
Medical Policy



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***Current Policy Effective Date: 3/1/26**
(See policy history boxes for previous effective dates)

Title: Percutaneous Electrical Nerve Field Stimulation (e.g., IB-Stim) for Functional Gastrointestinal Disorders Including IBS

Description

Percutaneous electrical nerve field stimulation involves the transmission of electrical impulses to cranial nerve bundles in the ear targeting brain areas involved in processing pain. In the case of patients with irritable bowel syndrome, nerves processing pain for the abdominal region are targeted.

Medical Policy Statement

The use of the percutaneous electrical nerve field stimulation (PENFS) device is established when criteria are met.

Inclusionary and Exclusionary Guidelines

Inclusions:

PENFS (e.g., IB-Stim) for children and adolescents when **ALL** of the following criteria are met:

- 11-18 years of age; **AND**
- Patient must be diagnosed with a ROME IV defined-functional gastrointestinal disorder (These include functional abdominal pain, functional abdominal pain syndrome, irritable bowel syndrome, functional dyspepsia, and abdominal migraine); **AND**
- Organic GI disease must have been ruled out; **AND**
- The problem has been present for at least 9 months; **AND**

- The patient has tried and failed medications in all 3 categories: acid suppression (H2-blockers or PPIs), antispasmodics or motility medications (hyoscyamine, dicyclomine, erythromycin/linaclootide, prucalopride) and neuromodulators (amitriptyline/nortriptyline/gabapentin/pericatin/aprepitant), in addition to diet modification.
 - For adolescents that have a documented contraindication or intolerance to a medication, it will not be a required step in therapy.

Exclusions:

- Use of IB-Stim when not meeting the criteria above.
- Repeat course of treatment.

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:

64567

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

N/A

Note: Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.

Background

Irritable Bowel Syndrome

Irritable bowel syndrome (IBS) is estimated to affect 5% to 10% of the population globally, and accounts for between 2.4 and 3.5 million physician visits in the United States each year.¹ Up to two-thirds of patients with IBS are female, and it is most common in patients less than 50 years of age. The cause of IBS remains unknown but is believed to be due to a dysfunction in gut-brain interaction.² Symptoms of IBS can include diarrhea, constipation, or both. Abdominal pain and bloating are also common IBS symptoms. These symptoms decrease patient quality of life and create a significant healthcare burden.³ The American College of Gastroenterology (ACG) recommends that patients diagnosed with IBS are categorized by subtypes: IBS with constipation (IBS-C), IBS with diarrhea (IBS-D), IBS with mixed symptoms (IBS-M), or IBS without abnormal stools (IBS-U).

Treatment

First-line treatment of patients with IBS generally involves dietary changes. If dietary changes fail to achieve therapeutic goals, there are numerous pharmacotherapeutic options for patients with IBS. Pharmacologic treatment is based on the IBS subtype, and the predominance of either constipation or diarrhea (Table 1).^{4,3,5} Notably, many IBS treatments are not Food and Drug Administration (FDA)-approved for children or adolescents. The American College of Gastroenterology recommends that gut-directed psychotherapy such as cognitive-behavior therapy and gut-directed hypnotherapy may be beneficial for global IBS symptoms.³

Table 1. Pharmacologic Treatment of Irritable Bowel Syndrome

IBS-D	IBS-C	Abdominal Pain
Antidiarrheal agents (e.g., loperamide)	Laxatives (e.g., polyethylene glycol)	Antispasmodics (e.g., dicyclomine, hyoscyamine, peppermint oil)
Mu-opioid receptor agonist (eluxadoline for refractory patients only)	Chloride channel activator (lubiprostone)	TCA
5-HT ₃ receptor antagonist (alosetron or ondansetron)	Guanylate cyclase agonists (linaclotide or plecanatide)	SSRI
Antibiotic (rifaximin)	Sodium/hydrogen exchanger 3 (tenapanor)	

HT: hydroxytryptamine (serotonin); IBS-C: irritable bowel syndrome with constipation; IBS-D: irritable bowel syndrome with diarrhea; SSRI: selective serotonin reuptake inhibitor; TCA: tricyclic antidepressant.

