Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

***Current Policy Effective Date: 9/1/24**
(See policy history boxes for previous effective dates)

Title: Bioimpedance Devices for Cancer Related Extremity Lymphedema

Description/Background

Secondary lymphedema may develop following treatment for multiple types of cancer. The type of cancer can help to predict where lymphedema may develop. Cancers that have an increased risk which may result in lymphedema include those that are near lymph nodes and or vessels. Lymphoma, breast, vulvar, vaginal, ovarian, endometrial, cervical, prostate, colorectal, and, head and neck cancers all have the potential to cause lymphedema in different parts of the body including: internally, in the abdomen, throat, arms, legs, groin, face, neck or chin. Bioimpedance, which uses resistance to electrical current to compare the composition of fluid compartments, could be used as a tool to diagnose lymphedema.

LYMPHEDEMA

Lymphedema is an accumulation of fluid due to disruption of lymphatic drainage. Lymphedema can be caused by congenital or inherited abnormalities in the lymphatic system (primary lymphedema) but is most often caused by acquired damage to the lymphatic system (secondary lymphedema). A diagnosis of secondary lymphedema is based on history (e.g., cancer treatment, trauma) and physical examination (localized, progressive edema and asymmetric limb measurements) when other causes of edema can be excluded. The extensive surgery involving the removal of lymph nodes, radiotherapy, and the use of Taxane chemotherapeutic agents contribute to an individual experiencing a higher risk for the development of lymphedema. A body mass index (BMI) over 30 kg/m^2 is associated with the development of lymphedema.

Diagnosis

The diagnosis of lymphedema is usually made by clinical examination and comparative limb measurement. Bioimpedance spectroscopy is a diagnostic test that may be used to identify early or subclinical lymphedema and initiate treatment to prevent progression of disease. Breast cancer mortality is decreasing due to improved diagnostics and treatments. As survival is

increased, the long-term sequelae of treatment and impaired quality of life become relevant. Breast cancer-related lymphedema (BCRL) affects about 3 to 5 million patients worldwide, with about 20,000 per year in the United States. BCRL rates range from 2% to 77% based on the type of local–regional and systemic therapies. Breast cancer statistics released by the American Society of Clinical Oncology (2023) indicate that the 5-year relative survival rate for women in the United States with non-metastatic invasive breast cancer is 91%. The 10-year relative survival rate for women with non-metastatic invasive breast cancer is 85%. Thus, minimizing the chronic effects of lymphedema is important.

Staging

Table 1 lists International Society of Lymphology (2016) guidance for staging lymphedema based on "softness" or "firmness" of the limb and the changes with an elevation of the limb.

Table 1. Recommendations for Staging Lymphedema

Stage	Description
Stage 0 (subclinical)	Swelling is not evident and most patients are asymptomatic despite impaired lymphatic transport
Stage I (mild)	Accumulation of fluid that subsides with limb elevation; soft edema that may pit, without evidence of dermal fibrosis
Stage II (moderate)	Does not typically resolve with limb elevation alone; limb may no longer pit on examination
Stage III (severe)	Lymphostatic elephantiasis; pitting can be absent; skin has trophic changes

Management and Treatment

Lymphedema is treated using elevation, compression, and exercise. Conservative therapy may consist of several features depending on the severity of the lymphedema. Individuals are educated on the importance of self-care including hygiene practices to prevent infection, maintaining ideal body weight through diet and exercise, and limb elevation. Compression therapy consists of repeatedly applying padding and bandages or compression garments. Manual lymphatic drainage is a light pressure massage performed by trained physical therapists or by individuals designed to move fluid from obstructed areas into functioning lymph vessels and lymph nodes. Complete decongestive therapy is a multiphase treatment program involving all of the previously mentioned conservative treatment components at different intensities. Pneumatic compression pumps may also be considered as an adjunct to conservative therapy or as an alternative to self-manual lymphatic drainage in individuals who have difficulty performing self-manual lymphatic drainage. In individuals with more advanced lymphedema after fat deposition and tissue fibrosis has occurred, palliative surgery using reductive techniques such as liposuction may be performed.

