# Medical Policy

Blue Cross Blue Shield Blue Care Network of Michigan

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***Current Policy Effective Date: 5/1/25**
**(See policy history boxes for previous effective dates)**

# Title: Intraoperative Fluorescence Imaging Systems

## Description/Background

The fluorescence imaging is an intraoperative imaging technique that employs the fluorescence of indocyanine green dye for visual assessment of vessels, blood flow, the lymphatic system, tissue perfusion, and/or related tissue transfer circulation before, during, and after vascular, gastrointestinal, organ transplant, plastic, micro-, reconstructive, and/or free flap surgeries. Examples of its use include autologous flap skin perfusion in breast reconstruction; tissue perfusion during organ transplant procedures; vascular surgeries involving grafted vessels during coronary artery bypass surgery, wounds or amputation; renal cancer surgeries; myocardial perfusion in cardiac and cardiovascular surgeries; gastrointestinal surgeries and parathyroid perfusion during endocrine surgery.

Once the graft vessels/tissues have been transplanted, the individual is injected with indocyanine green dye, which quickly binds to plasma proteins. A low intensity laser illuminates the dye as it passes through the grafts/tissues via the bloodstream. The fluorescence imaging system consists of a video camera and a laser light source. The camera, positioned above the operative site, captures images of the fluorescent graft vessels/tissues and displays them on a monitor. If the images reveal a compromised graft, revisions can be performed immediately prior to completion of the surgical procedure.

Indocyanine green was originally FDA approved (NDA) in 1959 for retinal angiography.

Since the approval of indocyanine green, multiple devices which can be used with indocyanine green have been FDA approved.

## Regulatory Status

Intraoperative fluorescence imaging has been approved by the FDA for use during coronary artery bypass, cardiovascular surgical procedures, plastic, micro- and reconstructive, gastrointestinal and organ transplant procedures. Products include: Fluoptics Fluobeam imaging, Pinpoint Endoscopic Fluorescence Imaging System, Novadaq SPY system, Hamamatsu PDE system, Quest Artemis and VisionSense VS3-IR-MMS system.

## Medical Policy Statement

Assessment of vascular patency, tissue viability, or organ identification or perfusion by any technology (i.e. Artemis Handheld Imaging Systems, Fluobeam 800, Infrared 800, Leica FL800, Lumisight, PDE-Neo, SPY Fluorescent Imaging System, VS3 Iridium System) is considered an incidental part of the procedure when clinical utility has been demonstrated (e.g., breast reconstruction, choroid blood flow, parathyroid perfusion, to aid in sentinel lymph node biopsy) and is **NOT** separately reimbursable.

## Inclusionary and Exclusionary Guidelines

N/A

## 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:*

N/A

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

76499

## Rationale

The intention of intraoperative fluorescence imaging is to offer real-time visualization of blood flow to skin and soft tissue in a way that might help surgeons make decisions about closure or coverage of a surgical site based on blood flow, potentially avoiding soft tissue reconstruction while preventing skin necrosis or wound breakdown after primary closures.

Fluorescent angiography allows real-time assessment of blood flow and tissue perfusion in the preoperative, intra-operative and postoperative setting by injecting an intravenous dye that emits infrared energy upon excitation by a light source. As a result, it enables the assessment of blood flow and tissue perfusion.

DSouza et al (2016) discussed the growing interest of using fluorescence imaging instruments to guide surgery and the leading options for open-field imaging were reviewed. While the clinical fluorescence-guided surgery (FGS) field has been focused predominantly on indocyanine green imaging, there is accelerated development of more specific molecular tracers. These agents should help advance new indications for which FGS presents a paradigm shift in how molecular information is provided for resection decisions. There has been a steady growth in commercially marketed FGS systems, each with their own differentiated performance characteristics and specifications. United States Food and Drug Administration 510(k) cleared commercial systems and some leading premarket FGS research systems were evaluated. There is no perfect imaging system, but the feature differences among them are important differentiators in their utility. Although new commercial research systems are regularly emerging, there is often an disconnect between the emergency technology and the surgeons need and flexibility. None of the reviews discussed provided direct guidance on how to choose the right imager based on objective criteria. System selection was found to be subjective and dependent on the end-user's preferences. Defining basic criteria for comparing imagers for specific applications can help the field of surgical-guidance mature in an organized manner. Despite the availability of these technologies, most surgeons still rely largely on visual and tactile cues combined with presurgical radiologic imaging to guide tissue resection.