Percutaneous Electrical Nerve Field Stimulation

Because there are few pharmacologic treatments for children and adolescents with IBS, nonpharmacologic options are commonly explored. Percutaneous electrical nerve field stimulation (PENFS) is a potential treatment option for these patients. PENFS involves a non-implantable device which stimulates nerves remotely from the site of pain and has been studied for a variety of musculoskeletal or neuropathic pain conditions or for patients with opioid withdrawal.⁶ The IB-Stim device is a type of PENFS. The device is disposable and battery-operated. Key components of the device include a percutaneous electrical nerve field stimulator placed behind the ear which connects to a multi-wire electrode array consisting of 4 leads. The electrodes have thin needles and attach to the ear at points (preauricular, lobule and superior crus) where cranial nerve peripheral branches are located just beneath the skin. A pen light included with the device is used to visualize the neurovascular features and aid in proper electrode placement.

This treatment modality has also been studied in other functional gastrointestinal disorders (i.e., functional abdominal pain, functional abdominal pain syndrome, functional dyspepsia, and abdominal migraine). The FGIDs share a key similarity in that they are believed to have a critical abnormality of impaired communication between the gut and brain. PENFS is purported to modulate the central pain pathways and attenuate abdominal pain.

SUMMARY OF EVIDENCE

The evidence includes a RCT, retrospective reviews and prospective reviews. PENFS has proven to be an effective and safe treatment for pediatric patients with abdominal pain disorders. Studies concluded that PENFS improves overall wellbeing in adolescents with abdominal pain. PENFS with Neuro-stim (IB-STIM) showed an 81% improvement in overall symptoms, and approximately 59% of test subjects showed at least a 30% reduction in their worst pain. Results consistently affirm that auricular neurostimulation reduces abdominal pain scores and improves overall wellbeing in adolescents with IBS. Some studies reported a durable effect and suggested it may be used as an alternative to medication when indicated.

Clinical input obtained in 2024 agreed that PENFS is effective in the management of functional gastrointestinal disorders. In addition, this treatment option for the adolescent population was supported by a conditional guideline recommendation from a collaborative effort of the European and North American Societies for Pediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN and NASPGHAN) in March 2025. The evidence is sufficient to determine that the technology results in an improvement in the net health outcomes.

Rationale

Evidence reviews assess clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. The following is a summary of the key literature to date.

Irritable Bowel Syndrome

Clinical Context and Therapy Purpose

The purpose of percutaneous electrical nerve field stimulation (PENFS) in patients who have irritable bowel syndrome (IBS) is to provide a treatment option that is an alternative to or an improvement on existing therapies.

Review of Evidence

Randomized Controlled Trials

Kovacic et al (2017) conducted an RCT comparing the Neuro-Stim PENFS device with a sham device in 115 adolescent patients with abdominal pain-related functional gastrointestinal disorders including IBS.⁷ Patients were randomly assigned (1:1) with a computer-generated randomization scheme to active treatment or sham (no electrical charge) for 4 weeks. Patients were stratified by sex and presence or absence of nausea. Allocation was concealed from participants, caregivers, and the research team. The primary efficacy endpoint was change in abdominal pain scores. Improvement in worse abdominal pain and composite pain score was measured. Participants with less than 1 week of data and those with organic disease identified after enrolment were excluded from the modified intention-to-treat population. After exclusion of patients who discontinued treatment (n=1 in the PENFS group; n=7 in the sham group) and those who were excluded after randomization because they had organic disease (n=2 in the PENFS group; n=1 in the sham group), 57 patients in the PENFS group and 47 patients in the sham group were included in the primary analysis. Patients in the PENFS group had greater reduction in worst pain compared with sham after 3 weeks of treatment (PENFS: median score 5.0 [IQR 4.0-7.0]; sham: 7.0 [5.0-9.0]; least square means estimate of change in worse pain 2.15 [95% CI 1.37-2.93], p<0.0001). Effects were sustained for an extended period (median follow-up 9.2 weeks [IQR 6.4-13.4]) in the PENFS group: median 8.0 (IQR 7.0-9.0) at baseline to 6.0 (5.0-8.0) at follow-up versus sham: 7.5 (6.0-9.0) at baseline to 7.0 (5.0-8.0) at follow-up (p<0.0001). Median PFSD composite scores also decreased significantly in the PENFS group (from 24.5 [IQR 16.8-33.3] to 8.4 [3.2-16.2]) compared with sham (from 22.8