Bioimpedance Spectroscopy

Bioimpedance spectroscopy (BIS) is based on the theory that the level of opposition to the flow of electric current (impedance) through the body is inversely proportional to the volume of fluid in the tissue. In lymphedema, with the accumulation of excess interstitial fluid, tissue impedance decreases.

In usual care, lymphedema is diagnosed with limb measurements or assessed with clinical observation. Use of bioelectrical impedance spectroscopy has been proposed as a way to diagnosis subclinical lymphedema to prevent progression to irreversible chronic lymphedema. Bioimpedance spectroscopy is a non-invasive, low-cost technology that can measure an individuals total body waters location in a clinical setting.

Regulatory Status

A selection of devices that have been cleared for marketing by the Food and Drug Administration through the 510(k) process to aid in the assessment of lymphedema are summarized in Table 2.

Table 2. FDA-Cleared Bioimpedance Spectroscopy Devices for Lymphedema

Year	Device	Manufacturer	510(k) Number	Indication
2018	SOZO	ImpediMed (Carlsbad, CA)	K180126	For adults at risk of lymphedema. Supports the measurement of extracellular fluid volume differences between the limbs and is presented to the clinician on an L-Dex scale as an aid to their clinical assessment of lymphedema. The device is only indicated for patients who will have or who have had lymph nodes, from the axillary and/or pelvic regions, either removed, damaged or irradiated.
2015	MoistureMeterD	Delfin Technologies (Stamford, CT)	K143310	Supports local assessment of tissue water differences between affected and contralateral non-affected arm tissues to aid in forming a clinical judgment of unilateral lymphedema in women. The device is not intended to make diagnosis or predict arm lymphedema.
2007	ImpediMed L-Dex™ U400	ImpediMed (Carlsbad, CA)	K050415	Supports the measurement of extracellular fluid volume differences between the arms to aid in the clinical assessment of unilateral lymphedema of the arm in women. This device is not intended to diagnose or predict lymphedema of an extremity.

FDA product code: OBH

Medical Policy Statement

Devices using bioimpedance (bioelectrical impedance spectroscopy) in the diagnosis, surveillance of cancer related extremity asymptomatic, sub-clinical lymphedema are considered established when criteria are met.

Inclusionary and Exclusionary Guidelines

Inclusions:

Individuals meeting one of the following criteria:

- Regional (axillary or inguinal) Lymph Node Dissection or Sentinel Lymph Node Biopsy with > 6 nodes removed
- Regional Node Irradiation
- Taxane based chemotherapy

Note: L-Dex measurements should be performed as (1) a baseline prior to surgery/treatment, (2) Quarterly for the first year post-operatively (3) Everly 6 months on years 2 and 3 post-operatively (4) Yearly for years 4 and 5 post-operatively.

Exclusions:

- Symptomatic lymphedema

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure.)*

Established codes:

93702

Other codes (investigational, not medically necessary, etc.):

N/A

Rationale

Bioimpedance spectroscopy (BIS) directly measures the extracellular fluid that is characteristic of early lymphedema. When fluid accumulates and remains in the affected limb, inflammatory and hemodynamic changes increase in severity, and early intervention may prevent or delay progression.

Early Detection is Preventative
The National Lymphedema Network indicates that screening and early identification of lymphedema is an important part of the clinical assessment for individuals who have had lymph nodes removed from the body. The congestion that results from lymphedema results in symptoms (i.e., heaviness, aching, tingling) being reported before visible signs of swelling occur. Tissue measurements should be routinely taken before lymph nodes are removed to establish a baseline limb volume and repeated through the duration of cancer treatment. This procedure allows the provider identify tissue changes at Stage 0 or Stage 1 when the condition is less severe and reversible. Early detection and intervention of lymphedema can prevent progression of symptoms that can become irreversible (Stage 2 and 3). Bioimpedance spectroscopy is listed as an effective tool for early detection.

