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: Ultrasound for Breast Cancer Screening

Description/Background

Ultrasound is useful for assessing breast changes because it can often distinguish between a fluid-filled cyst and solid masses. As a primary screening tool, ultrasounds are limited in that they cannot pick up the small details that can be seen through mammography such as microcalcifications, which are the first sign of cancer. Traditionally, breast ultrasound imaging has been used as a diagnostic adjunctive tool to assess small masses/abnormalities felt on clinical exam or seen on a mammogram.

Breast tissue is composed of varying amounts of fat, stroma (connective tissue) and epithelium (avascular cellular) tissue. Conventional mammography identifies fat tissue as translucent, appearing dark on radiographs. Conversely, stroma and epithelium appear as white areas, or densities, on mammograms. The National Cancer Institute estimates that approximately 50% of women undergoing screening mammography have dense breasts. . Dense breasts are more common in younger women, women who are breastfeeding, and women using hormone replacement therapy. Dense breasts may also make suspicious lesions more difficult to detect by mammography. As a result, mammography is less sensitive in individuals with dense breasts. Individuals who have dense breasts have a higher risk of breast cancer compared to individuals with less dense breast tissue.

The Breast Imaging Reporting and Data System (BI-RADS) for mammography contains 4 categories of breast composition that are defined by the visually estimated content of fibro glandular-density tissue within the breasts. The categories are listed as *a, b, c* and *d* so as not to be confused with the numbered BI-RADS assessment categories which is the standard used to describe findings and results. Earlier editions of BI-RADS breast composition measurements used percentages of dense tissue relative to fat to report a quartile (<25 percent, 25 to 50 percent, 50 to 75 percent, and >75 percent dense). The latest recommendation comes from the 2012 5th edition which assigns BI-RADS lexicon breast density based on the presence of any patch of dense mammography tissue as follows:

- A – Almost entirely fatty

- B – Scattered areas of fibro glandular density
- C – Heterogeneously dense (may obscure small masses)
- D – Extremely dense (lowers the sensitivity of mammography)

If the breasts are not of apparently equal density, the denser breast should be used to categorize breast density. The sensitivity of mammography for noncalcified lesions decreases as the BI-RADS® breast density category increases. The denser the breast, the larger the lesion(s) that may be obscured.

Mammography is considered the gold standard for breast cancer screening in the United States. Mammography is the only screening test which has been shown to reduce deaths due to breast cancer in randomized controlled trials. However, mammograms fail to detect some cancers; it is estimated that 1 in 5 cancers are not seen via mammography. The sensitivity and specificity of mammograms are greatly reduced in radiographically dense breasts. Due to this limitation, other imaging studies such as magnetic resonance imaging (MRI) may be performed in addition to screening mammography for women who are considered “high risk” for developing breast cancer, such as those individuals with a residual lifetime risk of breast cancer >20%.

Breast density notification laws have been put into effect. As of September 2024, the FDA requires that all mammogram reports sent to patients must include breast density, which should be described as either “not dense” or “dense”. The intent of such a law was to give women the necessary information to decide on further action if they had dense breast tissue.

The topic of utilizing ultrasonography for routine breast cancer screening in women with dense breast tissue is controversial. There are 2 methods of breast ultrasound imaging, hand-held breast ultrasound and automated breast ultrasound. During a hand-held breast ultrasound exam, a technician holds a small device called a transducer and moves it over the breast to create images of the breast by directing sound waves through the tissue. Special software analyzes how the sound waves are deflected off different tissues and then creates an image that a physician can evaluate for abnormalities. The image quality of handheld ultrasound devices is highly dependent on the expertise of the technician.

