HMO Benefit Guidelines

For IPAs/medical groups and their contracted providers

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HMO Benefit Guidelines Revision Index

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Accidental Injury to Natural Teeth – Basic Plan

Benefit Coverage

Hospital and professional services provided for treatment of damage to the natural teeth, gums, and jaws caused directly (solely) by accidental injury is limited to the immediate, medically necessary services for the initial, emergency palliative stabilization of the member. Definitive dental treatment to restore the teeth, dental bridges, dental implants, root canal treatment, denture repair or replacement, gum surgery, removal of fractured teeth or tooth roots following the immediate, initial, palliative medical stabilization of the dentition or mouth are not a covered benefit under the medical policy. This benefit does not include services for damage to the natural teeth that is not accidental (e.g., damage to teeth from chewing, clenching, grinding, natural attrition, or biting).

Treatment of accidental injury to the natural teeth covered under the Basic Plan must be reviewed and authorized.

Note: For the purposes of this policy, the definition of “emergency palliative” is the immediate and initial treatment to dentally or medically stabilize the teeth or oral structures and/or to manage or treat acute, intractable (severe) oral pain to prevent a more serious medical condition from occurring; it is not necessarily the definitive restoration of the teeth or oral structures. Covered services are limited to the immediate, medically necessary services for the initial, palliative medical stabilization (“first aid”) of the teeth and associated oral structures. Submission of pre- and post-accident radiographs of the site and medical quality photographs of the mouth and teeth will be required when requesting services.

Copayment

See the members’ *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Office Visits/Consultations/Surgery

Inpatient Hospital Services

Outpatient Hospital Services

Accidental Injury to Natural Teeth – Basic Plan

Benefit Exclusions

The following services are excluded:

- Routine dental care including bridges, dentures, oral orthotics, periodontal treatment, and cosmetic treatment (e.g., bleaching of darkened tooth).
- Replacement, repair or restoration of dentures, fixed dental bridges, crowns, fillings, dental implants, removable oral appliances, dental retainers, dental veneers, etc. as the result of accidents, loss, theft, or damage following a medical or dental clinic visit, a hospital visit, visit to an urgent care or emergency room, or the use of an ambulance service.
- Replacement, repair or restoration of dentures, fixed dental bridges, crowns, fillings, dental implants, removable oral appliances, dental retainers, dental veneers, etc. as the result of accidents or trauma.
- Services customarily provided by dentists and oral surgeons, including hospitalization incidental to routine dental care and services.
- Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate symptoms as a result of TMJ conditions or abnormalities or because of an accident or trauma. Any dental or medical emergency treatment as a result of loose orthodontic arch wires, broken orthodontic brackets, and broken or lost orthodontic retainers.
- Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures.
- Replacement or repair to dental implants (endosteal, subperiosteal, or transosteal) to include the implant abutment, implant crowns, implanted supported dentures, etc. as the result of accident, injury, or trauma.
- Treatment for damage to the natural teeth that is not accidental or from trauma (e.g., damage to teeth resulting from chewing, biting, bruxing, clenching, natural erosion, or attrition).
- Replacement of existing prosthesis, bridge, or partial removable denture in case of accident or trauma.
- All dental services provided **after** the emergency, initial, palliative, stabilizing medical treatment for the injury.
- Cosmetic dental services to include replacement of dental veneers.

Accidental Injury to Natural Teeth – Basic Plan

Benefit Exclusions *(cont'd.)*

- Amalgam restorations, resin-based restorations, cement restorations, or full coverage cast (crowns) restorations to include fillings that fall out as a result of accidents or trauma.
- Periodontal or gingival services not caused by accident or trauma (e.g., "acute necrotizing ulcerative gingivitis," diabetic gingivitis, "pregnancy gingivitis," gingivitis and periodontal disease caused by poor oral hygiene, dental neglect, etc. are not a benefit of this Plan).
- Tooth/teeth pain or oral swelling not caused by trauma or accident (e.g., tooth decay or from an unerupted tooth).
- Teeth or oral structures not directly associated with the accident or injury (for example, a front tooth is chipped due to a fall, but the dentist also repairs the teeth adjacent to the injured tooth because they need "fillings").
- Dental appliances constructed to stop certain parafunctional habits (e.g., thumb-sucking or lip biting appliances) to include the training on the proper use of the appliance.
- Removing dental implants and any associated procedures required to treat the dental or oral structures as the result of a failing implant(s) or the resultant of an accident or trauma.
- The services of dental pathologists, dental anesthesiologists, oral-facial pain specialists, dental radiologists, and dental medicine specialists.

Accidental Injury to Natural Teeth – Basic Plan

Examples of Covered Services

- X-rays and other imaging studies of injured teeth, jawbones and/or affected area **immediately** following an accident.
- Services in the Emergency Room to medically stabilize the acute-immediate dental or oral emergency.
- Limited problem focused on oral-dental evaluation of the oral-dental injury (accidental injury).
- Immediate palliative treatment of dental pain when related to accidental injury.
- Immediate tooth removal, treatment for the avulsion of tooth/teeth, reimplantation of tooth/teeth, stabilization of teeth with closed reduction splinting, removal of foreign body, treatment of jaw fractures, treatment of alveolar fractures, reduction of dislocation of the jaw joints, and repair of traumatic wounds involving jaws or gum tissue.
- *Note:* Excluded are root canal treatments due to tooth pulp problems vicariously or directly caused by or following an accident or trauma.
- Removing or re-shaping sharp edges around a fractured tooth caused by an accident or trauma to the tooth/teeth immediately following the accident.
- General anesthesia, when supporting above listed procedures (if medically required). General anesthesia is not a benefit if the dental emergency is normally treated with a local anesthetic and not simply because the patient is uncooperative or hysterical from the accident or trauma to the mouth or oral structures.
- *Note:* General anesthesia for dental treatment is a benefit when all the criteria outlined in the Blue Shield Medical Policy on “Dental Anesthesia” are met to include the dental office or facility possessing a general anesthesia or intravenous sedation permit from the Medical or Dental Board of California to provide general anesthesia or deep intravenous sedation. For the purpose of this policy, mobile anesthesia services do not meet these criteria.

Accidental Injury to Natural Teeth- Basic Plan

Examples of Non-Covered Services

- Orthodontia.
- Periodontal services (gum services).
- Restorative dentistry (fillings, dental veneers, etc.).
- Endodontic services (root canal treatment).
- Prosthodontic services (dentures, fixed dental bridges, removable dental bridges, dental implants, crowns, etc.).
- Oral medicine, oral pathology, oral radiology services.
- Cosmetic dental services.
- Preventive dental care.
- Treatment for damage resulting from chewing, teeth grinding, teeth clenching, or biting.
- Replacement of existing prosthesis, fixed bridge, or partial removable denture in case of accident.
- Prosthetic replacement of natural tooth/teeth (only) lost due to accidental injury to include the placement of implants or implant supported dentures.
- Mobile dental anesthesia services provided in a dental office.
- Removing a failing dental implant and treating the surrounding tissues for residual infection from the implant.
- The placement of dental implants.
- Any definitive dental treatment vicariously caused by an accident or after weeks, months or years following the accident or trauma to the mouth.

Accidental Injury to Natural Teeth – Basic Plan

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code Section 1367.71

HMO Benefit Guidelines for:

Teeth, Jaws, and Jawbones

Blue Shield HMO IPA/Medical Group Procedures Manual

Acupuncture

Benefit Coverage

Acupuncture with unlimited visits is included in IFP and Small Business HMO on and off exchange plans for treatment of nausea and as part of a chronic pain management program. These benefits are through American Specialty Health Plans (ASH Plans) when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. This benefit includes an initial examination and acupuncture services specifically for the treatment of nausea and as part of a chronic pain management program and must be determined as Medically Necessary by ASH Plans. A referral from the member's Blue Shield HMO primary care physician (PCP) is not required. The ASH Group provider will refer the member to the PCP for evaluation of conditions not related to chronic pain or nausea and for evaluation of non-covered services such as diagnostic scanning (CAT scans or MRIs).

ASH Plans must determine all subsequent services as Medically Necessary following the initial examination and emergency services by an ASH Group provider.

The standard HMO Mid and Large Group plans do not include services for or incidental to acupuncture.

Some HMO Mid and Large Group plans have the optional chiropractic and acupuncture benefits through ASH Plans when provided by an ASH Group participating provider. The benefits are similar to the above with the exceptions that the optional chiropractic and acupuncture benefit visit limits and copayments vary and services for Acupuncture include treatment for neuromusculoskeletal disorders. Refer to the members' EOC for details or call ASH Plans at (800) 678-9133.

HMO members may receive discounted acupuncture, chiropractic, and therapeutic massage services through the Alternative Care Discount Program on blueshieldca.com. Simply log on to blueshieldca.com, click on the *Be Well* tab at the top of the screen, then *Wellness Discount Programs*, then *Alternative Care*.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Acupuncture

Benefit Exclusions

- Standard HMO Mid and Large plans, services for or incidental to acupuncture
- Massage therapy provided by a massage therapist
- Services administered by an acupuncturist or chiropractor not in the ASH Group

Examples of Covered Services

Initial examination and acupuncture services specifically for the treatment of nausea and as part of a chronic pain management program, when determined by ASH Plans as Medically Necessary.

Examples of Non-Covered Services

- Cupping
- Electroacupuncture
- Moxibustion

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

Alternative Care Discount Program on blueshieldca.com

HMO Optional Benefits: Chiropractic and Acupuncture rider offered by American Specialty Health Plans (ASH Plans)

Acupuncture and Chiropractic Services (Optional Benefits)

Benefit Coverage

Medically necessary acupuncture services are covered up to the maximum visits* per calendar year when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. This benefit includes an initial examination and acupuncture services specifically for the treatment of neuromusculoskeletal disorders, nausea, and pain, and must be determined as Medically Necessary by American Specialty Health Plans (ASH Plans).

Medically necessary chiropractic services are covered up to the maximum visits* per calendar year for routine chiropractic care when provided by an ASH Group participating provider. This benefit includes an initial examination and chiropractic adjustments, and conjunctive therapy specifically for the treatment of neuromusculoskeletal disorders and must be determined as Medically Necessary by ASH Plans. Benefits are also provided for pre-authorized x-rays.

*Note: The two standard HMO plan designs are Acupuncture and Chiropractic Services with a combined maximum of 30 visits per calendar year with a $10 copay on standard HMO plans or a maximum of 30 chiropractic only visits per calendar year with a $10 copay. Some HMO Plans may have separate Acupuncture and Chiropractic maximum visit limits. The number of visits may vary. Refer to member's EOC for details or call ASH Plans at (800) 678-9133.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Acupuncture and Chiropractic Services (Optional Benefits)

Benefit Exclusions

Covered services do not include:

- Services administered by an acupuncturist or chiropractor not in the ASH Group
- Acupuncture treatment for services for treatment of asthma
- Acupuncture treatment for addiction (including without limitation, smoking cessation)
- Vitamins, minerals, nutritional supplements (including herbal supplements), or similar products
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Treatment of service for pre-employment physicals
- Services, laboratory tests, x-rays, and other treatment classified as experimental or investigational, or in the research stage
- Services for examination and/or treatment of strictly non-musculoskeletal disorders
- Massage therapy provided by a massage therapist
- Vocational rehabilitation
- Thermography
- Air conditioners, air purifiers, mattresses, supplies or any other similar devices or appliances
- Transportation costs including local ambulance charges
- Education programs, non-medical self-care, or self-help training, or any related diagnostic testing
- Any treatment or service caused by or arising out of the course of employment or covered under any public liability insurance
- MRI, CAT scans, bone scans, nuclear radiology, and/or other types of diagnostic radiology, other than plain film studies
- Hospitalization, anesthesia, manipulation under anesthesia, or other related services

Acupuncture and Chiropractic Services (Optional Benefits)

Benefit Limitations

- Refer to the member's EOC for benefit details including the copayment and if the member has chiropractic only, or chiropractic and acupuncture combined, or chiropractic and acupuncture separate, and the maximum number of annual visits or call ASH Plans at (800) 678-9133
- Chiropractic appliances are covered up to a maximum of $50.00 in a calendar year as authorized by ASH Plans
- Acupuncture services are limited to neuromusculoskeletal disorders, nausea, and pain as authorized by ASH Plans
- Chiropractic services are limited to neuromusculoskeletal disorders of the spine, neck, and joints

Exceptions

Emergency services by a non-ASH Group provider will be covered. Under certain circumstances in California counties without ASH Group participating providers, other services by non-ASH Group providers may be covered as well.

Examples of Covered Services

- Initial examination and office visits
- Acupuncture services for carpal tunnel syndrome or tennis elbow
- Acupuncture services for headaches
- Acupuncture services for menstrual cramps
- Acupuncture services for osteoarthritis or stroke rehabilitation
- Spinal manipulation or adjustments
- Adjunctive therapy
- Radiology procedures involving the spine and extremities
- Chiropractic appliances

Acupuncture and Chiropractic Services (Optional Benefits)

Examples of Non-Covered Services

- Vitamins, minerals, nutritional supplements (including herbal supplements)
- Acupuncture treatment for asthma or smoking addiction
- Treatment for cancer
- Hypnotherapy
- Diagnostic scanning (MRI or CAT scans) and diagnostic ultrasound

References

Combined Evidence of Coverage and Disclosure Form

HMO Access+ Evidence of Coverage

Local Access+ HMO Evidence of Coverage

Allergy Testing and Immunotherapy

Benefit Coverage

Physician office visits for the purpose of routine allergy testing and treatment, including allergy immunotherapy and allergy serum (antigens), are covered.

Copayment

See the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

The forms of allergy testing and treatment excluded by Blue Shield Medical Policy. (See Examples of Non-Covered Services.)

Examples of Covered Services

- Allergy testing/skin testing
- Immunotherapy (excluding antigen) – CPT code for office visit; serum billed separately with its own CPT code.
- Immunotherapy (including antigen) – office visit copay applies.
- Allergy serum (also called allergy vaccine, antigen, or extract) – CPT code for serum copay (50% of allowed charges); office visit charged separately.
- Immuno-peroxidase (IP testing)
- Fluorescent allergosorbent test (FAST)
- Modified allergosorbent test (MAST)
- Radioallergosorbent test (RAST)
- Food allergy testing
- Respiratory emulsion therapy
- Skin end point titration
- Smear of nasal secretions
- Sputum exam
- Total eosinophil count
- Total gamma globulins

Allergy Testing and Immunotherapy

Examples of Non-Covered Services

- Non-medically necessary services, including:
  - Serum allergy (screening) testing
  - Sublingual administration of allergy extracts
- Provocative and neutralization testing, subcutaneous and sublingual
- Over-the-counter allergy medications, such as calamine lotion, Benadryl®, hydrocortisone
- Allergy immunization therapy (Urine)
- Bacterial antigens in the treatment of arthritis
- Cytotoxic testing

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Ambulance Services

Benefit Coverage

Medically necessary emergency air and ground transportation is covered to the nearest hospital, when there is an emergency condition present which requires immediate medical intervention at the hospital, or on the way to the hospital.

Transportation from one hospital facility to another hospital facility, rehabilitation facility, or skilled nursing facility is covered when the member's condition is such that transportation by licensed ambulance or psychiatric transport van is medically necessary and prior authorization is obtained.

The basic plan covers ambulance services as follows:

Emergency Ambulance Services

Services are a covered benefit if Blue Shield HMO determines that emergency transportation (surface and air) by licensed ambulance or psychiatric transport van is, or was, required for emergency services to the nearest medical facility which can provide appropriate medical care. Medically necessary ambulance transportation is determined independently of medical necessity criteria for emergency room service.

Emergency ambulance services include those situations where a reasonable person would have believed that a medical emergency existed.

Non-Emergency Ambulance Services

Medically necessary authorized ambulance services (surface and air) to transfer the member from a non-plan hospital to a plan hospital or between plan facilities when in connection with authorized confinement/admission and use of the licensed ambulance or psychiatric transport van is authorized.

Benefits are also available for covered services provided by community paramedicine programs, triage to alternate destination programs, and mobile integrated health programs developed by local Emergency Medical Services (EMS) agencies. Covered services provided by these EMS programs are covered at the participating provider cost share, even if you receive treatment from a non-participating provider.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

Transportation services other than medically necessary ambulance transportation.

Ambulance Services

Benefit Limitations

Payment or denial of ambulance transport resulting from 911 calls will be determined based on medical necessity and a determination of the emergency nature of the services. For example, a reasonable person would believe it to be an emergency, based on the symptoms experienced.

A primary care physician (PCP) authorization for emergency services does not validate medical necessity for emergency transport. Dry run ambulance claims are not payable. This occurs when an ambulance responds to a call and the patient either did not need or refused medical care and/or transport to a hospital.

Paramedic services rendered at the scene where transport was not needed will require medical necessity review.

Examples of Covered Services

- Use of an ambulance in a life-threatening emergency. Examples of a life-threatening emergency include, but not limited to:
    - Heart attack
    - Loss of consciousness
    - Major burns
- Use of ambulance transportation when instructed to do so by emergency response personnel (e.g., police, paramedic, fire department, Coast Guard, etc.) in an emergency situation.
- Medically necessary life support and/or transport received from municipalities.
- Medically necessary transportation when prior authorization has been obtained (e.g., when a member requires professional medical care during a transfer from an acute setting to a skilled nursing facility).
- Air ambulance transportation from foreign countries to the U.S. when Blue Shield Medical Care Solutions authorizes a hospital-to-hospital transfer and determines that commercial airline transportation would be unsafe for the patient.