[IQR 8·4-38·2] to 15·2 [4·4-36·8]) with a mean decrease of 11·48 (95% CI 6·63-16·32; $p<0\cdot0001$) after 3 weeks. These effects were sustained at extended follow-up in the PENFS group: median 24·5 (IQR 16·8-33·3) at baseline to 12 (3·6-22·5) at follow-up, compared with sham: 22·8 (8·4-38·2) at baseline to 16·8 (4·8-33·6) at follow-up ($p=0\cdot018$). Ten patients reported side-effects (three of whom discontinued the study): ear discomfort ($n=6$; three in the PENFS group, three in the sham group), adhesive allergy ($n=3$; one in the PENFS group, two in the sham group), and syncope due to needle phobia ($n=1$; in the sham group). There were no serious adverse events. The authors concluded that PENFS had sustained efficacy for abdominal pain-related functional gastrointestinal disorders in adolescents. The authors believe PENFS is a safe and effective approach that expands treatment options and should be considered as a non-pharmacological alternative for these disorders.

In 2020, Kovacic et al examined whether pretreatment vagal efficiency (VE), respiratory sinus arrhythmia, and heart beat can predict pain improvement with auricular neurostimulation in pediatric functional abdominal pain disorders.⁸ A total of 92 adolescents with functional abdominal pain disorders underwent a 4-week randomized, double-blinded, sham-controlled auricular neurostimulation trial. Electrocardiogram-derived variables at baseline were used to predict pain using mixed effects modeling. A 3-way interaction (95% confidence intervals: 0.004-0.494) showed that the treatment group subjects with low baseline VE had lower pain scores in week 3. There was no substantial change in the placebo or high VE treatment group subjects. This effect was supported by a significant correlation between baseline VE and degree of pain reduction only in the treatment group. The authors concluded that impaired cardiac vagal regulation measured by VE predicts pain improvement with auricular neurostimulation.

Krasaelap et al (2020) evaluated the efficacy of PENFS in adolescents with irritable bowel syndrome (IBS).¹⁰ Data from pediatric patients with IBS who participated in a double-blind trial at a tertiary care gastroenterology clinic from June 2015 through November 2016 was analyzed. Patients were randomly assigned to groups that received PENFS ($n = 27$; median age, 15.3 y; 24 female) or a sham stimulation ($n = 23$; median age, 15.6 y; 21 female), 5 days/week for 4 weeks. The primary endpoint was number of patients with a reduction of 30% or more in worst abdominal pain severity after 3 weeks. Secondary endpoints were reduction in composite abdominal pain severity score, reduction in usual abdominal pain severity, and improvement in global symptom based on a symptom response scale (-7 to +7; 0 = no change) after 3 weeks. Reductions of 30% or more in worst abdominal pain were observed in 59% of patients who received PENFS vs 26% of patients who received the sham stimulation ($P = .024$). The patients who received PENFS had a composite pain median score of 7.5 (interquartile range [IQR], 3.6-14.4) vs 14.4 for the sham group (IQR, 4.5-39.2) ($P = .026$) and a usual pain median score of 3.0 (IQR, 3.0-5.0) vs 5.0 in the sham group (IQR, 3.0-7.0) ($P = .029$). A symptom response scale score of 2 or more was observed in 82% of patients who received PENFS vs 26% of patients in the sham group ($P \leq .001$). No significant side effects were reported. The authors concluded that auricular neurostimulation reduces abdominal pain scores and improves overall wellbeing in adolescents with IBS.

