitis B. A person’s risk for Hepatitis B increases if the person has hemophilia, End Stage Renal Disease (ESRD – permanent kidney failure requiring dialysis or a kidney transplant), or certain conditions that increase the person’s risk for infection. Other factors may also increase a person’s risk for Hepatitis B.
- **Other shots:** Some other vaccines when they are directly related to the treatment of an injury or illness

**Durable Medical Equipment (DME) supply drugs:** Some drugs used with DME, like infusion pumps and nebulizers, if considered reasonable and necessary

**Injectable drugs:** Most injectable drugs given by a licensed medical provider if the drug is considered reasonable and necessary for treatment and usually is not self-administered

**Osteoporosis drugs:** An injectable drug for women with osteoporosis who meet the criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn how to or unable to give herself the drug by injection.

**Some antigens:** If they are prepared by a doctor and given by a properly-instructed person (who could be the patient) under doctor supervision

**Erythropoiesis-stimulating agents:** For people undergoing dialysis and, if given as part of a doctor’s service, for certain other conditions

**Blood clotting factors:** For people with hemophilia who give themselves the drug by injection

**Oral anti-cancer drugs:** Some oral anti-cancer drugs if the same drug is available in injectable form for the same use and covered under Part B. As new oral anti-cancer drugs become available, Part B may cover them.

**Oral anti-nausea drugs:** Used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after the administration of the chemotherapy drug and must be used as a full therapeutic replacement for the intravenous anti-nausea drugs that would otherwise be given.
Outpatient Drugs (cont.)

**Oral ESRD drugs:** Some oral ESRD drugs, if the same drug is available in injectable form and covered under the Part B ESRD benefit

**Parenteral and enteral nutrition (intravenous and tube feeding):** Certain nutrients for people who can’t absorb nutrition through their intestinal tracts or cannot take food by mouth

**Intravenous Immune Globulin (IVIG) provided in the home:** For people with a diagnosis of primary immune deficiency disease. A doctor must decide that it’s medically appropriate for the IVIG to be given in the patient’s home. Part B covers the IVIG itself, but Part B does not pay for other items and services related to the patient getting the IVIG in his or her home.

**Interpretation:**

IPA assumes financial risk for drugs that are covered services under Medicare Part B.

HMO assumes financial risk for drugs that are covered services under Medicare Part D.

HMO assumes financial risk for Immunosuppressive drugs covered under Medicare Part B – Drug therapy for transplant patients, if the transplant meets Medicare coverage requirements.

**Coverage Variation:**

**Part D Drugs administered in a Part B (Physician) Setting**
The following Part D drugs which are often administered in a physician office setting are reimbursed under the member Part D drug benefit. Drugs following under this category change periodically. The IPA should ensure that physicians are informed of any Centers for Medicare & Medicaid Services (CMS) changes related to this section.

To receive reimbursement under the member Part D drug benefit, providers must follow the claims submission process established by the HMO.
### Outpatient Drugs (cont.)

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<th>Description</th>
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Outpatient Drugs (cont.)

**Part B Drugs administered in Part D (Pharmacy) Setting**
The following Part B drugs are often dispensed in a pharmacy setting. HMO-covered Part B drugs that are dispensed by a pharmacy will be paid by the HMO. The paid amount will be deducted from IPA Part B funding.

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<th>Code</th>
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Outpatient Drugs (cont.)

Situational Drugs Which can be Processed under Part B or Part D

The following list represents drugs that may be covered under Part B or Part D depending on the situation.

Part B Drugs: To receive reimbursement under the member’s Part D drug benefit, providers must follow the claims submission process established by the HMO.

Part D Drugs: HMO-covered Part B drugs that are dispensed by a pharmacy will be paid by the HMO. The paid amount will be deducted from IPA Part B funding.

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<tr>
<th>Code</th>
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### Outpatient Drugs (cont.)