Examples of Non-Covered Services

- Commercial aircraft
- Taxi
- Wheelchair van, other non-ambulance assisted transportation

Ambulatory Surgeries/Procedures

Benefit Coverage

Services and supplies for certain surgeries or diagnostic procedures performed in an office setting, outpatient hospital setting, or ambulatory surgery center are covered.

Ambulatory surgeries/procedures are divided into the following two categories:

Facility-Based Ambulatory Surgeries/Procedures

Facility-based ambulatory surgeries/procedures should be performed in an ambulatory surgery center or in an acute care facility on an outpatient basis. Surgical diagnostic procedures are identified as facility-based ambulatory surgeries/procedures.

The IPA/medical group is responsible for authorizing facility-based surgeries/procedures, including inpatient services, and providing Blue Shield with the required notification of authorized and denied services. Authorization can only be given if the Ambulatory Surgery Center is a valid entity having the required licensure and/or accreditation in accordance with state and federal laws. The services should only be authorized in a contracted facility unless there are extenuating circumstances. No facility fee is allowed for facility-based ambulatory surgeries/procedures performed in an office setting unless authorized.

Office-Based Ambulatory Surgeries/Procedures

Office-based ambulatory surgeries/procedures should be performed in the physician's office setting unless it is medically necessary that they be performed in a facility setting on an outpatient or inpatient basis. The IPA/medical group is responsible for authorizing office-based surgeries/ procedures and providing Blue Shield with the required notification of such authorization. A list of Office-Based Ambulatory Surgeries/Procedures appears later in this document.

Questions about the appropriate setting for a surgery/procedure should be referred to Blue Shield Medical Care Solutions.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Outpatient Hospital Services/Surgery

Physician – Outpatient/Surgery

Ambulatory Surgeries/Procedures

Benefit Exclusion

Ambulatory surgeries/procedures that are not medically necessary, not appropriately authorized by the IPA/medical group, or excluded by Blue Shield Medical Policy.

Examples of Covered Services

Facility-Based

- Cataract surgery
- Dilation and curettage of uterus (D&C)
- Heart catheterization
- Tubal ligation by laparoscopy
- Esophagogastroduodenoscopy

Office-Based

- Amniocentesis
- Removal of IUD
- Cryotherapy of warts

Examples of Non-Covered Services

- Cosmetic procedures

References

Blue Shield HMO IPA/Medical Group Procedures Manual

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Office-Based Ambulatory Surgeries/Procedures

CPT	DESCRIPTION
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)

CPT	DESCRIPTION
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20560	Ndl insert w/o inj 1 or 2 muscles
20561	Ndl insert w/o inj 3 or more muscles
20600	Drain/inject, joint/bursa
20604	Drain/inject, joint/bursa w/US
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us

CPT	DESCRIPTION
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst
20615	Treatment of bone cyst
20950	Fluid pressure, muscle
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast
29010	Application of body cast
29015	Application of body cast
29035	Application of body cast
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast

CPT	DESCRIPTION
29710	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast
29740	Wedging of cast
29750	Wedging of clubfoot cast
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31242	Nasal/Sinus ndsc dstrj rf ablation
31243	Nasal/Sinus ndsc dstrj cryoablatoin
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
42975	Dise eval slp do brth flx dx
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure

CPT	DESCRIPTION
51100	Drain bladder by needle
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
52284	Cysto w/dilat rx balo cath
53454	Tprnl balo cntnc dev adjmt
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
58580	Transcervical ablation uterine fibroid
59020	Fetal contract stress test
59025	Fetal non-stress test

CPT	DESCRIPTION
59050	Fetal monitor w/report
59051	Fetal monitor/interpret only
59200	Insert cervical dilator
59412	Antepartum manipulation
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital
64445	N block inj, sciatic, sng
64454	Inj Aa&/strd Genicular Nrv w/img
64455	N block inj, plantar digit
64596	Insj/rplcmt perq eltrd ra pn/int instim
64611	Chemodenerv saliv glands
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle larynx EMG
64624	Dest neurolytic agt genicular w/img
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli

CPT	DESCRIPTION
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rpt
0379T	Vis field assmnt tech supt
0419T	Dstrj Neurofibroma xtnsv
0420T	Dstrj Neurofibroma xtnsv
0474T	Insj aqueous drg dev io rsvr
0529T	Interrog Dev Eval IIMS IP
0530T	Removal Complete IIMS
0563T	Evac Meibomian gld heat bilat
0566T	Autol cell impt adps tiss njx knee
0588T	Rev or rem isdns post tibial nrv
A4252	Blood ketone test or strip
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Blood and Blood Plasma

Benefit Coverage

Blood and blood plasma are covered when provided as part of covered and authorized services including inpatient hospital care, ambulatory surgery, and emergency services.

Blood and blood plasma are covered in full whether or not they are replaced.

The blood and blood plasma, administration, and processing (including preparation, storage and transportation) of the blood and blood plasma are covered.

Copayment

See the members' *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage* for member copayments.

Examples of Covered Services

- Autologous blood (The patient's own blood which is frozen and stored prior to need)
- Plasma
- Whole blood

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

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Chemotherapy

Benefit Coverage

Chemotherapy or other drugs used to treat cancer related illnesses is a covered benefit when medically necessary for appropriate treatment of disease or illness and can be provided in a physician's office, facility, or other outpatient or home setting.

Chemotherapy and other drugs used for the treatment of cancer and services require prior authorization.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Inpatient Hospital Services

Outpatient Hospital Services

Chemotherapy/Radiation Therapy

Physician - Outpatient/Office Visit

Benefit Exclusions

- Experimental/investigational chemotherapy drugs or services unless specifically related to an approved Clinical Trial. All Clinical Trials require prior authorization. Prescribed drugs and medicines for outpatient care and over-the-counter medications not requiring a prescription.
- Drugs packaged in combination kits that include other non-prescription products or non-prescription drugs unless the drug is not otherwise available without the non-prescription components.

Chemotherapy

Examples of Covered Services

- FDA-approved chemotherapy drugs

Examples of Non-Covered Services

- Oral or topically self-administered medications (may be available under the *Outpatient Prescription Drug* benefit)
- Laetrile
- Chymotrypsin
- Experimental/Investigational Treatment(s) unless specifically related to an approved Clinical Trial

References

Blue Shield Medical Policy

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

Blue Shield HMO IPA/Medical Group Procedures Manual

Chiropractic Services (Optional Benefit)

Benefit Coverage

Medically necessary chiropractic services, for example, are covered up to 30 visits per calendar year* for routine chiropractic care when provided by an American Specialty Health Group, Inc. (ASH Group) participating provider. An initial examination, chiropractic adjustments, and conjunctive therapy specifically for the treatment of neuromusculoskeletal disorders are covered. Chiropractic x-rays are also covered and must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans).

A referral from the member's Blue Shield HMO Primary Care Physician (PCP) is not required. The ASH Group provider will refer the member to the PCP for evaluation of conditions not related to neuromusculoskeletal disorders and for evaluation of non-covered services such as diagnostic scanning (CAT scans or MRIs).

ASH Plans must determine all subsequent services as medically necessary except the initial examination and emergency services by an ASH Group provider.

One brief re-examination is covered for each treatment program.

* Some plan visit limits may vary. Refer to the members' *Evidence of Coverage (EOC)* for details or call ASH Plans at (800) 678-9133.

Copayment

See the members' *EOC* and *Summary of Benefits and Coverage* for member copayments.

Chiropractic Services (Optional Benefit)

Benefit Exclusions

- Services administered by a chiropractor not in the ASH Group
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Treatment or service for pre-employment physicals
- Services, laboratory tests, x-rays, and other treatment classified as experimental or investigational, or in the research stage
- Services for examination and/or treatment of strictly non-musculoskeletal disorders
- Massage therapy provided by a massage therapist.
- Vocational rehabilitation
- Thermography
- Air conditioners, air purifiers, mattresses, supplies, or any other similar devices or appliances
- Transportation costs including local ambulance charges
- Vitamin, minerals, nutritional supplements, or other similar products
- Education programs, non-medical self-care, or self-help training, or any related diagnostic testing
- Any treatment or service caused by or arising out of the course of employment, or covered under any public liability insurance
- MRI, CAT scans, bone scans, nuclear radiology and/or other types of diagnostic radiology, other than plain film studies
- Hospitalization, anesthesia, manipulation under anesthesia, or other related services

Chiropractic Services (Optional Benefit)

Benefit Limitations

- One examination for each treatment program may be provided by an ASH Plan provider.
- Services are provided up to a maximum of 30 visits per calendar year*
- Chiropractic appliances are covered up to a maximum of $50.00 in a calendar year as authorized by ASH Plans
- One brief re-examination is covered for each treatment program
- Covered services are limited to musculoskeletal disorders of the spine, neck, and joints

* Some plan visit limits may vary. Refer to the members' EOC for details or call ASH Plans at (800) 678-9133.

Exceptions

Emergency services by a non-ASH Group provider will be covered. Under certain circumstances, in California counties without ASH Group participating providers, other services by non-ASH Group providers may be covered as well.

Examples of Covered Services

- Initial examination
- Spinal manipulations or adjustments
- Adjunctive therapy
- Radiology procedures involving the spine and extremities
- Chiropractic appliances

Chiropractic Services (Optional Benefit)

Examples of Non-Covered Services

- Treatment of cancer
- Hypnotherapy
- Diagnostic ultrasound
- Thermography
- Nutritional and digestive supplements
- Vitamins and minerals

References

Supplement to the *Blue Shield HMO Evidence of Coverage for Chiropractic Services.*

Consultations

Benefit Coverage

Consultations with physicians or other qualified licensed health care professionals on a telehealth, inpatient, and outpatient basis for the additional evaluation of a medical condition or for the initial consultation to establish diagnosis are covered.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Office Visits/Consultations/Surgery

Physician-Inpatient

Visits/Consultations

Benefit Exclusion

See the members' benefit limitations.

Benefit Limitations

Services must be referred to by the member's primary care physician (PCP) and authorized by the IPA/medical group. Consultations are not limited as long as they are determined to be medically necessary by the PCP and appropriately referred and authorized, except as excluded.

Exceptions

- See the *HMO Benefit Guideline* for *Second Opinion Consultations*.
- For Access+ consultations, see the *HMO Benefit Guideline* on *Physician Services.*

Consultations

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Physician Services

Second Opinion Consultations

Contact Lenses

Benefit Coverage

Contact lenses are covered only if medically necessary to treat medical eye conditions such as keratoconus, keratitis sicca, or aphakia following cataract surgery when no intraocular lens has been implanted. The following medical necessity criteria are used by Blue Shield HMO to determine coverage:

- Keratoconus when visual acuity cannot be corrected to 20/40 with eyeglasses
- Anisometropia when three (3) diopters or more, provided visual acuity improves to 20/40 in weaker eye
- Astigmatism of three (3) diopters or more
- Aphakia (after cataract surgery), contacts in lieu of glasses
- Myopia when more than 12 diopters
- Hyperopia when more than seven (7) diopters
- Following cataract surgery when no intraocular lens has been implanted

Coverage is provided for medically necessary contact lenses when the member does not have supplemental benefits for vision care through a Blue Shield vision plan (administered by the vision plan administrator (VPA)) or another vision plan for contact lenses.

Contact Lenses

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services

Orthotics, Prosthetics (external)

Benefit Exclusion

Contact lenses needed for routine vision correction, cosmetic purposes, or other purposes not specifically listed above.

Benefit Limitations

Medically necessary contact lenses (except when used as an optical bandage) will not be covered under the Access+ HMO plan if the employer provides supplemental benefits for vision care that cover contact lenses through a Blue Shield vision plan administered by the VPA or another vision plan. There is no coordination of benefits between the health plan and the vision plan for these benefits.

Exceptions

Contact lenses used as medically necessary corneal bandages following a surgical procedure and not used solely for vision correction, when authorized.

CalPERS: Eyeglasses following cataract surgery are a benefit.

Contact Lenses

Examples of Covered Services

Medically necessary contact lenses are covered:

1. Following cataract surgery when no intraocular lens has been implanted.
2. To treat the following eye conditions such as:
    - Keratoconus
    - Keratitis Sicca
    - Aphakia
    - Amblyopia
    - Severe Anisometropia
    - Strabismus

Examples of Non-Covered Services

- All contact lenses used solely for the purpose of routine vision correction, or for cosmetic purposes
- Replacement of contact lenses due to loss
- Contact lenses in lieu of other eyewear
- Accommodative intraocular implants (e.g., Crystalens)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guideline for:

Vision Care – Optional Benefits

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Dental - Blue Shield HMO Plans (DHMO)

Benefit Coverage

Blue Shield of California Dental HMO (DHMO) covers diagnostic and preventive services, restorative services, oral surgery, periodontics, endodontics, prosthetics, and orthodontics.

DHMO plans are administered by Blue Shield's Dental Plan Administrator (DPA). Blue Shield contracts with the Dental Plan Administrator to provide services to members. The Dental Plan Administrator manages all covered services, provided by the Dental Provider or other plan providers, to members in an appropriate manner consistent with the contract. Each member is required to select a Primary Care Dentist within their dental center. The Primary Dental Provider will:

- Help the member to decide on actions to maintain and improve dental health by providing written treatment plans that address the member's dental requirements and needs to include alternative treatment options that better address the member's dental desires and treatment outcomes.
- Provide, coordinate, and direct all necessary covered dental care services.
- Arrange referrals to plan specialists when required, including required prior authorization.
- Authorize emergency services when necessary.

Note: All services must be medically or dentally necessary. The fact that a dentist or other plan provider may prescribe, order, recommend, or approve a service, procedure or dental material does not, in-of-itself, constitute or determine dental necessity even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services which are not dentally or medically necessary to restore the function of the teeth and oral cavity.

Note: Modern dental treatment spans a board continuum from purely dental treatment (fillings, dentures, etc.) to major surgical procedures. In the event there is a question whether or not a specific procedure or treatment falls into the "dental" category or "medical" category, the Blue Shield Dental Director will be the final arbiter (the person who makes the final decision) on what category (dental or medical) the treatment best fits based on the information provided to the Blue Shield Dental Director from the attending dentist.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Coverage *(cont'd.)*

Note: The *Evidence of Coverage*, *DHMO Benefit Guidelines*, and the *Summary of Benefits* are a summary of the Plan benefits and limitations and are not intended nor designed to cover ALL of the various specific plan benefits, dental codes, exclusions, limitations, medical-dental treatment rationale and restrictions (the totality of all utilization guidelines is maintained in the Blue Shield of California Utilization Management Matrix). In the event there is a question if a particular dental treatment or service is a benefit, Blue Shield highly recommends the member instruct their dental provider to request a "pre-authorization" for any anticipated dental treatments from the DPA before beginning any course of expensive dental treatment.

Note: If there is a question as to whether a facility, dentist, or dental specialist is a member of the Member's Provider Network, it is highly recommended the Member call Blue Shield to verify the status of the provider or facility.

The Dental Provider for each member must be located sufficiently close to the member's home or work address to ensure reasonable access to care, as determined by the DPA. A Primary Dental Provider must also be selected for a newborn or child placed for adoption.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

When the member and dentist elect(s) a more complicated or personalized procedure that is more expensive than the covered benefit, the member will be responsible for the copayment of the covered benefit plus the difference between the dentist's usual and customary fee for the covered service and the selected procedure. If no dental service appearing on the schedule of benefits is related to the procedure selected, the service is excluded.

Benefit Exclusions

General Exclusions:

Unless otherwise specifically mentioned elsewhere in the contract, DHMO Dental Plans do not provide benefits with respect to:

- Dental services not appearing on the schedule of benefits. If there is a question if a dental service is a benefit, the Member should request the provider request “pre-authorization” for the service from Blue Shield.
- Any service, procedure, or supply which is received or expenses incurred prior to the patient’s effective date of coverage. For the purpose of this limitation, the date on which a procedure shall be considered to have had expenses incurred is defined as follows:
    - For full dentures or partial dentures: on the date the final impression is taken;
    - For fixed bridges, crowns, inlays, onlays: on the date the teeth are first prepared;
    - For root canal therapy: on the later of the date the pulp chamber opened, or the date canals are explored to the apex;
    - For periodontal surgery: on the date the surgery is actually performed;
    - For all other services: on the date the service is performed.
- Dental treatment previously started under a Dental Plan other than Blue Shield prior to the Member’s eligibility to receive benefits under this Plan (e.g., an unfinished crown or partially completed root canal, incomplete dental implant services, etc.).
- Dental services for cosmetic purposes (e.g., bleaching, veneer facings, crowns; porcelain on molar crowns, minor orthodontic movement of teeth, or bridges and/or dentures).
- Dental services performed in a hospital and/or any related hospital fee(s).
- Treatment to correct congenital and developmental malformations including but not limited to cleft palate/lip, anodontia, mandibular prognathism, retrognathia, overjet/overbite issues, enamel hypoplasia, enamel dysplasia, enamel discolorations, and malocclusions caused by skeletal jaw discrepancies.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- Treatments which, in the professional judgement of the DPA, have a poor prognosis when an alternative treatment with a more favorable prognosis is available. *Note*: For the purpose of this policy, the term "poor prognosis" shall be defined (based on the information provided by the attending dentist) as the inability to control local or systemic factors making periodontal breakdown likely to occur even with comprehensive periodontal treatment and maintenance. In the event there is a disagreement on the prognosis of the teeth/tooth, it shall be the responsibility of the attending dentist to provide the following information to the DPA for evaluation: Age of the patient, probing depths, furcation involvement, mobility, tooth type, and smoking habits (https://www.ncbi.nlm.nih.gov/pmc/).
- Treatment to correct or restore teeth, oral soft tissues, the alveolus, or jaws as the result of naturally occurring attrition or erosion of the oral or dental structures to include atrophy of the jaws from edentulism and/or clenching or grinding of the teeth.
- Reimbursement to the member or another dental office for the cost of services secured from dentists, other than the Dental Provider or other DHMO plan authorized provider ("in-network provider"), except:
    - When such reimbursement is expressly authorized or approved by the DHMO plan; or
    - As cited under the Emergency Services and Emergency Claims provision (thorough documentation must be provided to the DPA). It is insufficient to simply write or send an x-ray for dental treatment provided on an emergency status without appropriate medical-dental documentation on the nature of the emergency.
- Treatment for any condition for which benefits could be recovered under any worker's compensation, accident insurance, occupational disease law or when no claim is made for such benefits.
- Treatment for which payment is made by any governmental agency (e.g., the Veterans Administration, military, Indian Health Service, Denti-Cal, county public health dental clinic, or etc.), including any foreign government.
- Treatment from dentists outside the United States of America except when emergency services are necessary to initially and immediately medically stabilize the oral or dental structures due to accidental injury or trauma to the mouth and associated structures. Pre-accident or pre-trauma radiographs must be submitted for review when making a dental claim of this nature (there are no exceptions to this policy).