Santucci et al (2022) evaluated the effects of PENFS on resting and evoked pain and nausea, sleep and psychological functioning, and long-term outcomes.¹¹ Patient ages 11-19 years with FAPD requiring PENFS as standard care were recruited. Evoked pain was elicited by a Water Load Symptom Provocation Task (WL-SPT) before and after four weeks of treatment. Pain,

gastrointestinal symptoms, sleep, somatic symptoms, and physical and psychological functioning were assessed. Actigraphy was used to measure daily sleep-wake patterns. Twenty patients (14.3 ± 2.2 years old) with FAPD were enrolled. Most patients were females (70%) and white (95%). During pain evoked by WL-SPT, visual analog scale (VAS) pain intensity and nausea were lower following PENFS compared with baseline ($p = 0.004$ and $p = 0.02$, respectively). After PENFS, resting VAS pain unpleasantness ($p = 0.03$), abdominal pain ($p < 0.0001$), pain catastrophizing ($p = 0.0004$), somatic complaints (0.01), functional disability ($p = 0.04$), and anxiety ($p = 0.02$) exhibited significant improvements, and some were sustained long-term. Self-reported sleep improved after PENFS (p 's < 0.05) as well as actigraphy-derived sleep onset latency ($p = 0.03$). Improvements in resting and evoked pain and nausea, sleep, disability, pain catastrophizing, somatic complaints, and anxiety after four weeks of PENFS therapy were realized. Some effects were sustained at 6-12 months post-treatment. This suggests that PENFS is a suitable alternative to pharmacologic therapy.

Bora et al (2023) investigated gut microbiome alterations by PENFS therapy in adolescent IBS patients.¹² A prospective study of females with IBS aged 11-18 years receiving PENFS therapy for 4 weeks with pre- and post-intervention stool sampling was conducted. Outcome surveys completed pre-therapy, weekly, and post-therapy included IBS-Severity Scoring System (IBS-SSS), Visceral Sensitivity Index (VSI), Functional Disability Inventory (FDI), and the global symptom response scale (SRS). Bacterial DNA was extracted from stool samples followed by 16S rRNA amplification and sequencing. QIIME 2 (version 2022.2) was used for analyses of α and β diversity and differential abundance by group. Twenty females aged 15.6 ± 1.62 years were included. IBS-SSS, VSI, and FDI scores decreased significantly after PENFS therapy ($P < 0.0001$, $P = 0.0003$, $P = 0.0004$, respectively). No intra- or interindividual microbiome changes were noted pre- versus post-therapy or between responders and non-responders. When response was defined by 50-point IBS-SSS score reduction, α diversity was higher in responders compared with non-responders at week 4 ($P = 0.033$). There was higher abundance of *Blautia* in excellent responders versus non-responders. There were no substantial microbial diversity alterations with PENFS. Subjects with excellent therapeutic response showed an enrichment of relative abundance of *Blautia*, which may indicate that patients with specific microbial signature have a more favorable response to PENFS.