**Fluorescence Imaging and Coronary Artery Bypass**
Coronary artery bypass graft (CABG) surgery is among the most frequently performed operations in the United States. Favorable outcomes are dependent on the success of the union and patency of the transplanted graft vessels. Approximately 4 to 12 percent of individuals who undergo CABG surgery experience an occlusion in a transplanted graft vessel during the operation, placing them at increased risk for a heart attack post-operatively.

Currently, the gold standard for evaluating the patency of newly a transplanted coronary artery graft is via conventional x-ray angiography. However, cardiac angiography is not typically performed during course of a CABG, when it would be most ideal to detect a graft failure and would subsequently allow the surgeon to intervene before the individual leaves the operating room. The most widely used technique for intraoperative graft assessment is transit-time flowmetry (TTF). TTF uses the principles of ultrasound to detect coronary artery graft failures, and its ease of use intraoperatively is an advantage over coronary angiography.

Since intraoperative imaging has emerged as a practical approach for early assessment and identification of coronary artery graft failures, alternative technologies have been developed.

Ohmes et al (2017) quarried PubMed using the terms "transit time flowmetry", "graft assessment", "intraoperative fluorescence", "indocyanine green" coupled, with "CABG", "imaging" and "patency." Examination of different techniques for graft assessment along with their limitations led authors to recommend the use of transit-time flowmetry, especially in the setting of technically difficult cases such as off-pump multivessel sequential CABG. Authors concluded that intraoperative fluorescence coronary angiography (IFI) appears to be a promising modality for graft evaluation, however, limited data exists and we do not recommend its widespread adoption at this time. More research is needed to delineate its diagnostic capacity. While IFI has been used for years in other surgical subspecialties, its use in determining coronary bypass patency has not been definitively proven. While several studies

have shown promising results, continued research with long-term follow-up will help delineate IFI's role in coronary surgery.

Singh et al (2010) sought to establish whether intraoperative graft assessment with criteria for graft revision would decrease the proportion of individuals with 1 or more graft occlusions or stenoses or major adverse cardiac events 1 year after CABG. In a single-center, single-blinded, controlled clinical trial, individuals were randomized to 1 of 2 groups: intraoperative graft patency assessment using IFI angiography and TTF. Patients underwent follow-up angiography at 1 year. Between September 2005 and August 2008, 156 individuals undergoing isolated CABG were enrolled (imaging, n = 78; control, n = 78). Angiography was performed at 1 year in 107 individuals (imaging, 55 individuals/160 grafts; control, 52 individuals/152 grafts). The proportion of individuals with 1 or more graft occlusions was comparable in the imaging (30.9%) and control (28.9%) groups, as were other graft patency end points. The researchers concluded that routine intraoperative graft assessment is safe but does not lead to a marked reduction in graft occlusion 1 year post-CABG.

Waseda et al (2009) conducted a study to evaluate the intraoperative fluorescence imaging system in the real-time assessment of graft patency during off-pump coronary artery bypass graft. Individuals undergoing off-pump coronary artery bypass graft received IFI analysis, intraoperative TTF, and postoperative x-ray angiography. A total of 507 grafts in 137 individuals received IFI analysis. Of all the IFI analyses, 379 (75%) grafts were visualized clearly up to the distal anastomosis. With regard to anastomosis location, anterior location was associated with a higher percentage of fully analyzable images (90%). More than 80% of images were analyzable, irrespective of graft type. Six grafts with acceptable TTF results were diagnosed with graft failure by IFI, which required on-site graft revision. All revised graft patency was confirmed by post-operative x-ray angiography. Conversely, 21 grafts with unsatisfactory TTF results demonstrated acceptable patency with IFI. Graft revision was considered unnecessary in these grafts, and 20 grafts (95%) were patent by post-operative x-ray angiography. The authors noted that "graft patency assessment using IFI was not in perfect agreement with those of postoperative angiography. Nine grafts were found to be occluded at the time of postoperative angiography, but the IFI system revealed acceptable intraoperative graft patency."