Benefit Exclusions *(cont'd.)*

- Temporomandibular Joint (TMJ) disorder or dysfunction to include any referred pain to the jaw joints, trismus, discomfort to the muscles of mastication to include any joint discomfort from using an oral appliance to manage obstructive sleep apnea or from/ during active or passive orthodontic treatment.
- Any oral-myofascial pain, headaches, cervicalgia, head position-postural issues, or migraines as the result of or associated with clenching, grinding of teeth (bruxism), orthodontic treatment, sudden traumatic insult to the jaws or joints, or from the use of an oral appliance to manage obstructive sleep apnea.
- Dental implants, transplants, implant abutments, ridge augmentations, bone grafts to the dental implant site or to the implant, periodontal procedures to the implant, or the implant site or teeth adjacent to the implant site, surgical implant guides, temporary crowns on implants as part of the immediate loading technique for an implant, diagnostic casts or working casts, 3-dimensional radiographs, rendering of the 3-dimensional radiographs, or removal of implants.
- The restoration of a dental implant body that was not approved or authorized by Blue Shield.
- Dental implants that the DPA believes will be used to support a denture or a fixed dental bridge.

  Note: Some Dental Plans provide a dental implant benefit and may be excluded from the policy above.
- General anesthesia including intravenous, conscious (oral route) and inhalation sedation (any medications used to alter mood, the perception of reality, calms patient anxiety will be referred to as "sedation") is considered medically necessary when its use is (a) in accordance with generally accepted professional standards, (b) due to the existence of a specific medical or developmental condition and (c) not furnished primarily for the convenience of the patient, the parents, the attending dentist or other provider, and not provided because of dental phobias, combativeness, and non-cooperation of the patient (e.g., general anesthesia requests are not a benefit because the child requires "lots of dental treatment" and it is more convenient to place the child to sleep and do all the treatments in one appointment). General anesthesia is not a benefit simply because the parents cannot "afford to take time off from work" to bring their child in for their dental appointments. General anesthesia is not a benefit because the provider will not or is unwilling to make multiple treatment appointments for the child.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

Note: The site/office/physical location where general anesthesia is administered must meet the minimal requirements/regulations set-forth for the administration of a general anesthetic in an outpatient facility and have the proper license and/or permit allowing for such procedures at the office or facility from the California Dental Board (this is a State of California Regulation). The use of a mobile dental anesthesia service does not meet this requirement.

Note: Written documentation of the medical condition necessitating use of general anesthesia or intravenous or inhalation sedation must be provided by a physician (M.D. or D.O.) to the DPA or DHMO Plan. Written documentation on the medical condition of a patient from a dentist or dentist- anesthesiologist requesting medically necessary sedation services are not acceptable.

Note: Patient apprehension or patient anxiety will not constitute medical necessity when requesting intravenous sedation, general anesthesia, or inhalation analgesia (nitrous oxide gas).

Note: A mental disability is an acceptable medical condition to justify use of general anesthesia. Autism is not necessarily a medical condition requiring the use of a general anesthetic for routine dental procedures. Documentation of a patient's degree of autism must come from the patient's medical doctor addressing the level of patient cooperation and not from a dentist or parents.

Note: The DHMO plan reserves the right to review the use of general anesthesia to determine dental or medical necessity.

Note: General anesthesia, intravenous sedation, etc. is limited to a total of 30 minutes per treatment session ("frequency limitation") regardless of the degree of difficulty of the dental procedure or the total length of time needed to complete the dental procedures.

- Dental prophylaxis more than twice per calendar year.
- Precious metals (gold and gold alloy) will be charged to the patient at the dentist's cost.
- The use of titanium metal or titanium alloy for cast metal restorations will be charged to the patient at the dentist's cost for the material.
- Replacement of an existing, lost, or stolen prosthetic appliance more than once in the five-year period commencing on the date the appliance was last supplied (delivered to the patient), whether under this contract or any prior dental care policy, unless for dental necessity.

Benefit Exclusions *(cont'd.)*

- Removal of 3rd molar (wisdom teeth) other than for dental necessity (pain, swelling, infection, causing decay to adjacent tooth). Removal of asymptomatic impacted, partially, or fully erupted 3rd impacted molars because of possibility of dental crowding or for pre or post orthodontic treatment may be considered not medically necessary by the DPA.
- Referral of a dependent child age 6 and over to a pedodontist (specialist in children's dentistry), unless for medical or dental necessity, or the child is uncooperative and will not allow the general dentist to treat after two attempts (thorough documentation must be provided to the DPA to include treatment attempts, behavioral management techniques employed, and level of uncooperativeness; there are no exceptions to this policy). All such exceptions must be approved by the DPA.
- Treatment as a result of accidental injury shall only be covered secondary to medical insurance, or any other primary insurance with accident coverage (thorough documentation must be provided to the DPA to include pre- and post-accident photographs and radiographs).
- Services, procedures, or supplies which are not reasonably necessary, medically and dentally, for the care and maintenance of the member's dental condition according to the broadly accepted standards of professional care in the United States or Canada, or which are experimental or investigational in nature or which do not have consistent-uniform professional endorsement.
- Dental treatment that does not meet Plan "utilization" guidelines (Blue Shield of California Utilization Management Matrix), frequency limitations, and/or when the mandatory "waiting period" for specified dental services have not been met.
- Any manner of prosthesis used to prevent a temporomandibular joint problem from developing (e.g., such as "morning aligners" used in conjunction with oral appliance to manage obstructive sleep apnea or during any phase of orthodontic treatment).
- Any manner of oral or facial prosthesis constructed to mask facial or jaw deformities/defects as the result of surgery, congenital, or developmental issues.
- Any dental treatment not provided by a California Dental Board licensed dentist, or a dentist not licensed to practice in the United States of America or Canada (except for emergency dental treatment to medically stabilize teeth and associated oral structures when the member is outside the United States; thorough documentation must be provided for payment).

Dental - Blue Shield HMO Plans (DHMO)

Benefit Exclusions *(cont'd.)*

- Any self- administered, self-prescribed dental treatment, dental therapies, or oral treatments (drug store purchased "nightguards, teething medications, self-administered teeth bleaching kits, self-administered orthodontic appliances, snore guards, appliances for obstructive sleep apnea, dental restoration kits, medications prescribed by a medical doctor for a dental problem, etc.) unless written prior approval has been obtained from the DPA.

Orthodontic Exclusions:

- Treatment already "in-progress" (after banding) at inception of eligibility. "After banding" is defined as the initial treatment taken by an orthodontist to prepare and place orthodontic bands, brackets, ligatures and etc. on a patient's teeth to include the placement of orthodontic separators.
- Surgical orthodontics incidental to orthodontic treatment, to include the extraction of non-symptomatic teeth (sometimes referred to as "serial extractions" of pre-molars and molars), the surgical placement of implant anchors, "bollard plates" to "distract" the growth or trajectory (direction) of the upper or lower jaws, exposing teeth, exposing the crowns of teeth to aid in the placement of orthodontic brackets, removing remaining deciduous teeth in the dental arches, up-righting a tooth or teeth, etc. The DPA will make the final determination on what constitutes "surgical orthodontics."
- Surgically assisted rapid palatal expansion (SARPE) procedures to treat transverse jaw issues or a high-narrow palate if the maxilla does not meet the criteria outlined under the Orthognathic Surgery Medical Policy of Blue Shield for transverse discrepancies.
- Surgical treatment to expose impacted teeth, surgical placement of tooth collars, or procedures to direct the eruption of teeth.
- Treatment to remove orthodontic cement from teeth, discoloration of teeth and periodontal or gingival surgery to expose the clinical crown(s) of teeth for the purpose of attaching an orthodontic bracket to the tooth.
- Treatment for myofunctional or myofascial therapy as part of an orthodontic treatment program.
- Changes in treatment necessitated by an accident.
- Re-treatment of orthodontic cases when the DPA concurs with the professional judgment of the attending dentist of a poor prognosis.
- Relapse of the occlusion or movement of teeth to their original position after primary orthodontic treatment is completed.
- Treatment for temporomandibular joint (TMJ) disorder (or dysfunction), bruxism or clenching of the teeth as the result of orthodontic treatment.

Benefit Exclusions *(cont'd.)*

- Special orthodontic appliances, including but not limited to, lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic.
- X-rays for orthodontic purposes (to include full mouth screen, 3-dimensional radiographs, rendering of 3-dimensionl images, and cephalometrics) - Dental - Blue Shield HMO Plans (DHMO).
- Replacement of lost, broken, or stolen appliances (e.g., orthodontic retainers) or repair of the same if broken.
- Charges for records fee to include but not limited to cephalometric tracing, photos, models, radiographs (initial, progressive, and final, as deemed necessary), 3-dimensional cone beam computerized tomography (CBCT), and computerized-digital modeling of the jaws and face.
- Interceptive orthodontics or "preventive-orthodontics" of any sort (sometimes referred to as "Phase One" orthodontic treatment) to the deciduous and/or transitional dentition.
- Orthodontic treatment for patients with deciduous and/or transitional dentition retained in the patient's mouth.
- Orthodontic treatment using a removable or fixed orthodontic appliance to achieve a limited cosmetic result (for example moving a single anterior tooth because it is positioned too far back in the mouth).
- Charges for broken or missed appointments.
- Appliances constructed to prevent a future malocclusion from developing. For example, a "thumb-sucking" device to prevent the patient from sucking the thumb and causing flaring of the front teeth.
- Treatment which is received in more than one course of treatment, or which is not received in consecutive months or treatment exceeding 24 months (for example, stopping approved orthodontic treatment then later returning to re-start orthodontic treatment).
- Any self-prescribed orthodontic treatment (orthodontic aligners that can be purchased from the Internet or a pharmacy) unless prior approval has been obtained from the DPA.

Benefit Limitations

Prosthodontics: Existing, lost, or stolen prosthetic devices will be replaced once in the five-year period commencing on the date the appliance was last supplied, whether under this contract or any prior dental care policy, unless for dental necessity. An "immediate," "remote," "temporary," or "provisional" dentures are viewed as a "denture" (partial, complete, full) and subject to the 5-year replacement guidelines. For example, if a patient elects to have an immediate

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

denture made by the attending dentist and then returns to have the immediate denture replaced with a remote denture, Blue Shield will view the immediate denture as the patient's final denture and there will be no replacement of the denture with another denture (remote denture) prior to the five year frequency limitation.

Note: Preparing asymptomatic teeth to support a dental prosthesis is not a benefit. For example, preparing two asymptomatic teeth for crowns to support a fixed dental bridge is not a benefit. In this example, the DPA will authorize a "pontic" to restore the empty space and the Member will be responsible for paying the cost of the two abutment crowns if a fixed bridge solution is pursued. Alternatively, an appropriate partial denture to restore the empty tooth space will be approved.

Partial Dentures: If a satisfactory result can be achieved by a standard cast chrome-resin partial denture, but the member and dentist select a more complicated precision appliance, or the use of special materials, or "flexible-esthetic" materials (e.g., "Valplast" partial dentures), the financial obligation of the DHMO plan will be for those procedures necessary to eliminate oral disease and restore missing teeth in the most cost efficient manner. The balance of the cost will remain the responsibility of the member.

Complete ("full") Dentures: If a satisfactory result can be achieved through the utilization of standard procedures and materials, and the member and the Dental Provider select a personalized appliance or one involving specialized techniques, or the use of special materials, or "flexible-esthetic" materials (e.g., "Valplast" partial dentures), the financial obligation of the DHMO plan will be any of the procedures necessary to eliminate oral disease and restore missing teeth in the most cost efficient manner. The balance of the cost will remain the responsibility of the member.

Dental prophylaxis: Dental prophylaxis (dental cleanings) are available not more than once in any period of 6 consecutive months. Prophylaxes performed in conjunction with fluoridation or any other periodontal procedure (e.g., gross debridement of tartar from teeth) shall be considered a dental prophylaxis for the purpose of applying this limitation. A dental prophylaxis should not be confused with a periodontal prophylaxis (also known as a "deep cleaning" or "subgingival curettage and root planning" procedure) which has a different treatment goal. The treatment goal of a dental prophylaxis is the mechanical removal of oral-dental debris, tartar (calculus), and stains on the teeth that project above the gum line primarily for cosmetic considerations; it is usually performed without the use of an anesthetic.

Endodontics: Root canal (endodontic) treatment includes pulp capping; therapeutic pulpotomy on deciduous teeth only (in addition to restoration); apexification; root canals on permanent teeth only, including pulpotomy or other palliative treatment and necessary x-rays, and apicoectomy (including apical curettage), but excluding the final restoration of the tooth. Documentation

Benefit Limitations *(cont'd.)*

requires the submission of pre- and post-operative radiographs clearly showing the apex of the treated tooth. The endodontic filling must meet current endodontic treatment guidelines (a three-dimensional root canal filling that is +/- 1.5 mm of the apex per UCSF-School of Dentistry Guidelines).

Palliative: This is emergency treatment for immediate relief of acute, intractable (severe) oral or tooth pain or the medical stabilization of the teeth or oral structures (not the definitive treatment or restoration of the dentition). For example, if a cusp is fractured on a tooth and there are "sharp edges that lacerate the soft tissues of the mouth, the "palliative" treatment is to smooth off the sharp edges of the tooth, not requesting a crown for the tooth (this is definitive treatment). Documentation requires submission of necessary pre- and post-radiographs and written documentation.

Periodontics: Periodontal (gum) treatment is available to treat emergency periodontal problems, periodontal abscess, and acute/chronic periodontitis.; Treatments include root planning (not dental prophylaxis); subgingival curettage, debridement, gingival and osseous surgery (including post-surgical visits). All periodontal surgery must be medically or dentally necessary and must meet Blue Shield guidelines of gingival pocket depths, root exposure, jawbone recession around the teeth, and a fair to good long-term prognosis. There must be radiographic evidence that there is sufficient exposed root surfaces and root calculus to accomplish the treatment goals associated with "root planning" of the roots of the tooth/teeth. A "periodontal prophylaxis" ("deep cleaning" or subgingival curettage-root planning) is limited to once in 24 months per quadrant of teeth. Periodontal prophylaxis should not be confused with routine "dental prophylaxis" or "dental cleaning" which has a very limited "cosmetic" treatment goal.

Note: The so-called "deep cleaning" (subgingival curettage and root planning or periodontal prophylaxis) is considered a definitive surgical treatment modality for moderate to severe periodontal conditions ("Community Periodontal Index and Treatment Needs" or CPITN levels III, IV). It is recommended the member direct the participating dentist to obtain pre-certification for such a procedure by submitting a full set of current radiographs, bitewing radiographs, a complete periodontal pocket charting and any intra-oral photographs, as needed, to document the dental necessity for a "deep cleaning" to the DPA. Per utilization management guidelines, only two quadrants of the mouth can be treated in one (1) appointment, and a local anesthesia must be utilized. For a "deep cleaning" to be authorized, the DPA will determine if there are periodontal pockets greater than four (4) mm, there are sufficiently exposed root surfaces of the teeth to allow for the planning of the root surfaces per the code definition and if there is radiographic calculus visible on the root surfaces. A deep cleaning should not be confused with a "dental cleaning (dental prophylaxis)." The treatment goals of a "dental cleaning" are to remove stains and supragingival tartar (calculus) from the teeth primarily for cosmetic considerations and not necessarily to treat "gum disease" (i.e., a dental cleaning is for a CPITN 0, I, II). If the attending

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

dentist makes a diagnose the member has "healthy gums," a "deep cleaning" is not needed, and payment will be denied.

Note: Gum (soft tissue) surgery to cover exposed roots, exposed margins of crowns, implant screws, etc. are generally considered cosmetic procedures and therefore are generally not a benefit of the Dental Plan.

Oral Surgery: Extractions; removal of symptomatic (painful, infected) impacted teeth (not for any orthodontic considerations), radical excision of small (to 1.25 cm) non-malignant lesions; other surgical procedures; includes local anesthesia and routine pre- and post-operative care. Removal of deciduous teeth that are within 6 months of natural exfoliation are not a covered benefit (adjudication by the Dental Plan Administrator). All oral surgery must be medically necessary. All ancillary procedures associated with the initial surgery are considered integral to the surgery and not separate billable procedures (sutures, follow-up treatments, removal of sutures, treatment for surgical complications, insertion of drains, prescriptions, bone fillers, post treatment materials, local anesthesia, etc.).