Automated whole breast ultrasound systems (AWBUS) have been developed and are proposed to be used as an adjunctive imaging modality to mammography for breast cancer screening in asymptomatic women with dense breasts for whom screening mammography findings are normal or benign and have not had previous clinical breast intervention. AWBUS systems are designed to automate breast ultrasound scanning, to eliminate the need for highly skilled technicians and to provide more standardization with regard to imaging. AWBUS uses a specially shaped transducer that is positioned over the entire breast to automatically produce several images in approximately 1 minute. Unlike handheld ultrasound devices that produce 2-dimensional images, AWBUS generates 3-dimensional images of the breast that are reproducible. AWBUS does not require a physician to be present during the examination, and the images can be readily available and interpreted following the scan.

According to the American Cancer Society ultrasound is not used as a routine screening test for breast cancer. Ultrasound can be useful for looking at some breast changes, such as lumps, especially in women with dense breasts (specifically those that can be felt but not seen on a mammogram). Ultrasound can also be used to evaluate suspicious areas that are identified on a mammogram.

In 2024, the United States Preventative Services Task Force (USPSTF) concluded that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram.

Regulatory Status:

Several imaging systems and devices have been approved by the U.S. Food and Drug Administration (FDA) for breast imaging. On September 18, 2012, the FDA approved the somo-v® Automated Breast Ultrasound System (ABUS) for breast cancer screening in asymptomatic women with normal or benign screening mammography findings. The system is not intended to be used as a replacement for diagnostic mammography or diagnostic handheld ultrasound.

On October 6, 2021, the FDA approved the SoftVue™ Automated Whole Breast Ultrasound System with Sequr™ Breast Interface Assembly for as an adjunct to mammography for breast cancer screening in asymptomatic women with dense breast parenchyma after confirmation that the breast density composition is BI-RADS cord at the time of screening mammography. The device is not intended to be used as a replacement for screening mammography.

Medical Policy Statement

Ultrasound imaging of the breast for breast cancer screening, either alone or as an adjunct to mammography is experimental/investigational. Evidence is insufficient to determine that it improves net health outcomes.

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.):

76376 76377 76641 76642

Rationale

The American Cancer Societies (ACS; 2025) recommendation for a breast ultrasound states that breast ultrasound is not a routine screening test for breast cancer. However, ultrasound can be useful in the evaluation of any suspicious breast changes that are noted on a mammogram. An ultrasound often helps a provider to differentiate between fluid filled masses (i.e., cysts), which are unlikely to be cancer, and solid masses, which may be cancer.

Berg et al (2008) compared the performance of screening with ultrasound plus mammography vs mammography alone in women at elevated risk of breast cancer. From April 2004 to February 2006, 2,809, women with dense breast tissue in at least 1 quadrant were recruited from 21 sites to undergo mammographic and physician-performed ultrasonographic examinations in randomized order by a radiologist masked to the other examination results. The study results were as follows: “Forty participants (41 breasts) were diagnosed with cancer: 8 suspicious on both ultrasound and mammography, 12 on ultrasound alone, 12 on mammography alone, and 8 participants (9 breasts) on neither. The diagnostic yield for mammography was 7.6 per 1,000 women screened (20 of 2,637) and increased to 11.8 per 1,000 (31 of 2,637) for combined mammography plus ultrasound; the supplemental yield was 4.2 per 1,000 women screened (95% confidence interval [CI], 1.1-7.2 per 1,000; *P*=0.003 that supplemental yield is 0). The diagnostic accuracy for mammography was 0.78 (95% CI, 0.67-0.87) and increased to 0.91 (95% CI, 0.84-0.96) for mammography plus ultrasound (*P*=0.003 that difference is 0). Of 12 supplemental cancers detected by ultrasound alone, 11 (92%) were invasive with a median size of 10 mm (range, 5-40 mm; mean [SE], 12.6 [3.0] mm) and 8 of the 9 lesions (89%) reported had negative nodes. The positive predictive value of biopsy recommendation after full diagnostic workup was 19 of 84 for mammography (22.6%; 95% CI, 14.2%-33%), 21 of 235 for ultrasound (8.9%, 95% CI, 5.6%-13.3%), and 31 of 276 for combined mammography plus ultrasound (11.2%; 95% CI. 7.8%-15.6%).” The authors concluded that “adding a single screening ultrasound to mammography will yield an additional 1.1 to 7.2 cancers per 1,000 high-risk women, but it will also substantially increase the number of false positives.”