In 2023, a prospective study was conducted by Chogle et al evaluating changes in quality of life (QoL), gastrointestinal symptoms, functional disability, somatization, global health, anxiety, and depression in patients aged 11-18 years who received PENFS therapy (IB-stim, NeurAxis, Versailles, IN) for treatment of pain related disorders of the Gut-Brain Interaction (DGBIs), once a week for four consecutive weeks.¹³ This study included 31 patients with an average age of 15.7 years ($SD = 2$); 80.6% were female. After PENFS therapy, patients reported significant reductions in abdominal pain, nausea severity, functional disability, somatization, and anxiety from baseline to week 4 ($p < 0.05$). Parents reported significant improvement in their child's QoL regarding physical function, psychosocial function, and generic core scale scores ($p < 0.05$). Parents also noted reduced abdominal pain, functional disability, and somatization. Average scores on the Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health scale significantly improved based on both patient and parent reports ($p < 0.05$). The patients' QoL was significantly lower than healthy controls at baseline and after treatment ($p < 0.05$). The authors concluded that their findings demonstrate the effectiveness of PENFS and its potential to alleviate the suffering of countless children.

Santucci et al (2023) assessed the efficacy of PENFS for treating functional dyspepsia (FD) and compare the outcomes with those who received the combination of PENFS + behavioral intervention (BI).¹⁴ Charts of patients with FD who completed four weeks of PENFS were evaluated. A subset of patients received concurrent BI. Demographic data, medical history, and symptoms were documented. Outcomes at different time points included subjective symptom responses and validated questionnaires collected clinically (Abdominal Pain Index [API], Nausea Severity Scale [NSS], Functional Disability Inventory [FDI], Pittsburgh Sleep Quality Index [PSQI], Children's Somatic Symptoms Inventory [CSSI], Patient-Reported Outcomes Measurement Information Systems [PROMIS] Pediatric Anxiety and Depression scales). Of 84 patients, 61% received PENFS + BI, and 39% received PENFS alone. In the entire cohort, API ($p < 0.0001$), NSS ($p = 0.001$), FDI ($p = 0.001$), CSSI ($p < 0.0001$), PSQI ($p = 0.01$), PROMIS anxiety ($p = 0.02$), and depression ($p = 0.01$) scores improved from baseline to three weeks and at three months. Subjective responses showed nausea improvement ($p = 0.01$) and a trend for improvement in abdominal pain ($p = 0.07$) in week three. Abdominal pain subjectively improved at week three and three months ($p = 0.003$ and 0.02 , respectively), nausea at week three and three months ($p = 0.01$ and 0.04 , respectively), and a trend for improvement in sleep disturbances at week three and three months ($p = 0.08$ and $p = 0.07$, respectively) in the PENFS + BI group vs PENFS alone. Abdominal pain, nausea, functioning, somatization, sleep disturbances, anxiety, and depression improved at three weeks and three months after PENFS in pediatric FD. Subjective pain and nausea improvement were greater in the PENFS + BI group than in the group with PENFS alone, suggesting an additive effect of psychological therapy.

SUPPLEMENTAL INFORMATION

CLINICAL INPUT FROM PHYSICIAN SPECIALTY SOCIETIES, ACADEMIC MEDICAL CENTERS AND EXTERNAL STAKEHOLDERS (PRACTICING CLINICIANS AND RESEARCH BASED EXPERTS IN THE FIELD)

Clinical input obtained in 2024 agreed that PENFS is effective in the management of functional gastrointestinal disorders consistent with the RCT that led to its FDA approval. Although the medications used to treat IBS in adolescents remain non-FDA approved, medication treatment has traditionally been first line therapy. BCBSMs approach to providing access to IBSTIM utilizes step therapy and was challenged by Neuraxis. The analysis of the 2025 NASPGHAN guideline concluded that PENFS with IBSTIM is not typically recommended as first line treatment. NASPGHAN gave a conditional recommendation on the traditional classes of medications that are typically used, albeit derived from low certainty evidence. However, BCBSM gives consideration for adolescents with an intolerance or contraindication to the medications that have been previously accepted as standard of care (SOC).

Practice Guidelines and Position Statements

American College of Gastroenterology

The American College of Gastroenterology (ACG) updated their recommendations for irritable bowel syndrome (IBS) management in 2021.³ The ACG recommendations do not include percutaneous electrical nerve field stimulation.

The ACG updated their guidelines on the diagnosis and management of cyclic vomiting syndrome (2024). The ACG recommendations do not include percutaneous electrical nerve field stimulation.