Note: Bone grafts to fill-in the empty tooth socket after tooth removal must be medically necessary. Bone grafts do not accelerate tooth socket healing, does not make the healing more comfortable, and does not necessarily prevent the atrophy of the edentulous space.

Note: Certain routine oral surgery procedures to include extractions of teeth have specific limitations to include age limitations per the Blue Shield of California (Blue Shield) Utilization Guidelines. Before having any oral surgical procedures and/or extractions performed, the provider (and member) is strongly advised to request pre-authorization of any oral surgery procedures. Failure to obtain a pre-authorization for any oral surgery or extraction procedures from Blue Shield will result in the strict adjudication of the surgical procedure(s) per Blue Shield Utilization Guidelines (sometimes referred to as the Blue Shield "Utilization Management Matrix").

Restorative Dentistry ("fillings"): Amalgam restorations and synthetic restorations (e.g., porcelain filling, plastic filling, and composite filling).

Note: Stainless steel crowns are used when the tooth cannot be restored with a direct filling material (stainless steel crowns, when properly prepared, are considered permanent restorations per the United States Department of Veterans Administration and subject to the 5 (five) year frequency limitations).

Orthodontic Services: If a particular Dental Plan provides for "medically necessary" orthodontics, the Member must score "26" on the State of California Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet (DC016) or have an "automatically qualifying" condition (clinical documentation to include radiographs and photographs must be provided for review) to be eligible for orthodontic care.

Benefit Limitations *(cont'd.)*

Waiting Period: A request to waive the mandatory "waiting period" for a bonified dental emergency and/or when there is acute, intractable (severe) dental or oral pain may be requested when the provider submits clinical information as to the nature of the dental or oral problem (clinical note written on office letterhead, radiographs, intra-oral photographs, etc.) and the reason why such a treatment waiver is justified. A member calling a "customer service representative" stating that they are "in pain," is insufficient clinical information to consider waiving the mandatory "waiting period" for a particular dental service. The treatment goal, when waiving the mandatory "waiting period" for a particular dental procedure, is the immediate relief of pain or to provide emergency dental services to medically or dentally stabilize an emergency condition; it is not necessarily to restore the dentition or to provide definitive treatment. Requests to waive the waiting period for crowns, fillings, gum surgery, orthodontic care, etc. will be denied.

Indirect Restorations: Non-precious metal crowns are generally specified for posterior teeth; porcelain fused to nonprecious metal restorations (crowns) are generally reserved for anterior teeth or when dental esthetics is a consideration. For crowns, a five-year frequency replacement period will start from the date the existing crown was last seated on the tooth or supplied, whether under this contract or under any prior dental care policy or Plan and must be dentally/medically necessary. Full ceramic, porcelain, ceramic-porcelain crowns are considered cosmetic procedures for anterior and posterior teeth; reimbursement will be at the same level as the appropriate metal or porcelain-non-precious metal crown for the tooth. The balance of the cost for such crowns will remain the responsibility of the member.

Note: Cast "inlays" (metal, ceramic, resin) will be reimbursed for the equivalent direct restoration ("fillings").

Note: Core build-up of the tooth is a benefit when used to increase the surface area of the tooth to retain a dental crown. For the purpose of this Plan, a "core" build-up is not defined as a procedure to fill-in undercuts in the crown preparation or fill-in small holes or gaps in the dental crown preparation. Core build-ups should not be confused with a "pulp-capping" procedure; in this case a sedative dental material is placed in a tooth when there is a pulpal exposure or the possibility of a pulpal exposure.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

Direct Restorations ("fillings"): Amalgam material is generally specified to restore posterior teeth; composite or plastic materials are used to restore anterior teeth. Judgement for materials used will be between the Member and the Dental Provider providing the covered service. The use of composite or plastic materials on posterior teeth will be paid at the same level as the comparable amalgam restoration; the balance of the cost will remain the responsibility of the member. If the Member's specific Dental Plan provides for posterior composite fillings as a benefit, then the DPA will not substitute the "alternative benefit" of an amalgam filling for a posterior tooth.

Note: Direct dental restorations are dental materials placed directly into a tooth preparation usually after removal of pathology (dental caries) or a tooth is to be restored due to an insult (e.g., fracture). Typical direct fillings materials are silver amalgam, resin fillings (composites), various types of dental cements, and gold foil. In most Blue Shield Dental Plans, silver amalgam is specified for posterior teeth (molars and premolars). Anterior teeth are usually restored with a resin material ("white fillings"). Some Blue Shield plans do not specify the type of dental filling material to be used to restore teeth. If there is a question as to the type of filling materials specified for a tooth, the provider is encouraged to request a pre-authorization of their treatment plan for their patient. Generally, resin fillings are expected to remain serviceable for 18 months from initial installation. Silver amalgams are expected to remain serviceable for 48 months after they are installed.

Note: Pulp capping and basing materials are integral and incidental to all direct filling procedures. They are not considered "core build-up" procedures.

Note: The term "serviceable" as used in the forementioned policy is defined as: No cracking or fractures of the dental material and no tooth-dental material voids. Discolored fillings, fillings with worn anatomy do not make a filling unserviceable.

Full Mouth Rehabilitation: If the member and the attending dentist select a course of full mouth rehabilitation, the obligation of the DHMO plan will be to cover only those benefits appropriate to those procedures necessary to eliminate oral disease and replace missing teeth in the most cost-efficient manner. The balance of the treatment, including costs to increase vertical dimension of the occlusion, improve esthetics or cosmetics, or to restore tooth loss by attrition or erosion, will remain the responsibility of the member.

Benefit Limitations *(cont'd.)*

Pedodontics: Referral of dependent children to a children's dentist (pedodontist) will be covered by the DHMO plan for children up to, but not beyond 6 years old, with prior approval. Benefits are not applicable for pediatric dental care provided by a plan specialist for children age 6 and over unless for clinically documented dental or medical necessity, or the child will not allow the general dentist to treat after two attempts (the provider must provide thorough clinical documentation, not just a note that states the "patient is uncooperative"). All such exceptions must be approved by the DPA (the DPA will adjudicate the treatment request for pediatric dental specialist services based on the training and reasonable treatment expectations of the scope of practice provided by general dentists practicing in the United States and Canada).

Note: Requests to obtain treatment from an "out-of-network" pediatric (or any) dental specialist because of personality or logistical issues (i.e., the parents do not "like" the "in-network" pediatric dental specialist or because the "drive is too far" to the "in-network" specialist) are not considered sufficient clinical rationale to allow the member to request services of a specialist outside the network.

Implants: Single cylinder implants are a benefit only when Plan criteria are met. Not a benefit are implants used to directly or indirectly support dentures, implants used as an abutment for a fixed dental bridge, when there are empty (edentulous) teeth spaces on both sides of the same dental arch ("bilateral edentulous spaces"), lower anterior teeth (teeth 22, 23, 24, 25, 26, 27), second molars (teeth 2, 15, 18, 31), third molars (teeth 1, 16, 17 and 32), when there is no opposing tooth/teeth, the tooth space is too small to accommodate a normal size tooth, and when the implant is not the initial replacement for a missing tooth. Depending on the Plan, the abutment (the metal screw that goes into the implant screw that supports the crown) for an implant is considered an integral part of the implant screw and not a separate billable item or procedure. Implant procedures such as mounting diagnostic casts on an articulator, special implant surgical guides, uncovering the implant, temporary crowns utilized in the "immediate loading" technique, temporary appliances to cosmetically cover a missing tooth while the implant heals, special manipulation or renderings of radiographs, extra or intra oral photographs, and three-dimensional radiographs are generally not a benefit of this Plan.

Dental - Blue Shield HMO Plans (DHMO)

Benefit Limitations *(cont'd.)*

Emergency Claims: The DHMO plan's liability for emergency services rendered outside of the service area will be limited to $50 in palliative treatment services only. If emergency services outside of the service area were received and expenses were incurred by the member, the member must submit a complete claim with the emergency service record, to include pre-accident or pre-trauma radiographs, (a copy of the dentist's bill) for payment to the DPA within one year after the treatment date. Claims should be sent to:

Blue Shield of California
P.O. Box 30567
Salt Lake City, UT 84130-0567

If the claim is not submitted within this period, the DHMO plan will not pay for those emergency services unless the claim was submitted as soon as reasonably possible as determined by the plan. If the services are not pre-authorized, the DPA will review the claim retrospectively.

References

Combined Evidence of Coverage and Disclosure Form Blue Shield of California Dental HMO Supplement.

Blue Shield of California Utilization Management Matrix

Diabetes Care

Benefit Coverage

The following medically necessary services for the treatment and management of diabetes and diabetes-related complications are covered when authorized:

- Diabetic equipment, supplies, and devices, including glucometers (See list of covered items in Examples of Covered Services.)
- Professional office visits for examination and diagnosis, including specialist office visits, consultations, and office surgery.
- Diabetic outpatient self-management training, education, and medical nutrition therapy necessary to enable the member to properly use covered equipment, supplies, and medications.
- Hospital outpatient care for services and supplies for treatments, diagnostic tests, emergency care, surgeries, and procedures performed in a hospital outpatient setting when appropriately authorized.
- Inpatient care for services customarily furnished by a hospital when appropriately authorized.
- Drugs and supplies (insulin, glucagon, disposable insulin needles and syringes, pen delivery systems, diabetic testing supplies including lancets, lancet puncture devices, and blood and urine testing strips and test tablets). For glucometers obtained at the pharmacy, coverage is limited to specific manufacturer brands. Preferred blood glucose test strips do not require prior authorization.

  Note: These drugs and supplies are covered by the Outpatient Prescription Drug benefit. No prescription is required by law for pen delivery systems (prior authorization required) or diabetic supplies; however, in order to be covered by the Outpatient Prescription Drug benefit, the member's physician must order them, and they must be processed by a pharmacy. For plans without an Outpatient Prescription Drug benefit, diabetic supplies and equipment are covered as basic plan benefits. However, insulin, prescription medications for treatment of diabetes, and glucagon are not covered unless the plan has Outpatient Prescription Drug coverage.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Diabetes Care

Benefit Exclusion

- Eyewear (even if it is designed to assist the visually impaired diabetic with proper dosing of insulin).
- Video-assisted visual aid devices.
- Routine foot care (see exceptions under covered services).

Examples of Covered Services

- Diabetic outpatient self-management training, education, and medical nutrition therapy necessary to enable the member to properly use covered equipment, supplies, and medications.
- Podiatric footwear and devices to prevent or treat diabetes-related complications and medically necessary foot care, with the exception of items listed under exclusion and limitations (such as, corn paring or excision, callus treatment, toenail trimming, etc. that is not medically necessary).
- Visual aids (excluding eyewear) needed to assist the visually impaired when measuring (or dosing) their own insulin (excluding video-assisted devices).
- When authorized, blood glucose monitors, including continuous blood glucose monitors and those designed to help the visually impaired, and all related necessary supplies for self-management of diabetes.
- Insulin pens, syringes, pumps, and all related necessary supplies.
- Dosing devices such as dosing devices for syringes, insulin gauges, measuring devices, insulin-measuring devices, needle guides and syringe/vial holders, syringe loading devices with magnifier.
- Magnifiers such as aspherical magnifiers with stand, dome magnifiers, fixed stand magnifiers, folding pocket magnifiers, hand-held magnifiers, illuminated magnifiers, insulin syringe magnifiers, magnifying lamps or rules, visor magnifiers.

Examples of Non-Covered Services

- Eyewear (even if it is designed to assist the visually impaired diabetic with proper dosing of insulin).
- Binoculars and other visual aid devices that only assist with distance vision.
- Video-assisted visual aid devices.

References

Evidence of Coverage

HMO Benefit Guidelines for:

Durable Medical Equipment (DME)

Orthoses

Blue Shield HMO IPA/Medical Group Procedures Manual

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Dialysis Benefits

Benefit Coverage

Inpatient and outpatient dialysis is covered until Medicare assumes primary coverage. When Medicare assumes primary coverage, Blue Shield HMO pays as secondary.

Benefits are available for dialysis services at a freestanding dialysis center, in the outpatient department of a hospital, in a physician office setting, or in the member's home.

For group members entitled to Medicare solely on the basis of renal disease there is a 30-to-33-month coordination period. During this time Medicare is the secondary payor. For IFP members, Medicare is primary after the initial three-month waiting period, when applied.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Outpatient Hospital Services

Renal dialysis

Hemodialysis

Peritoneal dialysis

Self-management training for home dialysis

Inpatient Hospital Services

Dialysis services and supplies

Benefit Exclusions

- Comfort, convenience, or luxury equipment.
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Benefit Limitations

For members who qualify for dialysis benefits under the Medicare program, Medicare is the primary payor and Blue Shield HMO is the secondary payor.

Exceptions

Not applicable.

Dialysis Benefits

Examples of Covered Services

- Outpatient dialysis performed in freestanding dialysis center, outpatient department of a hospital or physician office setting and is authorized by the member's primary care physician (PCP).
- Inpatient dialysis as authorized by the member's PCP and Blue Shield HMO.
- Dialysis outside a member's service area when temporarily traveling **only** when authorized by the PCP or Blue Shield HMO *(reference HMO Benefit Guideline for Out-of-Area Services)*.

Examples of Non-Covered Services

- Comfort, convenience, or luxury equipment.
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

References

IFP Evidence of Coverage and Disclosure Form

Evidence of Coverage

Blue Shield HMO IPA/Medical Group Procedures Manual

HMO Benefit Guidelines for*:*

BlueCard

Out-of-Area Services

Durable Medical Equipment (DME)

Benefit Coverage

Medically necessary and authorized durable medical equipment (DME) (also known as home medical equipment (HME)) and supplies needed to operate DME, oxygen and its administration, ostomy supplies, and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function are covered. Visual aids (excluding eyewear) needed to assist the visually impaired when measuring (or dosing) their own insulin are also covered. DME is defined as:

> *Equipment designed for repeated use, which is medically necessary to treat illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition.*

Delivery charges are covered. Rental of DME is covered up to the purchase price unless the HMO authorizes purchase of the equipment instead of rental.

If an emergency room visit is authorized, no additional authorization is needed for the related DME given to the member at the emergency room. For instance, if a member has a fracture and is given crutches, a separate authorization for the crutches is not needed. The DME given must match services on the ER claim.

Out of state DME claims should be processed by the local plan as with any out of state service. However, the local plan is not necessarily the state where the supplier resides. The local plan is defined as the plan in whose service area the ancillary services are rendered. For DME, the local plan would be the plan in whose service area the equipment was shipped to or purchased at a retail store.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services

Medical Supplies

Durable Medical Equipment (DME)/Prosthetics

Orthotics

Diabetes Care

Durable Medical Equipment (DME)

Benefit Exclusions

The following services are excluded:

- Comfort items
- Over-the-counter disposable medical supplies
- Environmental control and hygienic equipment
- Exercise equipment
- Devices to perform medical tests on blood or other body substances in the home.
- Home monitoring equipment and monitoring supplies (see Exceptions)
- Rental charges in excess of the purchase price (except rental charges for ventilators for long term use, and DME which are considered continuous rentals (e.g., oxygen & oxygen administration equipment). Provider-specific Agreements as well as Blue Shield payment and/or medical policy may also dictate DME which is eligible for continuous rental status.
- Routine maintenance, repair, or replacement of DME due to damage of any type, including loss resulting from fire or other accidents (see Exceptions)
- Self-help/educational devices
- Speech/language assistance devices
- Wigs
- Eyewear (even if it is designed to assist the visually impaired diabetic with proper dosing of insulin)
- Video-assisted visual aids for diabetics
- Generators
- Backup or alternate equipment
- Assisted Listening Devices

Benefit Limitations

Limited to the least costly item to meet the patient’s medical needs.

Exceptions

When authorized as DME, other covered items include peak flow monitor for self-management of asthma, glucose monitor including continuous blood glucose monitor and all related necessary supplies for the self-management of diabetes, apnea monitors for management of newborn apnea, and the home prothrombin monitor for specific conditions as determined by Blue Shield. Rental charges for ventilators for long-term use are covered when authorized.

When authorized, visual aids (excluding eyewear) designed to assist the visually impaired with proper dosing of insulin (excluding video-assisted visual aids) are covered.

When authorized, replacement parts to extend the lifetime of DME are covered as a cost-effective measure.

When authorized, replacement of DME is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item.

Note: For oral appliances (mouthpieces) used to manage “obstructive sleep apnea (OSA)” and the symptoms of temporomandibular dysfunction (TMD), the provider must provide photographic documentation of the current (non-useable) appliance, written clinical documentation as to the reason(s) why the oral appliance is no longer functional, documentation the appliance is effective in managing the symptoms of the medical issue, and whether or not the Member was compliant in the use of the oral appliance.