Nothacker et al (2009) conducted a systematic review of studies involving mammography and breast ultrasound for breast cancer screening. The review identified no randomized controlled trials or systematic reviews; 6 cohort studies of intermediate level of evidence (3b) were found. Two of the studies included adequate follow-up of subjects with negative or benign findings. Supplemental breast ultrasound after negative mammographic screening permitted diagnosis of primarily invasive carcinomas in 0.32% of women in breast density type categories II-IV of the American College of Radiology (ACR). Mean tumor size for those identified was 9.9 mm, 90% with negative lymph node status. Most detected cancers occurred in mammographically dense breast ACR types III and IV. Biopsy rates were in the range 2.3%-4.7%, with PPV of 8.4-13.7% for those biopsied due to positive ultrasound, or about one third of the PPV of biopsies due to mammography. Further validation studies should employ a uniform assessment system such as BI-RADS and report not only PPV, but also negative predictive value, sensitivity, and specificity. The researchers concluded that supplemental breast ultrasound in the population of women with mammographically dense breast tissue (ACR III and IV) permits detection of small, otherwise occult, breast cancers. Potential adverse impacts for women in this risk group are associated with an increased biopsy rate.

A study by Berg et al (2012) evaluated the cancer detection yield of supplemental ultrasound and MRI in women at elevated risk for breast cancer. From April 2004-February 2006, 2,809 women at 21 sites with elevated cancer risk and dense breasts consented to 3 annual independent screens with mammography and ultrasound in randomized order. After 3 rounds

of both screenings, 612 of 703 women who had an MRI had complete data. The reference standard was defined as a combination of pathology and 12-month follow-up. A total of 2,662 women underwent 7,473 mammogram and ultrasound screenings, 110 of whom had 111 breast cancer events: 33 detected by mammography only, 32 by ultrasound only, 26 by both, and 9 by MRI after mammography plus ultrasound; 11 were not detected by any imaging screen. Among 4,814 incidence screens in the second and third years combined, 75 women were diagnosed with cancer. Supplemental incidence screening ultrasound identified 3.7 cancers per 1,000 screens (95% CI, 2.1-5.8; *P*_.001). Sensitivity for mammography plus ultrasound was 0.76 (95% CI, 0.65-0.85); specificity, 0.84 (95% CI, 0.83-0.85); and PPV3, 0.16 (95% CI, 0.12-0.21). For mammography alone, sensitivity was 0.52 (95% CI, 0.40-0.64); specificity, 0.91(95% CI, 0.90-0.92); and PPV3, 0.38 (95% CI, 0.28-0.49; *P*=.001 all comparisons). Of the MRI participants, 16 women (2.6%) had breast cancer diagnosed. The supplemental yield of MRI was 14.7 per 1,000 (95% CI, 3.5-25.9; *P*=.004). Sensitivity for MRI and mammography plus ultrasound was 1.00 (95% CI, 0.79-1.00); specificity, 0.65 (95% CI, 0.61-0.69); and PPV3, 0.19 (95% CI, 0.11-0.29). For mammography and ultrasound, sensitivity was 0.44 (95% CI, 0.20-0.70, *P*=.004); specificity 0.84 (95% CI, 0.81-0.87; *P*_.001); and PPV3, 0.18 (95% CI, 0.08 to 0.34; *P*=.98). The number of screens needed to detect 1 cancer was 127 (95%CI, 99-167) for mammography; 234 (95% CI, 173-345) for supplemental ultrasound; and 68 (95% CI, 39-286) for MRI after negative mammography and ultrasound results. The authors concluded that the addition of screening ultrasound or MRI to mammography in women at increased risk of breast cancer resulted in a higher cancer detection yield. An increase in false-positive findings was also seen.