BIOIMPEDANCE SPECTROSCOPY IN INDIVIDUALS WITH KNOWN OR SUSPECTED LYMPHEDEMA

Clinical Context and Test Purpose
The purpose of using bioimpedance spectroscopy (BIS) in individuals who are at risk for, or have known, or suspected lymphedema is to inform a diagnosis subclinical lymphedema to initiate treatment sooner than with other diagnostic methods.

The following PICOs were used to select literature to inform this review.

Populations
The relevant population of interest is individuals with known or suspected lymphedema.

Interventions
The relevant intervention of interest is bioimpedance spectroscopy (BIS).

Management via BIS has been proposed as a way to implement early treatment of subclinical lymphedema to potentially reduce its severity.

Comparators
The relevant comparators of interest are volume displacement and circumferential measurement.

In usual care, lymphedema is recognized clinically or via limb measurements.

Volume is measured using different methods; e.g., tape measurements with geometry formulas, perometry, and water displacement.

Outcomes
The general outcomes of interest include a reduction in limb circumference and/or volume and reduction in the rates of infections (e.g., cellulitis, lymphangitis).

Subject-reported outcomes of interest include symptoms, quality of life (QOL), and functional measures. A systematic review of subject reported outcome instruments and outcomes used to assess QOL in breast cancer individuals with lymphedema, Pusic et al (2013) found that most studies included generic PRO instruments or oncology PRO instruments. Lymphedema-specific instruments are occasionally used; specifically, the Upper Limb Lymphedema 27 was found to have strong psychometric properties.

The time frame for outcomes varies from months to years after onset of lymphedema symptoms.

Study Selection Criteria
For evaluation of clinical validity of bioimpedance testing, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores)
- Included a suitable reference standard
- Individual/sample clinical characteristics were described
- Individual/sample selection criteria were described

For evaluation of clinical utility, comparative controlled prospective trials, with preference for RCTs were considered. In the absence of such trials, comparative observational studies, with preference for prospective studies were considered.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Observational Studies
After the Agency for Healthcare Research and Quality (AHRQ) review, several other studies have evaluated the diagnostic performance of bioimpedance devices for detecting lymphedema. Prospective studies that compared bioelectrical impedance analysis to a reference standard are described next.

A study by Barrio et al (2015) enrolled 223 women with newly diagnosed breast cancer and a plan for unilateral axillary surgery. Thirty-seven subjects were excluded due to ineligibility or withdrawal, leaving a sample size of 186. Prior to surgery, participants received baseline volumetric measurements with a bioimpedance device (L-Dex) and volume displacement (VD, the reference standard). Participants then had regular follow-up volumetric measurements every 3 to 6 months for 3 years. At the last follow-up (median, 18.2 months), 152 participants (82%) were normal, 21 (11%) had an abnormal L-Dex and no lymphedema by VD, 4 (2%) had an abnormal L-Dex and lymphedema by VD, and 9 (5%) had lymphedema without prior L-Dex abnormality. In an analysis including only participants with at least 6 months of follow-up, L-Dex had a sensitivity of 31% (4/13) and a specificity of 88% (129/147) for predicting subsequent lymphedema development. In addition, the correlation between changes in VD and changes in L-Dex results were in the low-to-moderate range at 3 months (r=0.31) and 6 months (r=0.21). However, at the time of lymphedema diagnosis, the L-Dex ratio was abnormal in 12 of 13 participants (diagnostic sensitivity, 92%).

Blaney et al (2015) reported on a prospective study with 126 women with stage I, II or III unilateral breast cancer. A total of 115 women underwent baseline assessment with a bioimpedance device (L-Dex) and circumferential measurement (CM). CM was used as the reference standard, although the authors noted the test is an imperfect criterion standard. Postsurgical follow-up assessments were planned every 3 months for a year. The number of women completing these assessments was 109 (95%) at 3 months, 89 (77%) at 6 months, 79 (69%) at 9 months, and 71 (62%) at 12 months. Over 12-month study, 31 participants were identified as having lymphedema by at least 1 of the assessment methods. Twenty-eight (90%) of 31 were identified by CM and 11 (35%) by bioimpedance analysis. There was no statistically significant correlation between bioimpedance analysis and CM.