A patient who requires a power wheelchair (PWC) is usually non-ambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease/condition. Power-operated wheelchairs/ vehicles are covered when prescribed by an MD or DO and when all of the following criteria are met:

- A mobility limitation exists that significantly impairs ability to participate in one or more mobility-related activities of daily living (MRADLs) in customary locations
- The mobility limitation cannot be resolved by the use of an appropriately fitted cane, crutch, or optimally configured manual wheelchair
- The patient does not have sufficient upper extremity function to self-propel a manual wheelchair to perform MRADLs
- The patient’s mental and physical capabilities are sufficient to safely operate a PWC that is provided

Durable Medical Equipment (DME)

Exceptions *(cont'd.)*

- If the patient is unable to safely operate a PWC, the patient has a caregiver who is available, willing, and able to safely operate a PWC for the patient but is otherwise NOT physically able to adequately propel a manual wheelchair
- The patient's weight does not exceed the weight capacity of the requested PWC
- The use of a PWC is expected to significantly improve or restore the patient's ability to perform or participate in MRADLs. For patients with severe cognitive and/or physical impairments, participation in MRADLs may require the assistance of a caregiver

Examples of Covered Services

Covered Services include, but are not limited to:

- Breast pumps
- Elastic, compression, or custom high-pressure support stockings knee length or thigh length for the treatment of chronic venous insufficiency and edema (e.g., Jobst, Juzo, Sidvaris)
- Canes
- Colostomy/ostomy supplies (See the *HMO Benefit Guideline* for *Medical Supplies*)
- Crutches
- Hospital beds
- Traction equipment
- Walkers
- Wheelchairs
- Positive airway pressure devices and supplies (for treatment of sleep apnea)
- Oral appliances to manage obstructive sleep apnea when all medical criteria are met for such an appliance

Examples of Covered Services *(cont'd.)*

- Non-surgical treatments and oral appliances to manage symptoms of temporomandibular joint (TMJ) discomfort. Medical documentation of joint pathology must be provided for review to include radiographs of the jaw joint and/or a medical radiology report on the condition of the jaw joints. It is the responsibility of the provider to unambiguously differentiate between "clenching and nocturnal grinding of teeth" (a dental problem) from a true medical jaw joint pathology (e.g., arthritic condition of TMJ, articulating joint disc displacement, aberrant wear of the TMJ condyles, etc.). The mere fact the patient demonstrates limited jaw opening, has pain to the face, pain to the muscles of the jaw (muscles of mastication), or pain to the area around the TMJ is insufficient medical documentation to make a definitive diagnosis of TMJ pathology
- Hydraulic patient lifts (e.g., Hoyer Lift) See non-covered services for types of patient lifts not covered
- Insulin pumps (including needles and tubing) per Blue Shield Medical Policy
- Dosing devices, such as dosing devices for syringes, insulin gauges, measuring devices, insulin measuring devices, needle guides and syringe/vial holders, syringe loading devices with magnifier or insulin syringe magnifiers
- Transcutaneous Electrical Nerve Stimulation (TENS) for the treatment of pain

Durable Medical Equipment (DME)

Examples of Non-Covered Services

Non-Covered Services include, but are not limited to:

- Environmental control and hygienic equipment, such as air conditioners, humidifiers, dehumidifiers, or air purifiers
- Over-the-counter disposable medical supplies for home use, purchased by the member (e.g., face masks (not including CPAP), gauze dressings (sterile/non-sterile), and gloves
- Support stockings and disposable/ thromboembolic deterrent stockings such as TED stockings, bandages, splints, etc. (See the *HMO Benefit Guideline* for *Medical Supplies*)
- Bandages
- Diapers
- Exercise equipment
- Spa or whirlpool baths
- Binoculars and other visual aid devices which only assist with distance vision
- Video-assisted visual aid devices
- Repair or replacement of DME due to damage of any type, including loss resulting from fire or other accidents
- Coverage for equipment that is not medically necessary is predominantly for the convenience or comfort of the member or is not primarily for a medical purpose
- Electric, elevator, stairwell-mounted, truck-mounted, or ceiling-mounted patient lifts
- Power operated wheelchairs for patients who are capable of ambulation within the home but require a power vehicle for movement outside the home, power operated wheelchairs/vehicles generally intended for use outdoors, and custom or heavy-duty wheelchairs unless required to accommodate a patient’s physical needs

Durable Medical Equipment (DME)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Home Health Care

Medical Supplies

Orthoses

Prostheses

Blue Shield HMO IPA/Medical Group Procedures Manual

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Emergency Benefits

Benefit Coverage

Blue Shield covers emergency services necessary to screen and stabilize members, without prior authorization, in cases where an enrollee reasonably believed he/she had an emergency medical condition given the enrollee's age, personality, education, background and other similar factors. Blue Shield will also cover ambulance transportation services provided to an enrollee due to a "911" call for assistance.

California Health & Safety (H&S) Code 1317.1(a) defines "emergency services and care" as medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

The same section of the H&S Code also includes in the definition of "emergency services and care" as an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention; and

Care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital; and

Solely to the extent required under the federal law, emergency services also include any additional items or services that are covered under the plan and furnished by a non-participating provider or emergency facility, regardless of the department where furnished, after stabilization and as part of outpatient observation or inpatient or outpatient stay.

For emergency services, members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The member should notify the primary care physician (PCP) by phone within 24 hours after care is received unless it was not reasonably possible to communicate with the PCP within this time limit. In such case, notice should be given as soon as possible.

Members should go to the closest plan hospital for emergency services whenever possible.

Emergency Benefits

Benefit Coverage *(cont'd.)*

Blue Shield HMO will provide care in a non-plan hospital only for as long as the member's medical condition prevents transfer to a plan hospital.

Coverage is provided for a screening exam to determine if a psychiatric medical emergency condition exists and for care and treatment to stabilize the patient.

Emergency services and follow-up health care treatment are provided without a cost share for members treated following a rape or sexual assault for the first nine months after the member begins treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

The cost share waiver is applicable to follow-up health care treatment provided by a participating provider, any provider of emergency services, or a non-participating provider when Blue Shield has approved your request to receive services from the non-participating provider at the participating provider cost share. The cost share waiver will only apply to services the treating provider has identified in their claim submission using accurate diagnosis codes specific to rape or sexual assault.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Emergency Care

Hospital ER Care

Physician Office Emergency Care

Durable Medical Equipment (DME)

Benefit Exclusions

- Unauthorized continuing or follow-up care after the initial emergency has been treated in a non-plan hospital or by a non-plan provider is not covered.

- Any dental treatment to restore the oral cavity following the initial, immediate, emergency, first aid care of teeth, gums, lips, tongue, bone ridge, and jaw because of an accident.

  Examples of emergency, initial and immediate first aid care to the mouth following an accident are:

  1. Immediate emergency removal, temporary stabilization, reduction of tooth/teeth fragments, avulsed teeth, and mobile teeth to prevent aspiration of foreign bodies into the lungs.

  2. Immediate emergency stabilization of fractured alveolus, fractured jaws, and displaced jaws.

  3. Immediate emergency treatments for pain and swelling.

  4. Immediate emergency treatments to stop bleeding.

  5. Immediate emergency suturing and bandaging of soft tissue of the mouth, tongue, cheeks, and face.

  6. Immediate emergency first aid treatments to adjacent facial structures involved in an accident.

  7. Medically necessary radiographs needed to image oral or dental problems directly caused by an accident.

  Note: Definitive restoration of teeth, hard tissue, soft tissues, replacement of dental appliances, broken veneers, damaged crowns, fixed bridgework, implants are not considered, for the purpose of this guideline, emergency dental services.

- The services of dentists and oral surgeons (including hospitalization related to the services), are not a benefit of the medical plan. If a member has dental coverage, these services may be covered under the dental plan. Please refer to the benefits section of the *Evidence of Coverage* (EOC) for more information.

Emergency Benefits

Examples of Non-Covered Services

- Prescribed drugs and medicines.
- Over-the-counter medications.
- Emergency room visits that are for non-emergency or routine problems, even if the visit is “after hours” or on the weekend. The member is to call the PCP or physician-on-call for instructions or make an appointment with his/her PCP.
- Emergency room visits for any routine and emergency dental or mouth problems to include tooth pain, mouth swelling due to a dental problem, gum bleeding, lacerations to the lips/soft tissues of the mouth/tongue/ cheeks, chipped teeth, fracture teeth, avulsed teeth, etc. The rationale for this policy is because emergency rooms in hospitals are never equipped to see, manage, or treat dental problems. Typically, the ER staff will simply tell the patient to visit their dentist for dental problems.
- *Any* definitive dental treatment that may only be vicariously associated (not directly caused) with an accident to include dental implants, root canal treatments, full and partial dentures, replacing or repairing damaged or lost dentures, replacing or repairing fixed dental bridges, fillings, removal of root tips that are not a risk of aspiration, restoration of any dental work due to intubation procedures or other procedures performed by surgical staff, crowns, cosmetic veneers, gum surgery, soft tissue surgery to the lips, tongue, cheeks, inner cheeks, 3-dimensional x-rays, flat plane x-rays, dental x-rays, molds of the teeth, intraoral photographs, extra oral photographs, palliative dental treatment, orthodontic treatment, occlusal orthotics, nightguards, TMJ appliances and removal of asymptomatic and non-restorable teeth.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Family Planning

Benefit Coverage

Family planning benefits include.

- Consulting services, and education for prescribing, monitoring, fitting, and administering of contraceptive devices, medication, and side effects.
- Injectable or implantable contraceptives
- Intrauterine device (IUD) insertion and removal
- Diaphragm fitting
- Follow-up services for counseling for continued adherence or side effects
- Tubal Ligation
- Vasectomy

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Family Planning

Tubal ligation
Vasectomy

Benefit Exclusion

Contraceptive drugs and devices that are covered under the Outpatient Prescription Drug benefit.

Family Planning

Benefit Limitations

No benefits are provided for infertility services related to the harvesting or stimulation of the human ovum (including medications, laboratory, and radiology service).

See *HMO Benefit Guidelines* for:

Infertility Services - Diagnosis and Treatment of the Cause

Infertility Services – Additional Benefits

Examples of Covered Services

- Physician office visits for injectable contraceptives, implantable contraceptives, or diaphragm fitting
- IUD and the insertion or removal of the device

Examples of Non-Covered Services

- Contraceptive drugs and devices, including diaphragms (covered under the Outpatient Prescription Drug benefit)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for*:*

Infertility Services - Diagnosis and Treatment of the Cause

Infertility Services – Additional Benefits

Family planning may also be covered under the Preventive Health Services Benefit and Prescription Drug Benefits Rider if the Employer selected it as an Optional Benefit.

Gynecological Examinations

Benefit Coverage

Routine breast and pelvic exams, Pap tests, or other Food and Drug Administration (FDA) approved cervical cancer and human papilloma virus (HPV) screening tests are covered annually for women.

A Blue Shield HMO female member may arrange for obstetrical and/or gynecological (OB/GYN) services by an obstetrician/gynecologist or family practice physician who is not their designated primary care physician (PCP) without referral from her PCP. The OB/GYN or family practice physician must be in the same medical group as the PCP. Obstetrical and gynecological services are defined as follows:

- Physician services related to prenatal, perinatal, and postnatal (pregnancy) care.
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia.
- Physician services for treatment of disorders of the breast.
- Routine annual gynecological examinations/annual well-woman examinations. (See Preventive Benefits.)
- Family Planning. (See Family Planning in the member's benefits.)

The OB/GYN or family practice physician will notify the PCP of the results of the examination. If the examination results identify the need for specialty services (for example, mammography, surgery, ultrasound, etc.), the member's PCP must provide or arrange for the additional services.

Additional medically necessary mammograms for screening and diagnostic purposes are covered without limitation when done upon the referral of the patient's PCP.

The benefit for a routine annual gynecological exam is in addition to the benefit for routine physical examinations, according to schedule, when performed by two different physicians.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Preventive Services/Routine physical exams

Physician - Outpatient/office visits

Outpatient Hospital Services/Lab/X-Ray/Ancillary Services

Gynecological Examinations

Benefit Exclusion

Physical examinations required for licensure, employment, insurance, etc., unless the examination corresponds to the schedule of routine physical examinations.

Benefit Limitations

Please see the Preventive Benefit Policy on Provider Connection at blueshieldca.com/provider under *Guidelines & resources,* then *Guidelines and procedures* for benefit limitations.

Referral for genetic risk assessment and evaluation for BRCA mutation testing for breast and ovarian cancer susceptibility is a covered service for patients who meet the criteria outlined in the Medical Policy for *Oncology: Circulating Tumor DNA and Circulating Tumor Cells (Liquid Biopsy)*. This policy can be found on Provider Connection under *Authorizations,* then *Clinical policies and guidelines.* These services are considered inclusive in the preventive care visit, and therefore not separately reimbursable. (See the Preventive Benefit Policy.)

Examples of Covered Services

- Mammography
- Pap tests or other FDA-approved cervical cancer screening tests
- Pelvic and breast examinations
- Urinalysis

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code Section 1367.695

HMO Benefit Guideline for *Physician Services*

Medical Policy for Oncology: Circulating Tumor DNA and Circulating Tumor Cells (Liquid Biopsy)

Preventive Benefit Policy

US Preventive Services Task Force, Guide to Clinical Preventive Services

Home Health Care (HHC) Services

Benefit Coverage

Home health care or home infusion services are a covered benefit when medically necessary and authorized by the primary care physician (PCP) and Blue Shield HMO. Hospice services to an Individual and Family Plan (IFP) member are covered under this benefit. See the separate guideline for hospice services for group members for information on the separate benefit for those members.

Covered home health care services include:

1. Intermittent and part-time home visits by a home health care agency to provide skilled services up to 8 hours total (see member's benefits) by any of the following professional providers:

    - Registered Nurse (RN)
    - Licensed Vocational Nurse (LVN)
    - Physical Therapist (PT), Occupational Therapist (OT), Speech Language Pathologist (SLP), or Respiratory Therapist (RT)
    - Certified Home Health Aide (CHHA)
    - Medical Social Worker (MSW) for consultation and evaluation of the home health care treatment plan

    Home health care visits by a RN, LVN, PT, OT, SLP, RT, CHHA or MSW are limited to a combined 100 visits per calendar year.

    Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

2. In conjunction with the professional services rendered by a home health care or home infusion agency, medical supplies, disposable medical supplies, limited durable medical equipment required for medication delivery, and medications administered by the home infusion agency necessary for the home health treatment plan are also a covered benefit.

3. Related pharmaceutical and laboratory services to the extent the services would have been provided had the member remained in the hospital or skilled nursing facility.

4. Home infusion therapy including parenteral and enteral nutrition services for tube feedings and associated supplies and solutions. Benefits are also provided for infusion therapy provided in infusion suites associated with a participating Home Infusion agency.

Home Health Care (HHC) Services

Benefit Coverage *(cont'd.)*

5. Medically necessary FDA-approved self-administered medications, that are prescribed by the PCP or specialist, may require prior authorization by Blue Shield. These drugs, also known as Specialty Drugs, may be obtained from a Blue Shield participating Specialty Pharmacy under the outpatient pharmacy benefit and are listed in the Blue Shield Outpatient Drug Formulary.

   Medically necessary FDA-approved medications, that are prescribed by the PCP or specialist and require a clinician to monitor the patient during the administration of the drug or cannot be self-administered, may require prior authorization by Blue Shield. These drugs, also known as Specialty Drugs, are covered under the medical benefit, and are listed in Blue Shield Medication Policy. They may be obtained from a home infusion pharmacy for home administration or from the physician if the drug is being given in the office. Specialty drug administration in an outpatient facility may require additional prior authorization as part of the site of service redirection program.

   Specialty Drugs are defined as specific drugs used to treat complex or chronic conditions that usually require close monitoring. Specialty Drugs may be self-administered by injection, inhalation, orally, or topically. These drugs may also require special handing, special manufacturing processes, have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, prior authorized for medical necessity by Blue Shield and obtained from a Blue Shield Specialty Pharmacy.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Agency visit

Durable Medical Equipment

Prosthetics/Orthotics

Physician Services

Physician Home Visit

Home Health Care (HHC) Services

Benefit Exclusion

The following services are excluded:

- Services for private duty nursing.
- Services for custodial, maintenance, or domiciliary care, services for rest, or services to control, or to change a person's environment.

Benefit Limitations

Group: The home health care services benefit is limited to a combined total of visits per calendar year by the following home health care agency professional providers: RN, LVN, PT, OT, SLP, RT, CHHA, and MSW.

IFP: The combined visit limitation for home health care includes visits by providers from a home health care agency, home infusion agency, or hospice agency (RN, LVN, PT, OT, SLP, RT, CHHA, or MSW). See the separate guideline for hospice services for group members.

Home self-administered medications are limited to a quantity not to exceed a 30-day supply. Prescriptions may be refilled at a frequency that is considered to be medically necessary.

Examples of Covered Services

- Intermittent nursing visits for wound care and IV medication treatments.
- Intermittent physical therapy visits for home traction treatment.
- Home infusion therapy, visits for chemotherapy for cancer catheterization, medical supplies used during a covered visit, and pharmaceuticals administered intravenously.
- Parenteral/enteral nutritional services and associated supplies and solutions provided by a home health agency or by a home infusion agency.
- Hemophilia factor or other injectables used to treat hemophilia and associated home infusion services that may require prior authorization that are provided by a network Hemophilia Infusion Provider or home infusion nurse.

Home Health Care (HHC) Services

Examples of Non-Covered Services

- Homemaker services.
- Custodial care in the home setting.
- Dental services provided by itinerant dentists or dental hygienists.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefits Guidelines for:

Chemotherapy
DME
Hospice Care
Orthoses
Physician Services
Prostheses

Blue Shield HMO IPA/Medical Group Procedures Manual

Home Health Care (HHC) Services - CalPERS

Benefit Coverage

Home health care or home infusion services are a covered benefit when medically necessary and authorized by the primary care physician (PCP) and Blue Shield HMO. See the separate guideline for Hospice Services. Covered home health care services include:

1. Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits per day, 2 hours per visit (8 hours total) by any of the following professional providers:

    - Registered Nurse (RN)
    - Licensed Vocational Nurse (LVN)
    - Physical Therapist (PT), Occupational Therapist (OT), Speech Language Pathologist (SLP), or Respiratory Therapist (RT)
    - Certified Home Health Aide (CHHA) in conjunction with services of an RN or LVN
    - Licensed Medical Social Worker (LMSW) for consultation and evaluation of the home health care treatment plan

    Skilled Nursing Services are defined as a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed vocational nurse).