Weigel et al (2012) published a study that evaluated the positive predictive values of incremental breast cancer detection (PPV1) relative to breast density and of performed biopsies (PPV3) resulting from supplemental bilateral physician-performed whole-breast ultrasound (US). A total of 2,803 recalled screening participants (50–69 years), who had additional bilateral US with prospectively completed documentation were included. The PPV1 of supplemental cancer detection only by US was 0.21 % (6/2,803) compared to 13.8 % (386/2,803) by mammography. The PPV1 of US-only cancer detection was 0 %, 0.16 % (2/1,220), 0.22 % (3/1,374) and 1.06 % (1/94) for women with breast density of ACR 1, ACR 2, ACR III and ACR IV, respectively. The PPV3 of US-only lesion detection was 33.3 % (9/27) compared to 38.0 % (405/1,066) by mammography. The proportion of invasive cancers no larger than 10 mm was 37.5 % (3/8) for US-only detection compared to 38.4 % (113/294) for mammographic detection. The researchers concluded that bilateral ultrasound at recall, in addition to the assessment of screen-detected mammographic abnormalities, resulted in a low PPV of incremental cancer detection only by US, without a disproportional increase of false positive biopsies. Additional ultrasound-only cancer detection had a low PPV (0.21%). Further, the authors concluded that “bilateral breast ultrasound offers little or only marginal benefit in routine screening.”

Berg et al (2015) studied ultrasound as the primary screening test for breast cancer. Two thousand eight hundred nine participants were enrolled at 20 sites in the United States, Canada, and Argentina in American College of Radiology Imaging. Two thousand six hundred sixty-two participants completed 3 annual screens (7473 examinations) with US and film-screen (n = 4351) or digital (n = 3122) mammography and had biopsy or 12-month follow-up. Cancer detection, recall, and positive predictive values were determined. All statistical tests were 2-sided. One hundred ten women had 111 breast cancer events: 89 (80.2%) invasive cancers, median size 12 mm. The number of US screens to detect 1 cancer was 129 (95% bootstrap confidence interval [CI] = 110 to 156), and for mammography 127 (95% CI = 109 to

152). Cancer detection was comparable for each of US and mammography at 58 of 111 (52.3%) vs 59 of 111 (53.2%, P=.90), with US-detected cancers more likely invasive (53/58, 91.4%, median size 12 mm, range = 2-40 mm), vs mammography at 41 of 59 (69.5%, median size 13 mm, range = 1-55 mm, P < .001). Invasive cancers detected by US were more frequently node-negative, 34 of 53 (64.2%) vs 18 of 41 (43.9%) by mammography (P=.003). For 4814 incidence screens (years 2 and 3), US had higher recall and biopsy rates and lower PPV of biopsy (PPV3) than mammography: The recall rate was 10.7% (n = 515) vs 9.4% (n = 453, P=.03), the biopsy rate was 5.5% (n = 266) vs 2.0% (n = 97, P < .001), and PPV3 was 11.7% (31/266) vs 38.1% (37/97, P < .001). The study found cancer detection rate with US was comparable with mammography, with a greater proportion of invasive and node-negative cancers among US detections. However, false positives are more common with US screening.