Section Summary: Clinically Valid

A 2010 AHRQ technology assessment identified few studies on bioimpedance analysis for diagnosing lymphedema. A few prospective studies, published after the AHRQ review, found suboptimal correlations between bioimpedance analysis and the reference standard. In the study that reported measures of diagnostic accuracy, bioimpedance analysis had a low sensitivity and specificity for predicting lymphedema development.

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

The ideal study design is an RCT comparing health outcomes in individuals managed with and without the use of bioimpedance devices.

Randomized Controlled Trial

One multi-center, international RCT conducted by Ridner et al (2019 and 2022), compared bioimpedance to volume measurements calculated from arm circumference using a tape measure (Table 3). The primary aim of the study was to determine if subclinical detection of extracellular fluid accumulation via bioimpedance and subsequent early intervention reduces the rate of progression to clinical lymphedema relative to the rates seen using standard tape measurements. Participants requiring early intervention were prescribed a compression sleeve

and gauntlet for 4 weeks and then re-evaluated. Predetermined thresholds were used to trigger early intervention. The implementation threshold for individuals in the bioimpedance group was a change that was >10 L-Dex units (3 standard deviations) higher than the presurgical baseline measure. Individuals in the tape measure (TM) group triggered when they had a volume change in the at-risk arm that was between >5 and <10% above the presurgical baselines. Progression to clinical lymphedema was defined as a 10% or greater increase in tape measure volume from baseline in the at-risk arm.

Results of the interim analysis are summarized in Table 4. At interim analysis, 109 of 508 (21.9%) participants received early intervention due to reaching the pre-determined threshold. Participants randomized to bioimpedance had a lower rate of trigger and longer times to trigger. A total of 12 triggering participants progressed to clinical lymphedema (10 in the TM group [14.7%] and 2 in the BIS group [4.9%]). At final analysis (median of 32.9 months follow-up), BIS triggered an intervention at a lower rate than TM patients (20.1% vs 27.5%; p=.011); however, fewer patients in the BIS group progressed compared with tape measure (7.9% vs 19.2%; relative risk, 0.41; 95% CI, 2.8-4.5; p=.001).

Table 3. Summary of Key RCT Characteristics

Study; Trial	Country	Sites	Dates	Participants	Interventions	
					Active	Comparator
Ridner et al (2019 and 2022) PREVENT NCT02167659	U.S. and Australia	13	2014-2018	Presurgical: Women >18 years of age with histologically confirmed, newly diagnosed, breast cancer (invasive or ductal carcinoma in situ with planned surgery Postsurgical: stage I–III invasive breast cancer or DCIS who received ≥1 of the following: mastectomy, axillary treatment, regional node irradiation or taxane-based chemotherapy	Bioimpedance n=263 at interim; 482 at final	Tape measure n=245 at interim 481 at final

BIS: bioimpedance spectroscopy; DCIS: ductal carcinoma in situ; NCT: national clinical trial; PREVENT: Bioimpedance Spectroscopy Versus Tape Measure in Prevention of Lymphedema; RCT: randomized clinical trial.

Table 4. Summary of Key RCT Results

Study	Intervention Triggered	Median (IQR) months to Intervention Triggered	Progression to clinical lymphedema	Median (range) months to progression to clinical lymphedema
Ridner et al (2019)				
Bioimpedance	41/259 (15.8%)	2.8 (0.6–5.6)	2/41 (4.9%)	6.0 (1.4, 16.9)
Tape measure	68/239 (28.5%)	4.0 (1.0–11.2)	10/68 (14.7%)	6.0 (0.8, 16.9))
P-value	0.001	0.002	0.130	0.389
Ridner et al (2022)				
BIS	89/442 (20.1%)	9.7 (3.6-18.2)	7/89 (7.9%)	4.9 (0.7-15.2)
Tape measure	120/437 (27.5%)	3.9 (1.0-11.6)	23/120 (19.2%)	10.7 (1.4-31.9)
p-value	.011	.001	.016	.100

BIS: bioimpedance spectroscopy; RCT: randomized controlled trial; IQR: interquartile range.