2. In conjunction with the professional services rendered by a home health care or home infusion agency, medical supplies, disposable medical supplies, limited durable medical equipment required for medication delivery, and medications administered by the home infusion agency necessary for the home health treatment plan are also a covered benefit. Benefits are also provided for infusion therapy provided in infusion suites associated with a Participating Home Health Care and Home Infusion agency.

3. Related pharmaceutical and laboratory services to the extent the services would have been provided had the member remained in the hospital or skilled nursing facility.

4. Medically necessary home visits by a physician.

5. Home infusion therapy including parenteral and enteral nutrition services for tube feedings and associated supplies and solutions.

Home Health Care (HHC) Services - CalPERS

Benefit Coverage *(cont'd.)*

Medically necessary FDA-approved medications, that are prescribed by the PCP or specialist and require a clinician to monitor the patient during the administration of a drug or cannot be self-administered, may require prior authorization by Blue Shield. These drugs, also known as Specialty Drugs, are covered under the medical benefit, and are listed in Blue Shield Medication Policy. They may be obtained from a home infusion pharmacy for home administration or from the physician if the drug is being given in the office. Specialty drug administration in an outpatient facility may require additional prior authorization as part of the site of service redirection program.

Specialty Drugs are defined as specific drugs used to treat complex or chronic conditions that usually require close monitoring. Specialty Drugs may be self-administered by injection, inhalation, orally, or topically. These drugs may also require special handing, special manufacturing processes, have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy and Therapeutics Committee, prior authorized for medical necessity by Blue Shield and obtained from a Blue Shield Specialty Pharmacy.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Home Health Care (HHC)

Physician Home Visit

Agency visit

Medical Supplies/IV Solutions

Durable Medical Equipment

Prosthetics/Orthotics

Benefit Exclusions

The following services are excluded:

- Services for private duty nursing
- Services for custodial, maintenance, or domiciliary care, services for rest, or services to control, or to change a person's environment.

Home Health Care (HHC) Services - CalPERS

Benefit Limitations

IFP: The combined visit limitation for home health care includes visits by providers from a home health care agency, home infusion agency, or hospice agency (RN, LVN, PT, OT, SLP, RT, CHHA, or LMSW). See the separate guideline for hospice services for group members. Home self-administered medications are limited to a quantity not to exceed a 30-day supply. Prescriptions may be refilled at a frequency that is considered to be medically necessary.

Examples of Covered Services

- Intermittent nursing visits for wound care and IV medication treatments.
- Intermittent physical therapy visits for home traction treatment.
- Home infusion therapy, visits for chemotherapy for cancer catheterization, medical supplies used during a covered visit, and pharmaceuticals administered intravenously.
- Parenteral/enteral nutritional services and associated supplies and solutions provided by a home health agency or by a home infusion agency.
- Hemophilia factor or other injectables used to treat hemophilia and associated home infusion services that may require prior authorization that are provided by a network Hemophilia Infusion Provider or home infusion nurse.

References

Evidence of Coverage

HMO Benefits Guidelines for:

Chemotherapy
DME
Hospice Care
Orthoses
Prostheses

Blue Shield HMO IPA/Medical Group Procedures Manual

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Hospice Care

Benefit Coverage

Hospice services by a participating hospice agency contracted with Blue Shield are covered for a member with a terminal illness as determined by the treating physician. The member must request and be formally admitted to an approved hospice program. Blue Shield's Medical Care Solutions department and the delegated IPA/medical group's utilization management department must approve admission to the hospice program through the prior authorization process.

Terminal illness is defined as medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

The following covered services are available on a 24-hour basis to the extent necessary to meet the needs of the member for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions:

1. Pre-hospice consultative visit by Hospice provider regarding pain and symptom management, hospice and other care options including Advanced care planning. *Note:* Members do not have to be enrolled in a Hospice Program to receive this benefit.
2. Interdisciplinary team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions.
3. Skilled nursing services, certified health aide services, and homemaker services under the supervision of a qualified registered nurse.
4. Bereavement counseling.
5. Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling by a qualified provider, when needed.
6. Medical direction with the hospice medical director being also responsible for meeting the general medical needs for the terminal illness of the members to the extent that these needs are not met by the primary care physician (PCP).
7. Volunteer services.
8. Short-term inpatient care arrangements.
9. Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions.
10. Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

Hospice Care

Benefit Coverage *(cont'd.)*

11. Respiratory therapy.
12. Nursing care services on a continuous basis for as much as 24-hours a day during periods of crisis as necessary to maintain a member at home and achieve palliation or management of acute medical symptoms. Either homemaker services or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care.
13. Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.
14. Occasional respite care services (no more than five (5) consecutive days at a time). Respite care services are short-term inpatient services covered only when necessary to relieve the family members or other caregivers.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits* for member copayments.

Benefit Exclusion

Hospice services provided by a non-participating hospice agency are not covered. See exceptions below.

Benefit Limitations

Members are allowed to change their participating hospice agency only once during each period of care. Members may receive care for a 30, 60, or 90-day period, depending on their diagnosis. The care continues through another period of care if the PCP recertifies that the member is terminally ill.

Hospice care received out of the IPA/medical group service area (e.g., member moves to a relative's household in another part of California or out of state) will not be covered unless authorized in advance by Blue Shield's Medical Care Solutions Department. Contact Blue Shield for more information.

Exceptions

Hospice services provided by a non-participating hospice agency are not covered except in certain circumstances in counties in California in which there are no participating hospice agencies. Such services must be approved in advance by the Blue Shield Medical Care Solutions Department. Contact Blue Shield for more information.

Examples of Covered Services

- Pre-hospice consultative visit by Hospice providers
- Continuous home care provided during a period of crisis
- Short-term inpatient care arrangements
- Inpatient respite care to relieve the family or other caregivers for no more than five (5) consecutive days at a time
- Interdisciplinary home care plan

Examples of Non-Covered Services

- Respite care for more than five (5) consecutive days
- Services by the hospice agency to treat conditions not related to the terminal illness
- Treatment by the hospice agency intended to cure a terminal illness rather than provide palliative care
- Care received from a non-hospice agency provider that duplicates care received from the hospice

References

Evidence of Coverage – Group

Evidence of Coverage and Health Service Agreement – IFP

Blue Shield HMO IPA/Medical Group Procedures Manual

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Hospital Services – Inpatient Care

Benefit Coverage

Inpatient services customarily furnished by a hospital for a member who is admitted to a hospital as a registered bed patient who requires an acute bed-patient (overnight) setting when services are medically necessary and appropriately authorized are covered.

For hospital admissions for mastectomies or lymph node dissections, the length of a hospital stay will be determined solely by the member's physician in consultation with the member.

For mental health and substance use disorder services, benefits are provided for inpatient hospitalization, professional services related to hospitalization, and residential treatment when prior authorized by Blue Shield and obtained from Blue Shield participating providers.

Members may call Blue Shield directly at (877) 263-9952 to arrange for mental health and substance use disorder services. Members may also ask their Primary Care Physician (PCP) to contact Blue Shield to arrange these services for them.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Infertility Services

Maternity Care

Normal Delivery/C-Sections

Mental Health and Substance Use Disorders

Physician Services

Rehabilitation and Habilitation Services

Hospital Services – Inpatient Care

Benefit Exclusions

The following inpatient services are excluded:

- Inpatient hospitalization for monitoring, testing, or diagnostic studies that could have been provided on an outpatient basis.
- Hospitalization in pain management center to treat or cure chronic pain.
- Hospitalization or confinement in a health facility primarily for rest, custodial, maintenance, domiciliary care, or for personal comfort.
- Inpatient mental health and substance use disorder services not prior authorized or not provided by Blue Shield participating providers.
- Testing for intelligence or learning disabilities.
- Services performed in a hospital and billed by hospital officers, residents, interns, or others in training.
- All routine dental services, e.g., root canals, fillings, crowns, dentures, third molar extractions, routine removal of any teeth, gum surgery, dental implants, any and all dental procedures associated with the future placement of dental implants, dentures, etc.

Benefit Limitations

Refer to the Benefit Limitation sections of the *HMO Benefit Guidelines* for:

Maternity Care

Mental Health and Substance Use Disorders

Infertility Services - Additional Benefits

Infertility Services – Diagnosis and Treatment of the Cause

Skilled Nursing Facility (SNF)

Hospital Services – Inpatient Care

Examples of Covered Services

- Semiprivate room and board unless a private room is medically necessary.
- Specialized care units, including adult intensive care, coronary care, pediatric and neonatal intensive care, and subacute care.
- General and specialized nursing care.
- Operating room, recovery, labor and delivery, and other specialized treatment rooms, newborn nursery.
- Hospital ancillary services including diagnostic laboratory and X-ray services.
- Medications and biologicals administered in the hospital, and up to a 3-day supply of drugs supplied upon discharge by the plan physician for the transition from the hospital to the home.
- Authorized medical and surgical procedures and supplies, surgically implanted devices, prostheses, and appliances.
- Blood and blood products.
- Radiation therapy, chemotherapy and renal dialysis and supplies.
- Clinical pathology, laboratory, radiology, and diagnostic services and supplies.
- Meals including special diets.
- Acute detoxification.
- Acute inpatient rehabilitative services.
- Therapy services, including physical, occupational, respiratory, and speech therapy.
- Emergency room services resulting in admission.
- Anesthesia, oxygen, medicines, and IV solutions.

Examples of Non-Covered Services

See Benefit Exclusions.

Hospital Services – Inpatient Care

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

- *Maternity Care*
- *Mental Health and Substance Use Disorders*
- *Infertility Services - Additional Benefits*
- *Infertility Services – Diagnosis and Treatment of the Cause*
- *Skilled Nursing Facility (SNF)*

Blue Shield HMO IPA/Medical Group Procedures Manual

Hospital Services – Outpatient Care

Benefit Coverage

Hospital outpatient care is covered for medically necessary services and supplies for treatments, diagnostic tests, and emergency care, surgeries, and procedures performed in a hospital outpatient setting when appropriately authorized.

Any questions about the appropriate setting for a surgery/procedure should be referred to Blue Shield Medical Care Solutions.

For mental health and substance use disorder services, benefits are provided for outpatient care when prior authorized by the Blue Shield and obtained from Blue Shield participating providers.

Members may call Blue Shield directly at (877) 263-9952 to arrange for mental health and substance use disorder services. Members may also ask their Primary Care Physician (PCP) to contact Blue Shield to arrange these services for them.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Emergency Care

Mental Health and Substance Use Disorders

Optional Benefits

Infertility Services

Outpatient Hospital Services

Benefit Limitations

Refer to the Benefit Limitation sections of the *HMO Benefit Guidelines* for:

Ambulatory Surgeries/Procedures

Chemotherapy

Emergency Services

Infertility Services - Additional Benefits

Infertility Services – Diagnosis and Treatment of the Cause

Mental Health and Substance Use Disorders

Hospital Services – Outpatient Care

Examples of Covered Services

Outpatient care is covered for:

- Computerized axial tomography (CAT) scans
- Chemotherapy or other infused/injected medications
- Lymph node biopsies
- Magnetic resonance imaging (MRI) tests
- Treadmill tests

Examples of Non-Covered Services

- Outpatient mental health and substance use disorder services not prior authorized or not provided by Blue Shield participating providers.
- All routine dental services, e.g., root canals, fillings, crowns, dentures, third molar extractions, routine removal of any teeth, gum surgery, dental implants, any and all dental procedures associated with the future placement of dental implants, dentures, etc.
- Administration of select infused or injected medications that are not approved for outpatient hospital administration.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Facility Based Ambulatory Surgery/Procedures List

HMO Benefit Guidelines for*:*

Ambulatory Surgeries/Procedures

Chemotherapy

Emergency Services

Infertility Services - Additional Benefits

Infertility Services – Diagnosis and Treatment of the Cause

Mental Health and Substance Use Disorders

Blue Shield HMO IPA/Medical Group Procedures Manual

Infertility – Additional Benefits

Benefit Coverage

The diagnosis and treatment of the cause of infertility are considered covered services under the medical plan benefits. Additional infertility services are covered services when defined as a benefit on the member's *Summary of Benefits and Coverage* document. These additional benefits are described in three different levels of coverage:

1) Base Assisted Reproductive Technology (ART) Benefit through Senate Bill 729 (SB 729).

   And the following two optional levels of Assisted Reproductive Technology (ART) Benefit Riders, that are separately purchased benefits:

2) Base ART Benefit Rider.

3) Additional ART Benefit Rider.

Base ART Benefit

For the Base ART Benefit, infertility is defined as:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility; or
- A person's inability to reproduce either as an individual or with their partner without medical intervention; or
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Infertility – Additional Benefits

Benefit Coverage *(cont'd.)*

Base and Additional ART Benefit Riders

For the optional Base or Additional ART Benefit Riders, infertility is defined as:

The member must be actively trying to conceive and has either:

1. A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or

2. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Infertility ART Benefit Riders are not available for Individual and Family Plan (IFP) members.

Note: When services are prior authorized by Blue Shield, within 5 days before the actual date of service, providers MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke their authorization prior to services being rendered based on cancellation of the member's eligibility.

Consult the Blue Shield HMO for a complete list of covered medications that are provided in the physician's office or for home self-administration and confirm medication coverage.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Infertility – Additional Benefits

Benefit Exclusions

The following infertility services are not provided under the Base ART Benefit Rider:

- Intracytoplasmic sperm injection (ICSI)
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)

The following infertility services are not provided under both the Base ART Benefit and Additional ART Benefit Rider:

- Services received from non-participating providers.
- Sexual dysfunction or sexual inadequacies except as provided for treatment of organically based conditions, for which covered services are provided only under the medical benefits portion of the *Evidence of Coverage (EOC).*
- Services incident to or resulting from procedures for a surrogate mother; however, if the surrogate mother is an enrolled member of a Blue Shield Health Plan, covered pregnancy and maternity care will be provided to her under her own plan.
- Collection, purchase, or storage of sperm/eggs/frozen embryos, ovarian tissue from donors other than the subscriber or enrolled spouse or domestic partner (if domestic partners are covered by the plan).
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the member entitled to the benefits under this Infertility Benefit.
- Home ovulation prediction testing kits or home pregnancy tests.
- Microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the member had a previous vasectomy.
- Oral drugs for the treatment of infertility (check with the member's pharmacy benefit).
- Reversal of surgical sterilization and associated services.
- Any services not specifically listed as a covered service above.
- Covered services in excess of the lifetime benefit maximums.

Benefit Limitations

See members' EOC for benefit/coverage limits.

Infertility – Additional Benefits

Examples of Covered Services

Infertility benefits mandated under SB 729 (Base ART Benefits) include the following medically necessary ART services and additional services for specific lines of business and employer groups who purchased additional ART services above the mandated benefits.

Additional benefits include prescribed injectable drugs to stimulate fertility, including needles and syringes, and the following procedures up to a lifetime benefit maximum. See the members' EOC for coverage limitations.

- Artificial insemination, including intrauterine insemination (IUI);
- Oocyte (egg) retrievals;
- In vitro fertilization (IVF);
- Unlimited embryo transfers;
- Gamete Intrafallopian Transfer (GIFT);
- Zygote Intrafallopian Transfer (ZIFT);
- Cryopreservation storage of sperm, reproductive tissue, oocytes, and embryos;
- Intracytoplasmic sperm injection (ICSI) for male factor infertility;
- Preimplantation genetic testing; and
- Treatment of low sperm count.

Base ART Benefits and the Additional ART Benefit Rider includes the following:

- Natural artificial inseminations supervised by a physician (without ovum (egg) stimulation).
- Stimulated artificial inseminations (with ovum (egg) stimulation).
- Gamete intrafallopian transfer (GIFT).
- Cryopreservation of sperm/eggs/embryos when retrieved from a subscriber, spouse or covered domestic partner. Benefits include cryopreservation services for a condition which the treating physician anticipates will cause infertility in the future (except when the infertile condition is caused by elective chemical or surgical sterilization procedures).

Additional ART Benefit Rider includes the Base ART Benefits as well as the following: (These are excluded from the Base ART Benefit Rider.)

- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Intracytoplasmic sperm injection (ICSI)

References

Additional Infertility Services, Supplement to the *Evidence of Coverage* and *Disclosure Form.*

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Infertility - CalPERS

Benefit Coverage

For the purpose of this benefit, infertility is defined as:

- A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Services to Diagnose and Treat the Cause of Infertility

Inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider to diagnose and treat the cause of infertility are covered. Depo Lupron is currently the only injectable medication covered when provided for the treatment of endometriosis as a cause of infertility.

Services to Treat Infertility

When authorized by Blue Shield, some inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider for the treatment of infertility are covered. These additional services must be provided to a covered member with conception in the member as the intended result of the services. Procedures must be consistent with established medical practice in the treatment of infertility and induced fertilization.

Services to treat infertility include prescribed home self-administered injectable drugs, including needles and syringes, and artificial insemination (with and without egg stimulation). (See “Benefit Exclusions” below for services that are specifically excluded.)

When the following injectables are approved for home self-administration, the member must purchase the injectable, needles, and syringes at a Blue Shield participating pharmacy and submit a receipt to Blue Shield HMO for reimbursement under the Family Planning benefit of the CalPERS HMO Plan.