Lee et al (2019) reported on a study that examined screening mammography with vs without ultrasonography examinations. Ultrasound screening was performed more often in women with dense breasts (74.3% [n = 4317 of 5810] vs 35.9% [n = 39 928 of 111 306] in the overall sample), in women who were younger than 50 years (49.7% [n = 3022 of 6081] vs 31.7% [n = 16 897 of 112 462]), and in women with a family history of breast cancer (42.9% [n = 2595 of 6055] vs 15.0% [n = 16,897 of 112,462]). While 21.4% (n = 1154 of 5392) of screening ultrasonography examinations were performed in women with high or very high (≥2.50%) Breast Cancer Surveillance Consortium 5-year risk scores, 53.6% (n = 2889 of 5392) had low or average (<1.67%) risk. Comparing mammography plus ultrasonography with mammography alone, the cancer detection rate was similar at 5.4 vs 5.5 per 1000 screens (adjusted relative risk [RR], 1.14; 95% CI, 0.76-1.68), as were interval cancer rates at 1.5 vs 1.9 per 1000 screens (RR, 0.67; 95% CI, 0.33-1.37). The false-positive biopsy rates were significantly higher at 52.0 vs 22.2 per 1000 screens (RR, 2.23; 95% CI, 1.93-2.58), as was short-interval follow-up at 3.9% vs 1.1% (RR, 3.10; 95% CI, 2.60-3.70). The positive predictive value of biopsy recommendation was significantly lower at 9.5% vs 21.4% (RR, 0.50; 95% CI, 0.35-0.71). The authors concluded that in a relatively young population of women at low, intermediate, and high breast cancer risk, these results suggest that the benefits of supplemental ultrasonography screening may not outweigh associated harms.

In Asian countries, ultrasound has been proposed as a possible alternative for mammography in breast cancer screening because of its superiority in dense breasts, accessibility, and low costs. Wang et al (2020) conducted a meta-analysis to evaluate the evidence for the diagnostic performance of ultrasound compared to mammography for breast cancer screening in Asian women. In total, 4424 studies were identified of which 6 studies met the inclusion criteria with a sample size of 124,425 women. The pooled mean prevalence of the included studies was 3.7% (range: 1.2-5.7%). The pooled sensitivity of mammography was significantly higher than that of ultrasound (0.81 [95% CI 0.71-0.88] versus 0.65 [95% CI 0.58-0.72], p = 0.03), but no significant differences were found in specificity (0.98 [95% CI: 0.94-1.00] versus 0.99 [95% CI: 0.97-1.00], p = 0.65). Authors concluded that based on the currently available data on sensitivity alone, there is no indication that ultrasound can replace mammography in breast cancer screening in Asian women.

Summary

Although studies suggest that ultrasound imaging may provide an added benefit to mammography screening for women with dense breasts and other high-risk factors, its role in routine breast cancer screening for this patient population has not been clearly established. Currently, there is little support from national and international oncology and radiology organizations for ultrasound imaging as a routine breast cancer screening modality.

Supplemental Information

PRACTICE GUIDELINES AND POSITION STATEMENTS

American Academy of Family Physicians
The American Academy of Family Physicians (2024) agrees with the USPSTF recommendations for breast cancer screening and indicated that digital mammography and digital breast tomosynthesis remain the effective primary screening modalities. No mention is made for the use of ultrasound during the screening process for breast cancer.

American Cancer Society
The American Cancer Society (2022-2025) recommendations do not endorse the use of ultrasound in lieu of or as an adjunct to mammograms for breast cancer screening in women with either an average risk or high risk of developing breast cancer. The ACS points out that when breast ultrasound is used for screening, there is a small chance of being diagnosed with a cancer that never would have caused any problems had it not been discovered during screening, this is referred to as overdiagnosis. ACS does endorse the use of other tests, including ultrasound, if something is found on a screening mammogram.

The American College of Obstetricians and Gynecologists
ACOG (2024) stands by the USPSTF recommendations and supports the use of mammograms for breast cancer screening. No mention is made for the use of ultrasound in the screening process.

American College of Radiology
The American College of Radiology (2024) practice guidelines for whole breast ultrasound (US) for screening includes an indication for breast ultrasound. ACR points out that routine US scanning did not have an effect on additional cancer detection, but it did increase the number of false-positive results. For women with dense breasts tissue but no additional risk factors or those with a high lifetime risk (≥ 20%) who are not candidates or are unable to tolerate, access or prefer not to undergo MRI, US may be useful as an adjunct to mammography for incremental cancer detection, but the balance between increased cancer detection and the increased risk of a false-positive examination should be considered in the decision. There are no data to support the use of US for average-risk women with non-dense breasts."