**Summary: Fluorescence Imaging and Coronary Artery Bypass**
Clinical studies indicate that fluorescence imaging is safe and correlates well with TTF, but there is no evidence to demonstrate that it is superior to TTF. Comparisons of fluorescence imaging to postoperative coronary angiography are less known. Additionally, there is no evidence to show that intraoperative coronary artery graft revisions based on the results of fluorescence imaging leads to improved clinical outcomes, which presents questions as to the diagnostic utility of this technique.

**Other Uses of Fluorescence Imaging**

*Colorectal Surgery*
Blanco-Colino et al (2018) discussed the intraoperative use of indocyanine green fluorescence imaging to reduce the risk of anastomotic leakage during colorectal surgery in a meta-analysis which compared fluorescence imaging with standard care. One thousand three hundred and two patients from 5 non-randomized studies were included. Fluorescence imaging significantly reduced the anastomotic leakage rate in individuals undergoing surgery for colorectal cancer

(OR 0.34; CI 0.16-0.74; p = 0.006). Low anastomotic leakage rates were shown in rectal cancer surgery (ICG 1.1% vs non-ICG 6.1%; p = 0.02). There was no significant decrease in the anastomotic leakage rate when colorectal procedures for benign and malignant disease were combined. To date, there are no published randomized control trials (RCTs) on this subject, though 3 ongoing RCTs were identified. Indocyanine green fluorescence imaging seems to reduce anastomotic leakage rates following colorectal surgery for cancer. However, the inherent bias of the non-randomized studies included, and their differences in anastomotic leakage definition and diagnosis could have influenced results. Large well-designed RCTs are needed to provide evidence for its routine use in colorectal surgery.

Fabar et al (2024) evaluated the efficacy of real-time assessment with near-infrared (NIR) fluorescence imaging with indocyanine green (ICG) in the prevention of anastomotic leakage in colorectal surgeries. A multicenter, randomised, controlled, phase 3 trial was done in 8 hospitals in the Netherlands. Nine hundred and thirty-one adults (aged >18 years) were randomly assigned (1:1) to fluorescence-guided bowel anastomosis (FGBA) or conventional bowel anastomosis (CBA) by variable block randomization (block sizes 4, 6, and 8) and stratified by site. Median age of participants was 68.0 years (IQR 59·0-75·0) and 485 (52%) were male and 446 (48%) were female. Ethnicity data was not available. Physicians and investigators were not blinded to group assignment. Subjects were unmasked after the surgical procedure or after the study ended. In the FGBA group, surgeons marked anastomosis levels per conventional perfusion assessment and then administered 5 mg of ICG by 2 mL intravenous bolus. They assessed bowel perfusion using near-infrared (NIR) fluorescence imaging and adjusted (or kept) transection lines accordingly. Only conventional methods for bowel perfusion assessment were used in the CBA group. No adverse events related to ICG use were observed. Three hundred and thirteen serious adverse events in 229 (25%) individuals were at 90-day follow-up (159 serious adverse events in 113 [24%] individuals in the FGBA group and 154 serious adverse events in 116 [25%] individuals in the CBA group). Eighteen (2%) people died by 90 days (10 in the FGBA group and 8 in the CBA group). Authors determined that ICG NIR fluorescence imaging did not reduce 90-day anastomotic leakage rates in this trial across all types of colorectal surgeries. Further research should be done in subgroups, such as rectosigmoid resections, for which evidence suggests ICG NIR might be beneficial.