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<td>Situational B or D</td>
<td>Part B bundled payment determination required for ESRD member.</td>
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<td>831000202220**</td>
<td>HEPARIN (PORCINE) IN SODIUM CHLORIDE SOLN</td>
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<td>831000202520**</td>
<td>HEPARIN SOD (PORCINE) IN D5W SOLN</td>
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<td>Part B bundled payment determination required for ESRD member.</td>
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<td>17100010********</td>
<td>HEPATITIS B VACCINE (RECOMB)</td>
<td>Situational B or D</td>
<td>Medium/High risk for Hep B?</td>
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<tr>
<td>9940***************</td>
<td>IMMUNOSUPPRESSIVE AGENTS</td>
<td>Situational B or D</td>
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<td>070000700025**</td>
<td>TOBRAMYCIN NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>1600005402120</td>
<td>AZTREONAM LYSINE FOR INHAL SOLN 75 MG (BASE EQUIVALENT)</td>
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<td>160000450021**</td>
<td>PENTAMIDINE ISETHIONATE SOLR</td>
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<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>SODIUM CHLORIDE SOLN NEBU 0.9%</td>
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<td>WATER, STERILE</td>
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<tr>
<td>441000301020**</td>
<td>IPRATROPIUM BROMIDE SOLN</td>
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<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>441500101025**</td>
<td>CROMOLYN SODIUM NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>442010101021**</td>
<td>ALBUTEROL SULFATE SOLR</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>442010121025**</td>
<td>ARFORMOTEROL TARTRATE NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>442010201025**</td>
<td>BITOLTEROL MESYLATE NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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### Outpatient Drugs (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Drug Name</th>
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<tr>
<td>442010271025**</td>
<td>FORMOTEROL FUMARATE NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>442010301025**</td>
<td>ISOETHARINE HCL NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>442010401025**</td>
<td>ISOPROTERENOL HCL NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>442010451025**</td>
<td>LEVALBUTEROL HCL NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>442010502025**</td>
<td>METAPROTERENOL SULFATE NEBU</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>44209902012015</td>
<td>ALBUTEROL-IPRATROPIUM NEBU SOLN</td>
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<tr>
<td>444000150018**</td>
<td>BUDESONIDE (INHALATION) SUSP</td>
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<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>453040200020**</td>
<td>DORNASE ALFA SOLN</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<tr>
<td>491000200020</td>
<td>ATROPINE SULFATE SOLN</td>
<td>Situational B or D</td>
<td>Retail: Not Covered Under Part D by Law, Submit to Part B LTC: Medicare A coverage exhausted?</td>
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<td>491000200022**</td>
<td>IMMUNE GLOBULIN (HUMAN)</td>
<td>Situational B or D</td>
<td>Is drug used in patient's home to treat primary immune deficiency?</td>
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<tr>
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<td>IMMUNE GLOBULIN (HUMAN) SUBCUTANEOUS INJ 160 MG/ML (16%)</td>
<td>Situational B or D</td>
<td>Is drug used in patient's home to treat primary immune deficiency?</td>
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<td>501000602003**</td>
<td>THIETHYLPERAZINE MALEATE TABS</td>
<td>Situational B or D</td>
<td>Used within 48 hours of chemo treatment?</td>
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<tr>
<td>502000701001**</td>
<td>TRIMETHOBENZAMIDE HCL CAPS</td>
<td>Situational B or D</td>
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<td>502500252003**</td>
<td>DOLASETRON MESYLATE TABS</td>
<td>Situational B or D</td>
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<td>502500351003**</td>
<td>GRANISETRON HCL TABS</td>
<td>Situational B or D</td>
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<tr>
<td>50250035102060</td>
<td>GRANISETRON HCL ORAL SOLN 2 MG/10ML (BASE EQUIVALENT)</td>
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<td>502500650003**</td>
<td>ONDANSETRON HCL TABS</td>
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<td>50250065007220</td>
<td>ONDANSETRON ORALLY DISINTEGRATING TAB 4 MG</td>
<td>Situational B or D</td>
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<td>50250065007240</td>
<td>ONDANSETRON ORALLY DISINTEGRATING TAB 8 MG</td>
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<td>ONDANSETRON HCL ORAL SOLN 4 MG/5ML</td>
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### Outpatient Drugs (cont.)

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<thead>
<tr>
<th>Code</th>
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<td>APREPITANT</td>
<td>Situational B or D</td>
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<td>Used w/in 48hr of chemo as IV replacement &amp; 3 drug regimen?</td>
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<td>221000300003**</td>
<td>METHYLPrednisolone TABS</td>
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<td>221000300064**</td>
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<td>FAT EMULSION EMUL</td>
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<td>Does patient have functioning GI tract?</td>
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<td>8030201010****</td>
<td>AMINO ACID INFUSION</td>
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<td>Does patient have functioning GI tract?</td>
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<td>803020102020**</td>
<td>AMINO ACID INFUSION IN D5W SOLN</td>
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<td>Does patient have functioning GI tract?</td>
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<td>Does patient have functioning GI tract?</td>
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<td>RABIES VIRUS VACCINE, HDC</td>
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<td>RABIES VACCINE, PCEC</td>
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<td>Used to treat an injury or exposure?</td>
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<td>TETANUS TOXOID ADSORBED SOLN</td>
<td>Situational B or D</td>
<td></td>
<td>Used to treat an injury or exposure?</td>
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</table>
Outpatient Surgery

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

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

The anesthesiologist or anesthetist’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 under the Partial MSA Agreement. Under the Global MSA Agreement, these services are the financial responsibility of the IPA.