Brand Name	Generic Name
Menopur	Menotropins
Novarel, Ovidrel APL, Pregnyl	Chorionic Gonadrotropin (HCG)
Gonal F, Follistim	Follitropin
Cetrotide	Cetrorelix
Ganirelix Acetate	Ganirelix Acetate

Infertility – CalPERS

Benefit Coverage *(cont'd.)*

Consult Blue Shield HMO for a complete list of covered medications that are provided in the physician's office or for home self-administration.
See the member's *Evidence of Coverage* (EOC) for benefit coverage.

Copayment

See the members' EOC and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

Infertility services are not provided for:

- Sexual dysfunction or sexual inadequacies
- Services incident to or resulting from procedures for a surrogate mother; however, if the surrogate mother is an enrolled member of a Blue Shield health plan, covered pregnancy and maternity care will be provided to her under her own plan

  Note: If a child resulting from a surrogate parenting arrangement meets the requirements and is enrolled as a "Dependent" (as defined by Blue Shield) of a Blue Shield subscriber, all covered services are available to such child from the first date of coverage.
- Collection, purchase or storage of sperm/eggs/frozen embryos from donors other than the enrolled spouse or domestic partner
- Gamete intrafallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Ovum transplant
- Any form of induced fertilization except for artificial insemination
- For or incident to the reversal of a vasectomy or tubal ligation or repeat vasectomy or tubal ligation
- Services or medications to treat low sperm count
- Sterilization reversals are excluded as a benefit

Examples of Covered Services

Services to diagnose and treat the cause of infertility

- Office visits (medical history and physical exams)
- Depo Lupron used for the treatment of endometriosis as a cause of infertility
- Diagnostic tests and surgical procedures specific to infertility

Male

- Epididymovasostomy, anastomosis of epididymis to vas deferens
- Semen analysis, sperm antibodies, sperm evaluation

Female

- Laparoscopy with lysis of adhesions or with aspiration
- Hysteroscopy
- Injection procedure for hysterosalpingography
- Transcervical introduction of fallopian tube catheter for diagnosis and establishing potency, with or without hysterosalpingography
- Hydrotubation of oviduct
- Lysis of adhesions
- Fimbrioplasty
- Salpingostomy
- Hysterosalpingography
- Echography, pelvic
- Ultrasonic guidance for aspiration of ova

Services to treat infertility

- Artificial insemination and supporting procedures

Infertility – CalPERS

Examples of Non-Covered Services

- Services for sexual dysfunction and sexual inadequacies, except as provided for organically based conditions
- Services incident to or resulting from procedures for a surrogate mother who is not covered for maternity services under her own Blue Shield health plan
- Services for collection, purchase, or storage of sperm/eggs from donors other than enrolled spouse or domestic partner
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Infertility services for an individual who is not a member

References

CalPERS Access+ HMO, EPO, and Trio HMO Combined Evidence of Coverage and Disclosure Form

Blue Shield HMO IPA/Medical Group Procedures Manual

Infertility – Diagnosis and Treatment of the Cause of Infertility

Benefit Coverage

Inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider to diagnose and treat the cause of infertility are covered services for group members under their medical benefits.

For Individual Family Plan (IFP) members, the cause of infertility is defined as:

The member must be actively trying to conceive and has either:

- A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

For Small and Large Group plan members, the cause of infertility is defined as:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of Infertility before the 12-month or 6-month period to establish infertility; or
- A person's inability to reproduce either as an individual or with their partner without medical intervention; or
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

The treatment of the cause of infertility does not include pregnancy by artificial means or assisted reproductive technology procedures.

Services to diagnose and treat the cause of infertility, or Assisted Reproductive Technology (ART) are not covered for IFP members.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Infertility – Diagnosis and Treatment of the Cause of Infertility

Benefit Exclusions

- Services for or incident to non-organic based sexual dysfunction or sexual inadequacies, services related to assisted reproductive technology, including but not limited to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) procedure, artificial insemination, services or medications to treat low sperm count, any other form of assisted fertilization (including related medications, laboratory, and radiological services), or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield Health Plan.
- Medications and drugs that may be covered under the basic benefit for treating the medical cause of infertility are not covered when used in conjunction with, or to enhance assisted reproduction, or any form of induced fertilization. (Injectable medications may be covered under optional Infertility - Additional Benefits.)
- Services for, or incident to, the treatment of infertility or any form of assisted reproductive technology, including but not limited to the reversal of a vasectomy or tubal ligation, are not covered, or complications of any such procedures.
- Services for IFP members are not covered.
- Services related to harvesting or stimulation of the human ovum, including medications, laboratory, and radiology services.

Exceptions

See *HMO Benefit Guidelines* for:

Infertility – Additional Benefits

Infertility – Diagnosis and Treatment of the Cause of Infertility

Examples of Covered Services

The diagnosis and treatment of infertility includes:

- Office visits (medical history and physical exams)
- Depo Lupron used for the treatment of endometriosis as a cause of infertility
- Diagnostic tests and surgical procedures specific to the treatment or diagnosis of infertility

Male

- Epididymovasostomy, anastomosis of epididymis to vas deferens
- Semen analysis, sperm antibodies, sperm evaluation

Female

- Laparoscopy with lysis of adhesions or with aspiration
- Hysteroscopy
- Injection procedure for hysterosalpingography
- Transcervical introduction of fallopian tube catheter for diagnosis and establishing potency, with or without hysterosalpingography
- Hydrotubation of oviduct
- Lysis of adhesions
- Fimbrioplasty
- Salpingostomy
- Hysterosalpingography
- Echography, pelvic

Infertility – Diagnosis and Treatment of the Cause of Infertility

Examples of Non-Covered Services for Diagnosis and Treatment of the Cause of Infertility

- Artificial insemination
- Gamete intrafallopian transfer (GIFT)
- In vitro fertilization (IVF)
- Intracytoplasmic sperm injection (ICSI)
- Other forms of induced fertilization
- Any service related to the harvesting or stimulation of human ovaries in conjunction with or to enhance any form of assisted reproduction or induced fertilization (which includes laboratory services, radiology services, or medications such as Gonal F, Follistin, Lupron, Fertinex, Pergonal, Humagon)
- Penile implant devices and surgery, except as covered under Reconstructive Surgery Benefits
- Services for or incident to sexual dysfunction and sexual inadequacy, except as provided for treatment of organic-based conditions
- Services incident to or resulting from procedures for a surrogate mother
- Services for collection, purchase, or storage of sperm/eggs
- Other services (semen analysis, other urological testing) for male spouse who is not also a member
- Services for, or incident to, the reversal of a vasectomy or tubal ligation (for example, vasovasostomy, vasovasorrhaphy, tubotubal anastomosis)
- Services or medication to treat low sperm count
- Sterilization reversals are excluded as a benefit

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Infertility – Additional Benefits

Infertility – CalPERS & FEHBP

Infertility - FEHBP

Benefit Coverage

For the purpose of this benefit, infertility is defined as:

- A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception

Services to Diagnose and Treat the Cause of Infertility

Inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider to diagnose and treat the cause of infertility are covered. Depo Lupron is currently the only injectable medication covered when provided for the treatment of endometriosis as a cause of infertility.

Services to Treat Infertility

When authorized by Blue Shield, some inpatient, outpatient, professional, and ancillary services prescribed or administered by the provider for the treatment of infertility are covered. These additional services must be provided to a covered member with conception in the member as the intended result of the services. Procedures must be consistent with established medical practice in the treatment of infertility and induced fertilization.

Services to treat infertility include prescribed home self-administered injectable drugs, including needles and syringes, and artificial insemination (with and without egg stimulation). (See “Benefit Exclusions” below for services that are specifically excluded.)

When the following injectables are approved for home self-administration, the member must purchase the injectable, needles, and syringes at a Blue Shield participating pharmacy and submit a receipt to Blue Shield HMO for reimbursement under the FEHBP HMO Plan.

Brand Name	Generic Name
Menopur	Menotropins
Novarel, Ovidrel APL, Pregnyl	Chorionic Gonadrotropin (HCG)
Gonal F, Follistim	Follitropin
Cetrotide	Cetrorelix
Ganirelix Acetate	Ganirelix Acetate

Infertility - FEHBP

Benefit Coverage *(cont'd.)*

Consult Blue Shield HMO for a complete list of covered medications that are provided in the physician's office or for home self-administration.
See the member's EOC for benefit coverage.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

Infertility services are not provided for:

- Sexual dysfunction or sexual inadequacies
- Services incident to or resulting from procedures for a surrogate mother; however, if the surrogate mother is an enrolled member of a Blue Shield Health Plan, covered pregnancy and maternity care will be provided to her under her own plan

  Note: If a child resulting from a surrogate parenting arrangement meets the requirements and is enrolled as a "Dependent" (as defined by Blue Shield) of a Blue Shield subscriber, all covered services are available to such child from the first date of coverage
- Collection, purchase, or storage of sperm/eggs/frozen embryos from donors other than the enrolled spouse or domestic partner
- Gamete intrafallopian transfer (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Ovum transplant
- Any form of induced fertilization except for artificial insemination
- For or incident to the reversal of a vasectomy or tubal ligation or repeat vasectomy or tubal ligation
- Services or medications to treat low sperm count
- Sterilization reversals are excluded as a benefit

Examples of Covered Services

Services to diagnose and treat the cause of infertility

- Office visits (medical history and physical exams)
- Depo Lupron used for the treatment of endometriosis as a cause of infertility
- Diagnostic tests and surgical procedures specific to infertility

Male

- Epididymovasostomy, anastomosis of epididymis to vas deferens
- Semen analysis, sperm antibodies, sperm evaluation

Female

- Laparoscopy with lysis of adhesions or with aspiration
- Hysteroscopy
- Injection procedure for hysterosalpingography
- Transcervical introduction of fallopian tube catheter for diagnosis and establishing potency, with or without hysterosalpingography
- Hydrotubation of oviduct
- Lysis of adhesions
- Fimbrioplasty
- Salpingostomy
- Hysterosalpingography
- Echography, pelvic
- Ultrasonic guidance for aspiration of ova

Services to treat infertility

- Artificial insemination and supporting procedures

Infertility - FEHBP

Examples of Non-Covered Services

- Services for sexual dysfunction and sexual inadequacies, except as provided for organically based conditions
- Services incident to or resulting from procedures for a surrogate mother who is not covered for maternity services under her own Blue Shield health plan
- Services for collection, purchase, or storage of sperm/eggs from donors other than enrolled spouse or domestic partner
- Zygote intrafallopian transfer (ZIFT)
- In vitro fertilization (IVF)
- Infertility services for an individual who is not a member

References

Blue Shield Access+ HMO FEHBP Plan Brochure

Blue Shield HMO IPA/Medical Group Procedures Manual

Infertility – Additional Benefit - SFHSS

Benefit Coverage

Additional infertility services are covered for San Francisco Health Service System (SFHSS) members when defined as a benefit on the member's Blue Shield Health Plan. (The basic plan has limited benefits for the diagnosis and treatment of the cause of infertility.)

For the purpose of this benefit, the definition of infertility means any of the following:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis of infertility before the 12- month or 6-month period to establish infertility; or

- A person's inability to reproduce either as an individual or with their partner without medical intervention; or

- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this definition "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify for as having infertility.

Benefits are provided for a subscriber, spouse or domestic partner who has a current diagnosis of infertility for a medically appropriate diagnostic work-up and Assisted Reproductive Technology (ART) procedures.

Covered services for infertility include all professional, hospital, ambulatory surgery center, ancillary services, and injectable drugs when authorized by the primary care physician (PCP), to a subscriber, spouse, or domestic partner for the inducement of fertilization as described herein.

Benefits include cryopreservation services for a condition which the treating physician anticipates will cause infertility in the future (except when the infertility condition is caused by elective chemical or surgical sterilization procedures). The subscriber, spouse or domestic partner is responsible for the copayment or coinsurance listed for all professional and hospital services, ambulatory surgery center and ancillary services used in connection with any procedure covered under this benefit, and injectable drugs administered or prescribed by provider to induce fertilization. Procedures must be consistent with established medical practice for the treatment of infertility and authorized by the PCP.

Infertility – Additional Benefit - SFHSS

Copayment

See the members' *Evidence of Coverage* (EOC), *Summary of Benefits and Coverage,* and the *Infertility Services Rider* for member copayments.

Benefit Exclusions

Infertility services are not provided for:

- Services received from non-participating providers;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which covered services are provided only under the medical benefits portion of the EOC;
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California Health Plan, covered services for pregnancy and maternity care for the surrogate mother will be covered under that health plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the subscriber, spouse or domestic partner entitled to benefits under this infertility benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the subscriber, spouse, or domestic partner entitled to benefits under this infertility benefit;
- Home ovulation prediction testing kits or home pregnancy tests;
- Microsurgical epididymal sperm aspirations (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the subscriber, spouse, or domestic partner had a previous vasectomy;
- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a covered service in the member's EOC;
- Covered services in excess of the lifetime benefit maximums; or
- Services for or incident to a condition which the subscriber, spouse, or domestic partner anticipates may cause infertility in the future except as described in the benefit for cryopreservation of embryos, oocytes, ovarian tissue, or sperm.

Examples of Covered Services

- Assisted Reproductive Technology (ART) procedures and associated services
- Natural artificial inseminations
  - Without ovum (oocyte or ovarian tissue (egg)) stimulation
- Stimulated artificial inseminations
  - With ovum (oocyte or ovarian tissue) stimulation
- Gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or in vitro fertilization (IVF)
- Intracytoplasmic sperm injection (ICSI)
- Assisted embryo hatching
- Elective single embryo transfer, including preparation of embryo for transfer
- Preimplantation genetic screening for embryo biopsy preimplantation genetic diagnosis (PGD)
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm
  - Retrieved from the subscriber, spouse, or domestic partner. Includes one year of storage.

Infertility – Additional Benefit - SFHSS

References

San Francisco Health Service System Additional Benefits Summary of Benefits

Medical Supplies

Benefit Coverage

Ostomy and medical supplies to support and maintain gastrointestinal, bladder, or respiratory function, continuous glucose monitors, insulin pumps, and medical supplies needed to operate home medical equipment, prostheses, and orthoses are covered when appropriately authorized.

Note: Disposable insulin needles and syringes, pen delivery systems, diabetic testing supplies including lancets, lancet puncture devices, blood and urine testing strips, and test tablets are covered by the Outpatient Prescription Drug benefit. No prescription is required by law for pen delivery systems (prior authorization required) or diabetic supplies; however, in order to be covered by the Outpatient Prescription Drug benefit, the member's physician must order them. For plans without an Outpatient Prescription Drug benefit, diabetic supplies and equipment are covered as basic plan benefits.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and coverage* for member copayments for:

Home Health Care

Other Services

Durable Medical Equipment (DME)

Medical Supplies

Orthoses, Prostheses (external)

Benefit Exclusion

Non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Home Health Care Services, Hospice Program Services, Diabetes Care, Durable Medical Equipment, and Prostheses.

Medical Supplies

Examples of Non-Covered Services

The following over-the-counter (OTC) medical supplies are not covered:

- Adhesive remover
- Alcohol and peroxide solution
- Alcohol wipes/towelettes
- Band-Aids
- Betadine and iodine wipes/towelettes
- Composite dressings
- Hydrocolloid dressings
- Hydrogel dressings
- Iodine/Betadine solutions
- Paraffin
- Rib belts
- Skin sealants, protectants, moisturizers, ointments
- Slings
- Conductive paste/gel
- Deodorant
- Elastic bandage/Ace wraps
- Face masks (not including CPAP)
- Gauze dressings (sterile/non-sterile)
- Gloves
- Splints
- Standard 4V, 6V, 9V batteries
- Sterile saline
- Tape
- Thermometers
- Transparent film dressings (covered if used with an insulin pump)
- Under pads/Chux/Diapers (such as Depends)

Examples of Non-Covered Dental Services

The following are non-covered dental services and supplies:

- Athletic mouth guards
- Dental floss
- Denture adhesives
- Denture cleaning supplies
- Fluoride rinses
- Lip balm
- Oral rinses (mouth wash)
- Orthodontic waxes
- OTC antiviral medicaments
- OTC bruxing-clenching appliances
- OTC dental cements/filling materials
- OTC denture relining kits
- OTC denture repair kits
- OTC orthodontic appliances
- Teeth bleaching supplies
- Teething analgesics
- Toothbrushes
- Toothpaste

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for: *Diabetes Care, Durable Medical Equipment, Home Health Care, Hospice Care, Orthoses and Prostheses.*

Mental Health and Substance Use Disorders

Benefit Coverage

Blue Shield plans provide coverage for the diagnosis and treatment of medically necessary mental health and substance use disorders for all Blue Shield HMO plans in accordance with the federal Mental Health Parity and Addiction Equity Act and the California Mental Health Parity Act. These Acts require that coverage for mental health and substance use disorder benefits be in parity with medical benefit coverage. Coverage includes conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Mental health and substance use disorder benefits include medically necessary basic health care services and intermediate services, at the full range of levels of care, including but not limited to, residential treatment, Partial Hospitalization Program, Intensive Outpatient Program, and prescription drugs.

Members must utilize the Blue Shield provider network to access mental health and substance use disorder services.

If the member is unable to schedule an appointment with a participating provider for medically necessary mental health and substance use disorder services, Blue Shield will either schedule an appointment with a participating provider or select a non-participating provider in the area within five (5) calendar days and contact the member regarding available appointment times. For any medically necessary mental health and substance use disorder, the member will be responsible for no more than the cost share for using a Blue Shield participating provider. Blue Shield may work with the member to transition to a participating provider when one becomes available.