The American Gastroenterological Association

The American Gastroenterological Association (AGA) updated guidelines for both IBS with constipation and IBS with diarrhea in 2022.^{5,4} Neither of these guidelines include recommendations for percutaneous electrical nerve field stimulation.

North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN)¹⁵

In a 2025 guideline recommendation related to IB-Stim states that PENFS is suggested as a treatment option (conditional recommendation, moderate certainty evidence). The Guideline Development Group suggests that this treatment option may be utilized for patients who have shown considerable difficulty in achieving pain relief.

Executive summary of other recommendations:

- Amitriptyline may be suggested as a treatment option (Conditional recommendation, Low certainty evidence)
- Domperidone may be suggested as a treatment option (Conditional recommendation, Low certainty evidence)
- Cyproheptadine may be suggested as a treatment option (Conditional recommendation, Low certainty evidence)
- Cognitive Behavioral therapy (CBT) is recommended as a treatment option (Strong recommendation, Low certainty evidence)
- Hypnotherapy is recommended as a treatment option (Strong recommendation, Moderate certainty evidence)

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 2.

Table 2. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
<i>Ongoing</i>			
<i>Unpublished</i>			
NCT04428619	Neuromodulation With Percutaneous Electrical Nerve Field Stimulation for Adults with Irritable Bowel Syndrome: A Randomized, Double-Blind, Sham-Controlled Pilot Study	54	Nov 2024

NCT: national clinical trial.

Regulatory Status

In 2019, the IB-Stim device (previously known as Neuro-Stim; Innovative Health Solutions, Inc.) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the de novo 513(f)(2) process (DEN180057). Both the IB-Stim and the similar NSS-2 BRIDGE device (Innovative Health Solutions, Inc.) are derivatives of the Electro Auricular Device (Navigant Consulting, Inc.). The IB-Stim device is indicated for patients 11 to 18 years of age with functional abdominal pain associated with IBS when combined with other IBS therapies. It is intended to be used for 120 hours per week up to 3 consecutive weeks. The First Relief v1 (DyAnsyst, Inc.) device was deemed substantially equivalent to the IB-Stim device in 2020. FDA product code: QHH.

Government Regulations

National:

There is no NCD for this service.

Local:

There is no LCD for this service.

(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

- Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT), and Restorative Neurostimulation Therapy
-

References

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12. Bora G, Atkinson SN, Pan A, et al. Impact of auricular percutaneous electrical nerve field stimulation on gut microbiome in adolescents with irritable bowel syndrome: a pilot study. *J Dig Dis.* May 2023; 24(5): 348-358.
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14. Santucci NR, Beigarten AJ, Khalid F, et al. Percutaneous electrical nerve field stimulation in children and adolescents with functional dyspepsia-integrating a behavioral intervention. *Neuromodulation.* Aug 2023; S1094-7159(23)00707-9.
15. Groen J, Gordon M, Chogle A, et al. ESPGHAN/NASPGHAN guidelines for treatment of irritable bowel syndrome and functional abdominal pain not otherwise specified in children aged 4-18 years. *J Pediatr Gastroenterol Nutr.* 2025; 81: 442-471.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through November 2025, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
3/1/25	12/17/24		Joint policy established
3/1/26	12/16/25		Rationale updated. NASPGHAN guidelines updated, clinical input documented. Code 0720T was deleted and replaced with code 64567. Vendor managed: N/A (ds)

Next Review Date: 4th Qtr., 2026

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN:	Revised:
BCBSM:	Revised:

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: PERCUTANEOUS ELECTRICAL NERVE FIELD STIMULATION (E.G., IB-STIM) FOR
FUNCTIONAL GASTROINTESTINAL DISORDER INCLUDING IBS

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Per policy
BCNA (Medicare Advantage)	See government section
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.
- Duplicate (back-up) equipment is not a covered benefit.