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, under both the Partial and Global MSA arrangement.

**Paid By:**

**Partial MSA:**
- Physician/professional charges: IPA
- Hospital/ambulatory facility charges: HMO (see above)

**Global MSA:**
- Physician/professional charges: IPA
- Hospital/ambulatory facility charges: IPA
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.

Coverage of services furnished under outpatient hospital pain rehabilitation programs, including services furnished in group settings under individualized plans of treatment, is available if the patient's pain is attributable to a physical cause, the usual methods of treatment have not been successful in alleviating it, and a significant loss of ability by the patient to function independently has resulted from the pain. If a patient meets these conditions and the program provides services of the types discussed in §10.3 of the NCD Manual, the services provided under the program may be covered.

Non-covered services (e.g., vocational counseling, meals for outpatients, or acupuncture) continue to be excluded from coverage, and intermediaries would not be precluded from finding, in the case of particular patients, that the pain rehabilitation program is not reasonable and necessary under §1862(a)(1) of the Act for the treatment of their conditions.

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

*Note: See related benefits interpretation on Day Rehabilitation Programs.*

**Paid By:**

**Partial MSA:**
- Inpatient facility charge: HMO
- Outpatient charges: IPA
- Professional charges: IPA

**Global MSA:**
- Inpatient facility charge: IPA
- Outpatient charges: IPA
- Professional charges: IPA
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 Grid to confirm the extent of therapy benefits.

Copayments for outpatient rehabilitative therapy visits should apply per modality. In other words, if a member is sent for PT but at the visit the member is also provided ST, a copayment should be charged for each treatment that was provided.

Paid By:

Partial MSA:

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

Global MSA:

Professional charges: IPA
Inpatient facility charges: IPA
Outpatient facility charges: IPA
Home health charges (for homebound member): IPA
Positron Emission Tomography (PET Scan)

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

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

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

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

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

Paid By:
Partial MSA:
- Outpatient facility charges: IPA
- Professional charges: IPA
- Inpatient facility charges: HMO

Global MSA:
- Outpatient facility charges: IPA
- Professional charges: IPA
- Inpatient facility charges: IPA
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:
Partial MSA:
- Professional charges: IPA
- Facility charges: HMO

Global MSA:
- Professional charges: IPA
- Facility charges: IPA

Note: See related benefits interpretation on Orthotics
Private Duty Nursing

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

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

**Paid By:**
- Inpatient charges: Member
- Outpatient charges: Member
Prostate Procedures

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

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

Cryosurgery consists of the administration of liquid nitrogen into diseased tissue under ultrasound guidance. It is in benefit for selected members with prostate cancer.

Laser prostatectomy is in benefit as an alternative to TURP for members with any disease for which TURP is indicated.

Transurethral Radiofrequency Needle Ablation (RFNA) via TUNA® RFNA device is in benefit for men with BPH, as an alternative to TURP.

Brachytherapy, which is the implantation of radioactive seeds for the treatment of prostate cancer, is in benefit. Seeds are placed under ultrasound, fluoroscopic, and/or computed tomographic guidance.

Transrectal ultrasound is in benefit for a number of indications, including but not limited to screening, diagnosis, cancer staging, and guidance of biopsy sampling and radioactive seed implantation.

Paid By:
Partial MSA:
- Professional charges: IPA
- Outpatient radiation therapy charges: IPA
- Inpatient facility charges: HMO
- Outpatient surgery facility charges: HMO

Global MSA:
- Professional charges: IPA
- Outpatient radiation therapy charges: IPA
- Inpatient facility charges: IPA
- Outpatient surgery facility charges: IPA
Prosthetic Devices

**Benefit:** Prosthetic devices necessary for the alleviation or correction of conditions arising out of illness or injury are covered.