An industry sponsored systematic review by Shah (2016) indicated that newer diagnostic modalities like bioimpedance spectroscopy (BIS) have increased sensitivity, which allows for

the earlier detection of BCRL. It has been reported that the detection of subclinical lymphedema through surveillance and early intervention reduces progression to clinical lymphedema. Authors concluded that this device may lead to early recognition of lymphedema for which intervention could potentially prevent long term complications and irreversible stages of lymphedema.

Ridner et al (2022) compared rates of progression to chronic breast cancer related lymphedema following an intervention for subclinical lymphedema based on measurements obtained via bioimpedance spectroscopy (BIS) or tape measurement in an industry sponsored, multi-center, randomized, prospective study. Over a 4-year period (2014-2018), 963 individuals with breast cancer met inclusion criteria and were randomized to be assessed using either BIS (n=482) or TM (n=481) over a median follow-up of 32.9 months. Postoperative BIS or TM assessments for all end points were at 3, 6, 12, 18, 24, and 36 months and following compression intervention. Initially the intervention trigger for the BIS group was ≥ 10 L-Dex units in the absence of a >10% volume change from pretreatment baseline and for the TM group an at-risk arm volume change of ≥ 5% and <10% compared to baseline and contralateral measurements. In 2016, published studies demonstrated the presence of early-stage C-BCRL with the BIS of 7 rather than 10L-Dex units. Thus, with Vanderbilt University Institutional Review Board and Vanderbilt Ingram Center Scientific Review Committee approval the intervention trigger was modified from ≥ 10 L-Dex units to ≥ 6.5 L-Dex units for all previously enrolled and subsequent individuals assigned to the BIS group. Individuals that met the intervention trigger for subclinical breast cancer related lymphedema wore a class 2 (23–32 mmHg, medi flat knit custom or Harmony® circular knit) compression sleeve and gauntlet for 4 weeks, 12 hours/day. In either group, a volume change of ≥ 10% arm volume change resulted in direct referral for complex decongestive physiotherapy and removal from the study. Authors reported that BIS individuals triggered an intervention at a lower rate than TM individuals, median months to trigger were longer with BIS than TM and, overall, 14.4% (n=30) progressed post-intervention, with reduced likelihood for BIS individuals than TM individuals.

Observational Studies
Multiple uncontrolled observational studies have reported rates of lymphedema identified through surveillance with bioimpedance in women at high-risk following breast cancer treatment.

Whitworth et al (2018) observed that, of 93 high-risk patients who underwent axillary lymph node dissection and were managed with prospective surveillance, only 3% required additional therapies or had evidence of chronic BCRL over a median 2 years of follow-up. Similarly, Kilgore et al (2018) reported that only 6% of 146 patients developed chronic lymphedema after early intervention, supporting the observations of Whitworth et al (2018).

Section Summary: Clinical Utility
Industry sponsored results from an RCT comparing bioimpedance with standard tape measure following treatment for breast cancer have been published. Authors concluded that BIS compared to TM provides a more precise identification of individuals likely to benefit from an early compression intervention. An additional retrospective analysis suggested that postoperative bioimpedance monitoring is feasible.

SUMMARY OF EVIDENCE

For individuals who have known or suspected lymphedema who receive bioimpedance spectroscopy, the evidence includes a systematic review, RCTs, industry sponsored studies, and multiple uncontrolled observational studies. The relevant outcomes are test validity, symptoms, and quality of life. Results from an ongoing RCT comparing bioimpedance with standard tape measure following treatment for breast cancer have been published. Median follow-up was 32.9 months. Overall, 209 of 508 patients received early treatment due to reaching a pre-determined threshold to trigger an intervention. BIS patients triggered intervention at a lower rate than tape measured patients (20.1% vs 27.5%) and fewer patients progressed in this group (7.9% vs 19.2%) Relative rates of progression were reduced by about 59% in the BIS arm. The single prospective comparative study found a significantly lower rate of clinical lymphedema in individuals managed with bioimpedance devices. Retrospective studies suggested that postoperative bioimpedance monitoring is feasible. The evidence is sufficient to determine the effects of the technology on health outcomes may be equivalent to that of using a tape measure.