*Breast Reconstruction*

Griffiths et al (2016) reviewed literature spanning from 1950-2015 regarding the use of fluorescent angiography to assess blood flow, tissue perfusion and clinical utility with breast reconstruction procedures. Numerous commercial near infrared light detection devices can be used to derive quantitative data from the indocyanine green (ICG)-derived fluorescence, including SPY Elite (Novadaq, Canada), FLARE (Curadel LLC, USA), PDE-Neo (Hamamatsu Photonics, Japan), Fluobeam 800 (Fluoptics, France), and IC-View (Pulsion Medical Systems AG, Germany). In breast reconstruction, ICG has been established as a safer, more accurate tracer agent, in lieu of the traditional blue dyes, for detection of sentinel lymph nodes with radioactive isotopes ([99m]-Technetium). In prosthesis-based breast reconstruction, intraoperative assessment of the mastectomy skin flap to guide excision of hypo-perfused areas translates to improved clinical outcomes. Similarly, in autologous breast reconstructions, fluorescent angiography can be utilized to detect poorly perfused areas of the free flap, evaluate microvascular anastomosis for patency, and assess superficial inferior epigastric artery vascular territory for use as an alternative free flap with minimal donor site morbidity. The authors concluded that ICG-based fluorescent angiography is a novel, useful tool for

various applications in breast reconstruction. More studies with higher level of evidence are currently lacking to validate this technology.

*Parathyroid Gland Preservation and Perfusion*

Kim et al (2017) reported on the clinical utility of fluorescence angiography in identifying the parathyroid glands during a thyroidectomy. Surgeons have cited difficulties in identifying the parathyroid glands during thyroidectomy. Preventing or minimizing post-thyroidectomy complications such as recurrent laryngeal nerve injury or parathyroid gland hypofunction remains a challenge. Preservation of the parathyroid gland is critical to reducing postoperative complications in every thyroid surgery. Proper identification and careful dissection is crucial. Parathyroid glands are very small and embedded within paratracheal fat tissues and have a color similar to surrounding tissues. Less experienced surgeons find it difficult to identify and preserve the gland. Even experienced surgeons sometimes find it challenging to locate all the parathyroid glands with visual inspection and palpation during surgery. Inadvertent parathyroid excision has been reported to be up to 15% of thyroidectomy cases in experienced surgeons. Predicting function of parathyroid glands after surgery was easier with indocyanine green uptake than with visual evaluation. Fluorescence angiography allows direct assessment of the parathyroid gland feeding vessels that are at risk of damage during surgery. It can guide decisions if the parathyroid needs auto transplantation. Authors concluded that indocyanine green will help surgeons determine the best approach to minimize parathyroid damage in thyroidectomies, thus reducing postoperative complications.

*Ophthalmology*

Stattin et al (2020) did a prospective explorative study to investigate 27 eyes of 17 individuals with diabetes maculopathy by fluorescein/indocyanine green angiography (FA/ICGA; SPECTRALIS HRA-OCT, Heidelberg Engineering) and by swept source-optical coherence tomography angiography (SS-OCTA; DRI-OCT Triton Plus, Topcon) to identify clinically relevant microaneurysms. The SS-OCTA cubes were split into the superficial capillary plexus and the deep capillary plexus according to the automated segmentation. The images of all modalities were superimposed for alignment by an Early Treatment Diabetic Retinopathy Study grid overlay and compared to each other. In total, the mean number of microaneurysms in FA was 33.4 ± 22 (standard deviation) (median 27.5 [q1:21.75;q3:38.25]), in ICGA 24.9 ± 16.9 (17.5 [14;35]), in the superficial capillary plexus 6.5 ± 3.7 (5.5 [3.75;9.25]) and in the deep capillary plexus 18.1 ± 10.5 (18.5 [10.75;23.5]). Mixed effects models between ICGA and the deep capillary plexus were borderline significant ($p = 0.048$; 95% confidence interval 0.21 to 13.49), whereas all other imaging methods differed significantly. Quantitative analysis of microaneurysms in diabetes maculopathy showed a plausible agreement between ICGA and the deep capillary plexus in SS-OCTA. These findings contribute to the imaging methodology in diabetes maculopathy.