**Interpretation:** Prosthetic devices are those items used as a replacement or substitute for a missing body part.

Benefits are available for, but not limited to the following devices and appliances:

- Artificial eyes
- Artificial limbs (including harnesses, stump socks, etc.)
- Breast prosthesis (regardless of mastectomy date)
- Mastectomy bras
- Cardiac pacemakers
- Cleft palate devices
- Colostomy and other ostomy accoutrements directly related to ostomy care
- Electronic speech aids (in post-laryngectomy situations)
- Extraocular and intraocular lenses – Extraocular lenses means contact lenses and eyeglass lenses (frames not included). These are in benefit for aphakic post-surgery members (when an intraocular lens is not implanted during surgery). These are also in benefit for members with keratoconus. Intraocular lenses are covered only when replacing the original lens in the eye. For extraocular lenses for these specific conditions – the IPA may refer to provider of their choice. The use of a contracted provider is not required. The member pays for any refraction services.
- Maxillofacial prosthetic devices
- Penile implants and prostheses (for organic causes only)
- Prosthetic ears
- Prosthetic nose
- Shoe(s) only when either one or both shoes are an integral part of artificial limb(s)
- Space shoes (used as a substitute device when all of a substantial portion of the forefoot is absent)
- Testicular prosthesis
- Urethral sphincters
- Batteries used to operate eligible artificial devices

Functional adjustments and repair of prosthetics are covered when necessary as long as the device is medically required and meets the stated criteria of eligibility.

Replacement of prosthetic devices is covered when the replacement is necessitated by surgery (such as a pacemaker replacement), growth of the member, accidental destruction of the device or wear.

Benefits will not be provided for dental appliances or hearing aids, or for replacement of covered cataract lenses unless a prescription change is required. Wigs (cranial prosthesis) are generally not in benefit. Refer to the note on the next page.
Prosthetic Devices (cont.)

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.

Paid By:
Partial MSA:
Physician/professional charges: IPA
Device charges: HMO
Facility charges (if applicable): HMO

Global MSA:
Physician/professional charges: IPA
Device charges: IPA
Facility charges (if applicable): IPA
Respiratory Therapy (Inhalation Therapy)

**Benefit:** Respiratory therapy is a covered benefit.

**Interpretation:** This process consists of treatment of a disease, injury or condition by means of respiratory therapy by or under the supervision of a qualified Respiratory Therapist. It can be provided on an inpatient or outpatient basis.

Respiratory therapy provided by the member or the member's family in the member's home or place of work is excluded.

Some equipment and supplies are covered see Benefits Interpretation for Durable Medical Equipment.

**Paid By:**

**Partial MSA:**
- Outpatient charges: IPA
- Inpatient charges: HMO

**Global MSA:**
- Outpatient charges: IPA
- Inpatient charges: IPA
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:**
- Partial MSA: Professional fees: IPA
- Global MSA: Professional fees: IPA
Sensory Evoked Potentials (SEP)

**Benefit:** Evoked potentials are in benefit in a limited number of situations.

**Interpretation:** Sensory Evoked Potentials (SEP) are electrical waves generated by sensory neurons in response to stimuli. Changes in the electrical waves are averaged by a computer and then interpreted by a physician to assist the diagnosis of certain neuropathic states or to provide information for treatment management.

Sensory evoked potentials are detected by superficial electrodes attached to the skin or needle electrodes placed into the skin. Various means of stimulation are used:

- Auditory evoked potentials - Clicks or tones delivered through headphones.
- Somatosensory evoked potentials - Transcutaneous stimulation of nerve trunks in arms or legs.
- Visual evoked potentials - Flashes of light or alternating checkerboard patterns.

Sensory evoked potentials are in benefit for evaluation of these symptoms or diagnoses:

1. **Auditory**
   - Evaluation of brainstem functions (e.g., hypoxic encephalopathy)
   - As a second line test to identify presence of brainstem tumors (e.g., acoustic neuromas).
   - May be a first line test if CT or MRI scanning is not available
   - To supplement EEG findings in evaluating irreversibility of coma or brain death
   - To evaluate hearing impairment in young children or mentally handicapped members of any age

2. **Somatosensory**
   - Evaluation of spinal cord injury in unconscious trauma members
   - To diagnose or manage somatosensory deficits (e.g., multiple sclerosis)

3. **Visual**
   - To diagnose or manage multiple sclerosis both in the acute phase and the chronic phase
   - To localize visual field defects occurring in the absence of structural lesions (e.g., metabolic or infectious diseases)

**Paid By:**

**Partial MSA:**
- Professional charges: IPA
- Facility charges: HMO

**Global MSA:**
- Professional charges: IPA
- Facility charges: IPA
Skilled Nursing Facility (SNF)

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

Interpretation: Skilled nursing facility care is in benefit if the member has a documented need for skilled care and the PCP refers for the service.