Supplemental Information

CLINICAL INPUT RECEIVED THROUGH PHYSICIAN SPECIALTY SOCIETIES AND ACADEMIC MEDICAL CENTERS

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, Blue Cross Blue Shield Association received clinical input from 2 specialty societies and 2 academic medical centers while this policy was under review in 2011. Three of 4 reviewers agreed that bioimpedance devices are considered investigational for diagnosis, surveillance, and treatment of individuals with lymphedema. The fourth reviewer, who was from an academic medical center, thought that use of the technology is a reasonable alternative, especially in situations in which minor lymphedema can have a large impact on an individual. One specialty society supported further research into effectiveness of this technology and recommends reimbursement in the context of relevant clinical trials.

PRACTICE GUIDELINES AND POSITION STATEMENTS

National Comprehensive Cancer Network Clinical Practice Guidelines on Survivorship, recommends that survivors at risk for lymphedema should be regularly screened for lymphedema by symptom assessment, clinical exam, and, if available, bioimpedance spectroscopy

National Comprehensive Cancer Network Clinical Practice Guidelines on Breast Cancer addresses breast cancer related lymphedema recommend education, monitoring, and referral for lymphedema management as needed. For further information they refer the reader to the Survivorship Guidelines.

The American Society of Breast Surgeons Foundation (2017) promote newer methods for early detection of lymphedema post breast cancer treatment (i.e. bioimpedance spectroscopy, tissue dielectric constants, infrared perometry) as superior to the standard circumferential tape

measurement because they are less subjective and have more reproducible results. Recommendations include:

- Establishing a surveillance plan which allows for early diagnosis and leads to early treatment in order to increase the likelihood for limited disease burden.
- Baseline and follow-up measurements of the ipsilateral (operated side) and contralateral (non-operated side) arms of all breast cancer patients are critical. A comprehensive measurement strategy should include a combination of objective and subjective measures.

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS
Not applicable.

Government Regulations

National:

There is no national coverage determination.

Local:

There is no local coverage determination.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 4/4/24, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
5/1/10	3/16/10	2/16/10	Joint policy established
1/1/11	10/12/10	10/27/10	Code update: added 0239T; removed NOC code 38999. "Spectroscopy" added to end of title
11/1/12	8/21/12	8/21/12	Policy updated to reflect BCBSA policy; title changed from "Lymphedema Assessment by Bioimpedance Spectroscopy" to "Bioimpedance Devices for Detection of Lymphedema"; no change in policy position.
5/1/14	2/24/14	3/3/14	Routine maintenance
5/1/15	2/17/15	2/17/15	Routine maintenance; code 0239T deleted and 93702 added, effective date 1/1/15
5/1/16	2/16/16	2/16/16	Routine maintenance
5/1/17	2/21/17	2/21/17	Routine maintenance
5/1/18	2/20/18	2/20/18	Routine maintenance
5/1/19	2/19/19	2/19/19	Routine maintenance
11/1/19	8/20/19		Routine maintenance
11/1/20	8/18/20		Routine maintenance
11/1/21	8/17/21		Routine maintenance
11/1/22	8/16/22		Routine maintenance
9/1/23	6/13/23		• Routine maintenance (slp) • Vendor managed: N/A • Stance changed to EST • Title changed from: Bioimpedance Devices for Detection of Lymphedema.
9/1/24	6/11/24		• Routine maintenance (slp) • Vendor managed: N/A

Next Review Date: 2nd Qtr, 2025

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: BIOIMPEDANCE DEVICES FOR CANCER RELATED EXTREMITY LYMPHEDEMA

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply
BCNA (Medicare Advantage)	Refer to the Medicare information under the Government Regulations section of this policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines:

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.