Centers for Disease Control
The CDC quotes the USPSTF recommendations for breast cancer screening. Ultrasound is not mentioned as a screening modality.

European Commission Initiative on Breast Cancer
The European Commission (EC) guidelines (2024) for asymptomatic women with high mammographic breast density and negative mammography (either digital breast tomosynthesis or digital mammography), the EC's Guidelines Development Group (GDG) suggests not implementing tailored screening with additional automated breast ultrasound, in the context of an organized population-based screening program.

European Group for Breast Cancer Screening
The European Group for Breast Cancer Screening (1998) states that: “Ultrasound of the breast is an important adjunct to mammography and clinical examination in the further assessment of both palpable and impalpable breast abnormalities. The use of ultrasound to screen asymptomatic women is associated with unacceptable false positive and false negative outcomes. At present there is little evidence to support the use of breast ultrasound in routine primary population breast cancer screening.”

National Cancer Institute
The National Cancer Institute (updated 2024) states “Ultrasound is used for the diagnostic evaluation of palpable or mammographically identified masses, rather than serving as a primary screening modality. A review of the literature and expert opinion by the European Group for Breast Cancer Screening concluded that there is little evidence to support the use of ultrasound in population breast cancer screening at any age.”

National Comprehensive Cancer Network (NCCN)
National Comprehensive Cancer Network states that “although there is increasing evidence that breast ultrasonography can be useful in the incremental detection of breast cancer as an adjunct to screening mammography in the evaluation of women with dense breasts, the routine use of ultrasound as a universal supplemental screening test in individuals at average risk of breast cancer is not recommended by the NCCN Panel at this time. Ultrasonography is commonly used for diagnostic follow-up of an abnormality seen on screening mammography and palpable clinical concerns.”

Society of Breast Imaging
The Society of Breast Imaging (2010) recommends that ultrasound (in addition to mammography) can be considered in high-risk women for whom magnetic resonance imaging (MRI) screening may be appropriate but who cannot have MRI for any reason and can be considered in women with dense breast tissue as an adjunct to mammography. Additionally, the guideline states that “Performing supplemental screening with ultrasound in these women adds no additional benefit over screening with mammography and MRI. However, screening breast ultrasound may have a role as a supplemental screening tool for high-risk women who have contraindications to MRI or in those whose levels of risk do not reach the level recommended for breast MRI screening by the ACS.”

United States Preventative Services Task Force (USPSTF)
In 2024, the United States Preventative Services Task Force (USPSTF) concluded that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram.

Government Regulations

National:

There is no National determination for the use of ultrasound of the breast for cancer screening.

Local:

There is no Local determination found for ultrasound screening of the breast.

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

- Breast Elastography – Ultrasound or Magnetic Resonance
- Digital Breast Tomosynthesis (3D Mammography)
- Magnetic Resonance Imaging for Detection and Diagnosis of Breast Cancer
- Magnetic Resonance Imaging to Monitor Integrity of Silicone-Gel-Filled Breast Implants
- Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through December 5, 2024, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
3/1/13	12/11/12	12/31/12	Joint policy established
9/1/14	6/20/14	6/23/14	Routine maintenance
7/1/15	4/24/15	5/8/15	Code 76645 deleted and replaced with 76641 and 76642
7/1/16	4/19/16	4/19/16	Routine maintenance
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	2/18/20		Routine maintenance
5/1/21	2/16/21		Routine maintenance
5/1/22	2/15/22		Routine maintenance
5/1/23	2/21/23		• Routine maintenance (slp) • Vendor managed: N/A • Title updated from: Stand-Alone Ultrasound For Routine Breast Cancer Screening • MPS simplified – stance remains same
5/1/24	2/20/24		• Routine maintenance (slp) • Vendor managed: N/A
5/1/25	2/18/25		• Routine maintenance (slp) • Vendor managed: N/A

Next Review Date: 1st Qtr, 2026

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: ULTRASOUND FOR BREAST CANCER SCREENING

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Not covered
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 resources 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.