Campagnoli et al (2015) conducted a retrospective case series including 5 eyes of 5 patients with choroidal melanoma that were originally diagnosed and treated as choroidal hemangioma. Four men and 1 woman (26-61 years) were included. All patients were white and presented with nonspecific symptoms (visual field defect, decreased visual acuity, and metamorphopsia) and visual acuity ranging from 20/30 to 20/80. Four of the 5 tumors were yellow and/or orange and 1 was partially melanotic. All tumors were dome shaped (one bilobed) and had associated subretinal fluid overlying the lesion. Two tumors had high internal reflectivity on standardized A-scan ultrasonography, whereas others had low internal reflectivity. Three tumors were hypofluorescent on early phases of indocyanine green and intrinsic vasculature was also

observed in 2 of these 3. Four of 5 patients who were initially treated by photodynamic therapy did not respond to treatment. However, they did respond to radiation therapy (after revised diagnosis), with documented regression and no evidence of detectable metastasis (mean follow-up 24.2 months). Authors concluded that differentiating between amelanotic melanoma and choroidal hemangioma can be challenging. Relying solely on ophthalmoscopic features can be misleading. Ancillary studies such as indocyanine green and standardized A-scan ultrasonography bring clarity in differentiating circumscribed choroidal hemangioma from choroidal melanoma. Although cytology or histopathology is the only definitive method of establishing the diagnosis, careful emphasis on key diagnostic features can obviate the need for diagnostic fine-needle aspiration biopsy in most cases.

### Summary: Other Uses of Fluorescence Imaging

The clinical literature referencing intraoperative fluorescence imaging for use in plastic, micro- and reconstructive surgical procedures and tissue perfusion during gastrointestinal and organ transplants revealed small case studies and active clinical trials. Intraoperative fluorescence imaging for the use of SLN mapping resulted in mixed opinions regarding efficacy and clinical utility of the technology use. Larger prospective studies are needed to determine the long term clinical outcomes that result from this technology.

### Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

**Table 1. Summary of Key Trials**

| NCT No. | Trial Name | Planned Enrollment | Estimated Completion Date |
|---|---|---|---|
| NCT03602677 | Indocyanine Green Fluorescence Imaging in Prevention of Colorectal Anastomotic Leakage | 1062 | December 2023 (Recruiting) |
| NCT01042379 | I-SPY Trial: Neoadjuvant and Personalized Adaptive Novel Agents to Treat Breast Cancer | 4000 | December 2031 |
| NCT06129669 | ICG Indocyanine Green in Reconstructive Surgery (ICG-R) | 160 | May 2025 |

## Supplemental Information

No evidence-based guidelines were identified regarding the intraoperative assessment of the integrity and patency of coronary artery bypass grafts. Standardized approaches to the intraoperative evaluation of graft patency are lacking.

### European Association for Endoscopic Surgery (EAES)

An expert panel of surgeons was selected and invited to participate in reviewing a total of 18,273 abstracts which included 117 articles, 22 statements and 16 recommendations. The large number of evidences in literature has resulted in EAES (2023) strongly recommending the use of ICG for a better anatomical definition and a reduction in post-operative complications. ICG fluorescence-guided surgery could be considered a safe and effective technology. Future robust clinical research is required to specifically validate multiple organ-specific applications and the potential benefits of this technique on clinical outcomes.

In 2024, during an international fluorescence-guided surgery course, participants anonymously voted on 36 statements. Consensus was defined as agreement ≥70% with participation grade of ≥80%. The following was determined:

- Fluorescence imaging of lymphatics & lymph nodes
  - Pooled consensus for agreement was achieved in 6 out of 13 (46%) statements concerning fluorescence imaging of lymphatics and lymph nodes. This consensus was observed for the efficacy of intraoperative NIR fluorescence imaging in breast (93% agreement), gastric, esophageal (88% agreement), melanoma (76% agreement), and gynecological tumors (74% agreement). However, consensus was not reached for colorectal and neuroendocrine tumors. As for adopting intraoperative NIR fluorescence imaging of lymphatics and lymph nodes as standard-of-care, consensus was achieved solely for breast (76% agreement) and melanoma surgery (81% agreement). There was no consensus on completely replacing conventional SLN localization (e.g., radionuclide-based Tc-99) with NIR fluorescence imaging.

- Tissue perfusion using ICG
  - This consensus was observed for standard-of-care fluorescence angiography in vascular (75% agreement), reconstructive (84% agreement), and gastrointestinal surgery (83% agreement), but not in endocrine surgery. There was also consensus (75% agreement) on the importance of considering hemodynamic variables (e.g., cardiac output, blood pressure) when interpreting fluorescence signals.