Skilled care is care that requires the services of a trained medical professional, and cannot reasonably be taught to a person without specialized skill and professional training. Examples of skilled care are:

- Frequent extensive, sterile dressing changes
- Infusions of IV medications
- Daily physical therapy with documentation of continuing objective improvement
- Frequent non-self-injectable medications

It is the IPA’s responsibility that one or more IPA physicians maintain privileges with at least one HMO-contracted SNF. The IPA (especially the physician) must regularly assess the level of care required by any member in a SNF. In particular, the physician should assess the member’s need for skilled services. Care should not be custodial (see separate benefits interpretation on Custodial Care). Ongoing eligibility for benefit coverage depends on the member’s continuing need for skilled care. The nature of the care provided, rather than the setting of care, determines whether or not the care is skilled.

Skilled Nursing facility means an institution or a distinct part of institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. There is no benefit coverage for holding a skilled nursing bed during the time that a SNF member is hospitalized.

SNF days are charged against the Utilization Management Fund at a rate of 0.50 units per day if an HMO contracting facility is used, or at a rate of 1.50 units per day if a non-contracting facility is used.

Paid By:
Partial MSA:
- Physician charges: IPA
- Facility charges: HMO

Global MSA:
- Physician charges: IPA
- Facility charges: IPA
Speech Therapy

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

**Interpretation:** Speech therapy must be prescribed by a licensed physician and provided by, or under the supervision of, a Registered Speech Therapist to be in benefit. Speech therapists guide the improvement of speech and also help diagnose and treat infants and adults with swallowing disorders.

Results of a trial of therapy may help an IPA physician determine whether or not ongoing speech therapy is medically necessary.

Speech therapy which maintains, rather than improves, speech communication is not covered. Communication devices, such as computer boards, are in benefit. The instruction of sign language or lip reading is not covered.

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

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

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

**Paid By:**
- Professional charges (inpatient/outpatient): IPA
- Facility charges (inpatient): HMO
- Outpatient facility charges: IPA
- Device charges (from a contracted provider): HMO
- Device charges (from a non-contracted provider): IPA
Topographic Brain Mapping (TBM)

Benefit: TBM is in benefit for selected members.

Interpretation: TBM, sometimes referred to as Brain Electrical Activity Mapping (BEAM), is an extension of conventional electroencephalography. Clinical application of this technology continues to expand.

Topographic brain mapping is appropriate for the following:
- Preoperative evaluation of brain tumor resection
- Preoperative evaluation of seizure foci in seizure disorders poorly responsive to medical therapy
- Localization of brain centers, such as the speech center, before or during selected surgical procedures

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

Paid By:
Partial MSA:
- Professional fees: IPA
- Outpatient facility fees: IPA
- Inpatient facility charges: HMO

Global MSA:
- Professional fees: IPA
- Outpatient facility fees: IPA
- Inpatient facility charges: IPA
Ultrasonic Bone Stimulation

Benefit: Ultrasonic bone stimulation is in benefit for selected members with fractures.

Interpretation: Ultrasonic bone stimulation refers to the administration of ultrasonic energy produced by a portable generator to a fracture through a surface transducer. Therapy is instituted when the fracture is fresh, and it is adjunctive to conventional management of the fracture. Fracture healing is promoted by one daily self-administered 20-minute application for a period of up to 90 days.

Ultrasonic bone stimulation is in benefit to treat adults with recent fractures when:
- The fracture is otherwise treated by closed reduction without surgery or other methods of fixation; and
- The reduced fracture gap is less than 0.5cm; and
- There is no underlying bone disease; and
- The member is not taking steroids, anticoagulants, or non-steroidal anti-inflammatory drugs (NSAIDs).

Ultrasonic bone stimulation is also used to treat fracture non-union of bones other than skull or vertebrae.

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

Paid By:
Partial MSA:
  Professional charges: IPA
  Equipment charges or services: HMO

Global MSA:
  Professional charges: IPA
  Equipment charges or services: IPA
Ultraviolet (UV) 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 UVA light is called “PUVA” therapy. If the physician recommends home UV light treatment, the member may rent or purchase medical UV equipment under the DME benefit. Sunlamps or "treatments" obtained at commercial tanning spas do not qualify for coverage.

**Paid By:**

**Partial MSA:**
- Professional fees: IPA
- Equipment charges (from contracted provider): HMO
- Equipment charges (from non-contracted provider): IPA

**Global MSA:**
- Professional fees: IPA
- Equipment charges (from contracted provider): IPA
- Equipment charges (from non-contracted provider): IPA