- Biliary and urinary tracts
  - Pooled consensus for agreement was achieved in 4 out of 6 (67%) statements on fluorescence imaging of the biliary and urinary tracts. Specifically, there was consensus on effective identification of the biliary tracts (83% agreement) and earlier visualization of the critical view of safety using ICG fluorescence cholangiography (83% agreement). However, consensus was not reached on the standard-of-care use of ICG for biliary tract visualization, nor on the replacement of conventional cholangiography with fluorescence cholangiography. Furthermore, pooled consensus for agreement was obtained for NIR fluorescence visualization of the urinary tracts to reduce the risk of iatrogenic urethral injury during pelvic surgery (72% agreement). It was also agreed that renally cleared and intravenously administered dyes were preferable to retrograde urethral injection of a fluorescent dye via a urinary catheter (79% agreement).

It was determined that this consensus paper demonstrates that the opinions of experts and trained users vary greatly by application, as well as variation within the expert panel and trained users within the degree of consensus for individual statements.

**National Comprehensive Cancer Network**

The NCCNs (1.2025) principles of evaluation and surgical staging for endometrial cancer indicate the lymph node assessment may be performed by any surgical route, although the standard in those with apparent uterine-confined disease is to perform the procedure via a minimally invasive approach. Intra-operative lymph node assessment includes evaluation of the nodal basins that drain the uterus, and often comprises either SLN mapping and resection of sentinel nodes or a pelvic nodal dissection with or without para-aortic nodal dissection (assessment techniques are not discussed). Pelvic lymph nodes from the external iliac, internal iliac, obturator, and common iliac nodes are frequently removed for staging purposes. Sentinel lymph node mapping may be preferred.

## Government Regulations
## National:
There is no National Coverage Determination (NCD) for fluorescence imaging systems.

## Local:
There is no Local Coverage Determination (LCD) for fluorescence imaging systems.

*(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

- Contrast-Enhanced Computed Tomography Angiography (CTA, CCTA, MDCT, MSCT) of the Heart and/or Coronary Arteries
- Myocardial Sympathetic Innervation Imaging

## References


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*The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 12/27/24, the date the research was completed.*

## Joint BCBSM/BCN Medical Policy History

| Policy Effective Date | BCBSM Signature Date | BCN Signature Date | Comments |
|---|---|---|---|
| 5/1/12 | 2/21/12 | 2/21/12 | Joint policy established |
| 11/1/13 | 8/20/13 | 9/3/13 | Routine maintenance; no change in policy position. |
| 3/1/15 | 12/12/14 | 12/29/14 | Routine maintenance |
| 7/1/16 | 4/19/16 | 4/19/16 | • Routine maintenance, Updated references<br>• no change in policy status<br>• Added current clinical trials |
| 7/1/17 | 4/18/17 | 4/18/17 | • Routine maintenance |
| 7/1/18 | 4/17/18 | 4/17/18 | • Routine maintenance |
| 5/1/19 | 2/19/19 | | • Routine maintenance |
| 5/1/20 | 3/17/20 | | • Routine maintenance<br>• Literature review of SPY Elite<br>• C codes removed from policy MPS statement changed to not separately reimbursable statement<br>• Changed to Mixed stance policy |
| 5/1/21 | 2/16/21 | | • Routine maintenance |
| 5/1/22 | 2/15/22 | | • Routine maintenance |
| 5/1/23 | 2/21/23 | | • Routine maintenance<br>• Vendor Managed: N/A |
| 5/1/24 | 2/20/24 | | • Routine maintenance (slp)<br>• Vendor Managed: N/A |
| 5/1/25 | 2/18/25 | | • Routine maintenance (slp)<br>• Vendor managed: N/A |

Next Review Date: 1st Qtr, 2026

# BLUE CARE NETWORK BENEFIT COVERAGE
# POLICY: INTRAOPERATIVE FLUORESCENCE IMAGING SYSTEMS

## I. Coverage Determination:

| | |
|---|---|
| **Commercial HMO (includes Self-Funded groups unless otherwise specified)** | Not separately reimbursable |
| **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.