Upon request to Blue Shield Customer Service, and at no cost to the member, Blue Shield Customer Service will provide the clinical review criteria and any training materials or resources used to conduct utilization reviews for mental health and substance use disorder benefits and services.

IPA/medical groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of eating disorder, substance use disorder, or gender affirming care may be the responsibility of the IPA/medical group.

Mental Health and Substance Use Disorders

Benefit Coverage *(cont'd.)*

The member can self-refer by calling the Blue Shield Member Self-Referral Number at (877) 263-9952 to obtain a referral to an appropriate mental health or substance use disorder provider and receive an authorization for services and/or crisis intervention services. The member can also get help in finding a participating mental health or substance use disorder provider by calling this number. This phone number is available 24 hours/day; 7 days per week, 365 days a year.

Benefits are provided for the medically necessary treatment of mental health and substance use disorders, subject to any applicable deductible, copayment, or coinsurance. The services identified with an asterisk (*) must be prior authorized by Blue Shield:

- Professional office visits, including telebehavioral health, in an individual, family, or group setting.
- *Inpatient hospital admissions, including acute and residential treatment, and related professional services.
- *Other outpatient mental health and substance use disorder services, including services provided through telebehavioral health, as listed below:
  - *Behavioral Health Treatment – Professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, prescribed by a physician or licensed psychologist, and provided under a treatment plan approved by Blue Shield to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.
  - *Electroconvulsive Therapy – The passing of a small electric current through the brain to induce a seizure, used in the treatment of severe depression.
  - *Intensive Outpatient Program – Outpatient care for mental health and substance use disorders when the condition requires structure, monitoring, and medical/psychological intervention that may be in a free-standing or Hospital-based facility and provides services at least three (3) hours per day, three (3) days per week.
  - *Partial Hospitalization Program – Outpatient care for mental health and substance use disorders when the condition requires structure, monitoring, and medical/psychological intervention that may be in a free-standing or Hospital-based facility and provides services at a minimum of 20 hours per week.

Benefit Coverage *(cont'd.)*

- *Neuropsychological Testing – Testing to diagnose a mental health condition used to measure a psychological function known to be linked to a particular brain structure or pathway. Neuropsychological testing is covered through the member's mental health benefit when:
  - After completion of a comprehensive behavioral health evaluation and neurological evaluation, if the mental health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request. Blue Shield will cover neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).
- *Transcranial magnetic stimulation – A non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Member Cost Share

See the members' *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage* for applicable member deductible, copayment, or coinsurance.

Benefit Exclusions

Benefits are not provided for:

- Select physical and occupational therapies, such as:
  - Training or therapy for the treatment of learning disabilities or behavioral problems;
  - Social skills training or therapy;
  - Vocational, educational, recreational, art, dance, music, or reading therapy; and
  - Testing for intelligence or learning disabilities.
- Treatment for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

  This exclusion does not apply to services deemed medically necessary for the treatment of a mental health or substance use disorder.

Mental Health and Substance Use Disorders

Benefit Classification

- Inpatient services which are medically necessary to treat the acute medical complications of detoxification are covered as a medical benefit.
- Neuropsychological testing is covered through the member's medical benefit when:
    - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request. Blue Shield will cover neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).

Examples of Covered Services

See Benefit Coverage.

Examples of Non-Covered Services

- Non-medical services provided by a vocation or rehabilitation therapist, or an employment counselor.
- Maintenance drugs dispensed during covered visits (some exceptions apply).

References

Large Group Evidence of Coverage

Small Group Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Blue Shield HMO IPA/Medical Group Procedures Manual

Blue Shield Medical Policy

Newborns

Benefit Coverage

Immediate accident and sickness coverage from and after the moment of birth of each newborn infant of any enrolled subscriber or spouse is provided, as required by the Health and Safety Code (Knox-Keene Act). Benefits are provided for the first 31 days regardless of whether the newborn has been added to the subscriber's health plan. This immediate accident and sickness coverage include newborn of enrolled member who is a surrogate mother until the adoptive parents have the right to control the newborn's health care. All other provisions and rules of the plan apply. Newborn must be added as a dependent within the first 31 days to avoid a gap in coverage. *Exception:* FEHBP, CalPERS, and Small Group plan member have 60 days from the date of birth/placement for adoption.

Individual and Family Plans (IFP): If the parents fail to put in a request to add the child within the first 31 days, they will be able to submit an application between the 32nd and 63rd days as this would be a qualifying event under California law for late enrollees who are under age 19.

Note: If the mother is not covered as a subscriber or spouse by the Blue Shield HMO plan, and the newborn qualifies as a dependent of the subscriber, newborn nursery charges are eligible for coverage under the subscriber's inpatient hospital benefits, Coordination of benefit rules will apply if applicable. This coverage applies regardless of whether the newborn is added to the subscriber's plan.

The primary care physician (PCP) selected for a newborn must be in the same IPA or medical group as the mother's PCP during the calendar month of birth. If the mother of the newborn is not enrolled as a subscriber or spouse, the PCP selected must be a physician in the same IPA or medical group as the subscriber during the calendar month of birth. If the child has been placed with the subscriber for adoption, the PCP selected must be a physician in the same IPA or medical group as the subscriber or covered spouse during the calendar month the subscriber has the right to control health care of the child. If the mother of the newborn, or subscriber if the mother is not enrolled, has selected a virtual PCP with Accolade Care (available to Trio HMO plan members), the newborn will be assigned to an in-person PCP with a different IPA.

The PCP for a newborn may be changed after the birth month. If the newborn is ill or hospitalized during the birth month, the effective date of the new PCP will be the first of the month following discharge from the hospital, or the date it is medically appropriate to transfer care to the new PCP. Exceptions must be approved by the Blue Shield Medical Director.

Retinal Screening exams for infants with low birth weight (<1500g) or < 32 gestational weeks and infants weighing between 1500 and 2000g or > 32 gestational weeks with an unstable clinic course are covered.

Newborns

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Emergency Services

Inpatient Hospital Services

Physician-Outpatient

Benefit Exclusion

- Well baby services not provided by the PCP.

Examples of Covered Benefits

- Well baby services provided by the PCP. These services are available to enrolled newborns and to newborns that are not enrolled for the first 31 days.
- Routine circumcision performed within 18 months of birth. The newborn must be enrolled to access these services after the first 31 days of life.
- Treatment for illness or injury (active or non-active).
- Apnea monitors for the management of newborn apnea.

Examples of Non-Covered Services

- Medical care after 31 days if the newborn is not enrolled.
- Well baby services provided by non-plan providers.
- Infant nutritional formulas such as Enfamil, and Similac. (See guideline on Home Health Services for possible coverage under Medical Benefits.)
- Over the counter supplies for newborn (diapers, ointments, etc.).

References

Evidence of Coverage

Health & Safety Code (Knox-Keene Act), Section 1373

HMO Benefit Guideline for *Pregnancy and Maternity Care*

IFP Evidence of Coverage and Health Service Agreement

Orthoses

Benefit Coverage

Medically necessary orthoses and related services for maintaining normal Activities of Daily Living, defined as, “Mobility skills required for independence and normal everyday living. Recreational, leisure, or sports activities are not included.” The following services are covered:

- Initial fitting and replacement after expected life of the item.
- Repairs, even if due to damage.
- Supplies necessary for the operation or function of orthoses.
- Special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, or by accident or developmental disability.
- Podiatric devices to treat diabetes-related complications, including extra-depth orthopedic shoes.
- Medically necessary functional foot orthoses that are custom-made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle, or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device. They are usually made of high-impact thermal plastic. (See list of covered diagnoses under Examples of Covered Services below.)

Routine maintenance of orthoses is not covered. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. Orthoses must be authorized.

Copayment

See the members’ *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services - Orthoses, Prostheses (external)

Orthoses

Benefit Exclusions

- External accommodative, digital, and supportive foot orthoses, including services associated with fitting. Accommodative, digital, or supportive orthotics are flexible or semi-rigid devices and are used to ease foot pain. Since they do not correct the condition, they are considered comfort and convenience items and are excluded from coverage. Orthopedic shoes are not covered except extra-depth orthopedic shoes used to prevent or treat diabetes-related complications.
- External foot orthoses not authorized and prescribed by a physician.
- Non-custom made or over-the-counter shoe inserts or arch supports.
- Routine maintenance.
- No benefits are provided for backup or alternate items.

Benefit Limitations

Limited to least costly item to meet patient's medical needs.

Exceptions

- Orthopedic shoes are covered when attached to a leg brace.
- Special footwear required for foot disfigurement as a result of, but not limited to, cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurements caused by accident or developmental disability are covered.
- Functional foot orthoses (custom-made rigid inserts for shoes) when used to treat specific diagnoses (See Examples of Covered Services below).

Examples of Covered Services

- Back brace
- Cervical halo
- Knee brace for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis
- Orthopedic shoes (with leg brace)
- Functional foot orthoses for foot disfigurement
- Arch supports, foot orthotics, toe separators, custom built shoes, and extra-depth orthopedic shoes to prevent or treat diabetes-related conditions
- Functional foot orthoses used to treat one of the following diagnoses when improvement has not occurred with a trial of strapping or of an over-the-counter stabilizing device (except that a trial of strapping or of an over-the-counter stabilizing device is not required for the management of genu varum/ valgum*):
  - Abnormal pronation of the foot
  - Apophysitis in children
  - Calcaneal spur
  - Diabetes
  - Femoral torsion antetorsion
  - Genu varum/valgum*
  - Hallux valgus
  - Lateral ankle instability
  - Metatarsalgia
  - Patellofemoral dysfunction
  - Pescavus/planus/planovalgus
  - Plantar fasciitis
  - Tarsal tunnel syndrome
  - Tendonitis
  - Tibial torsion

Orthoses

Examples of Non-Covered Services

- Functional foot orthoses for a non-covered diagnosis
- External accommodative, digital, and supportive foot orthoses except those used to prevent or treat diabetes-related conditions
- Orthopedic shoes (without leg brace), including any associated professional services except for extra-depth orthopedic shoes used to prevent or treat diabetes-related complications
- Backup or alternate items
- Repair or replacement of backup/alternate items due to loss or misuse
- Over-the-counter shoe inserts or arch supports

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Out-of-Area Services

Benefit Coverage

The subscriber, spouse and dependents are covered for the following types of services while outside the primary care physician's (PCP) service area:

- Non-emergency services referred out-of-area and authorized by the IPA/medical group and/or Blue Shield HMO.
- Urgent Services within California – Members who are traveling within California but outside of the PCP service area who are unable to contact their PCP should call the phone number listed on the back of their ID card for assistance in receiving urgent services.
- Urgent Services within the United States - When traveling within the United States, a member can access a network of participating health plans that will provide urgent services. Members can also receive urgent care from non-participating providers. The member should call the 24-hour toll-free number at (800) 810-BLUE (2583) to obtain information about the nearest participating provider.
- Urgent Care and Emergency Services outside of the United States –The member may call Blue Shield Global Core at (800) 810-BLUE (2583) for the nearest participating provider, or when outside the country, call collect at (804) 673-1177. If the member does not use Blue Shield Global Core, and the claim is for services other than inpatient care, the member will need to pay the claim at the time the service is rendered. The member can obtain a Blue Shield Global Core International Claim Form (C14764) by calling the member services number on the back of their ID card. The member will then need to submit the claim form and a copy of the bill to the following address:

  Blue Shield of California Foreign Claims Unit
  P.O. Box 272550
  Chico, California 95927-2550

- Urgent Mental Health and Substance Use Disorder Services - Within California, the member should contact Blue Shield at (877) 263-9952.
- Services provided through the Away From Home Care℠ Program.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Out-of-Area Services

Benefit Exclusions

Unauthorized treatment outside the PCP's service area when it is determined by the Plan that emergency services were not required, or urgent services received were obtained and retrospective review indicated the services would not have been authorized as urgent services, is not covered.

Follow-up care to urgent or emergency services that is not medically necessary is not covered.

Benefit Limitations

Blue Shield HMO members who qualify for Away From Home Care will receive services through the local BCBS HMO where they reside. Their benefit plan will be one offered by the local HMO.

Authorization by Blue Shield HMO is required for more than two out of area follow-up outpatient visits following an urgent or emergency visit or for care that involves a surgical or other procedure or inpatient stay. Blue Shield HMO may direct the patient to receive follow-up services from the PCP.

Exceptions

Out-of-area treatment for renal failure is covered while the member is temporarily traveling **only** when prior authorized by the IPA/medical group or Blue Shield HMO.

Examples of Covered Services

- Emergency services
- Emergency ("first aid" care), immediate, and initial palliative services to medically or dentally stabilize the teeth and the structures of the mouth immediately following trauma or an accident to the mouth and oral structures
- Non-emergency/non-urgent services rendered out-of-area and authorized by the IPA/medical group and/or Blue Shield HMO
- Urgent services received through the Blue Shield network, a non-network provider, the Away From Home Care Program, or BlueCard network

Out-of-Area Services

Examples of Non-Covered Services

- Non-emergency/non-urgent self-referrals
- Out-of-area follow-up care for an urgent or emergency visit that is not medically necessary
- Out-of-area follow-up care for an urgent or emergency visit in excess of two outpatient visits (except for non-marketed IFP plan members) that was not authorized by Blue Shield HMO
- Out-of-area follow-up care for an urgent or emergency visit that involves any procedure or facility component unless prior authorized by Blue Shield HMO
- All dental services that are not the immediate, initial and emergency palliative treatments performed as the direct result of an accident to include fillings falling out, crowns falling out, extraction of teeth, lost dentures, broken dentures, broken fixed dental bridges, foreign objects “stuck” to the gums or teeth, broken orthodontic brackets, broken orthodontic arch wires, gum surgery, oral appliances of any type (TMJ, obstructive sleep apnea, nightguards for bruxing, orthodontic retainers) and etc. Thorough documentation from the provider must be submitted to the Dental Plan Administrator for reimbursement consideration to include pre, post-operative radiographs and medical quality photographs

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for*:*

Emergency
Urgent Services

Blue Shield HMO IPA/Medical Group Procedures Manual

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Physician Services

Benefit Coverage

Outpatient

Professional office visits for examination, diagnosis, and treatment of a medical condition, disease, or injury including specialist office visits, consultations, counseling, education, urgent care visits, second medical opinions, diabetic counseling, asthma self-management training, administration of injectable medications that must be administered by a health care provider, administration of radiopharmaceutical medications, office surgery, outpatient chemotherapy, and radiation therapy are covered. This benefit includes services delivered via telehealth.

Medically necessary home visits by a physician are covered.

Inpatient

Physician services in a hospital, residential treatment center, emergency room, or skilled nursing facility for examination, diagnosis, treatment, and consultation including the services of a specialist, surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist are covered when the inpatient stay has been authorized by the Blue Shield HMO. Physician services must either be provided by, or referred by, the member's primary care physician (PCP), including services for members who are admitted for detoxification.

Access+ *Specialist* and Trio+ *Specialist* Services

The member may arrange an Access+ or Trio+ *Specialist* office visit with a plan specialist in the same IPA/medical group as the PCP without a referral when the IPA/medical group participates as an Access+ or Trio+ Provider Group. Each visit is subject to a copayment, including follow-up visits that are not referred or authorized by the PCP. The Access+ or Trio+ *Specialist* visit includes:

- An office visit examination or consultation provided by a specialist in the same IPA/medical group as the PCP.
- Conventional X-rays, but does not include diagnostic imaging such as CT, MRI, or bone density measurement.
- Routine laboratory services.
- Diagnostic or treatment procedures which a plan specialist would routinely provide under a referral from the PCP. Only minor office based surgical procedures will be included as part of the Access+ or Trio+ *Specialist* visit (e.g., minor dermatology procedures, casting of minor fractures, removal of foreign body of the eye, etc.). If the specialist believes that additional surgical or other treatment is necessary, authorization should be requested through the PCP

Physician Services

Benefit Coverage *(cont'd.)*

Access+ *Specialist* and Trio+ *Specialist* Visit for Mental Health and Substance Use Disorder Services

The member may arrange an Access+ or Trio+ *Specialist* office visit for mental health and substance use disorder services without a referral (except for neuropsychological testing) from Blue Shield as long as the provider is a Blue Shield Participating Provider. Each visit is subject to a copayment, including follow-up visits that are not referred or authorized by Blue Shield.

Adverse Childhood Experiences (ACEs) Screening

An ACEs screening, as defined by California Health and Safety Code Section 1367.34, is a screening for all individuals covered under fully insured plans with Blue Shield. Training to perform ACEs screenings, approved by the California Department of Healthcare Services, is available on the ACEs website at https://www.acesaware.org/wp-content/uploads/2019/12/ACE-Clinical-Workflows-Algorithms-and-ACE-Associated-Health-Conditions.pdf. See the Preventive Benefit Policy for benefit coverage details.

OB/GYN Physician Services

Female members may arrange for obstetrical and gynecological physician services directly from an OB/GYN or family practice physician, designated as providing gynecological services, in the same IPA/medical group as her PCP without obtaining a referral from the PCP. Obstetrical and gynecological services are defined as:

- Physician services related to preconception, prenatal, perinatal, and postnatal (pregnancy) care.
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia.
- Physician services for treatment of disorders of the breast.
- Routine annual gynecological examinations/annual well-woman examinations.

Mental Health and Substance Use Disorder Services

Members may arrange for mental health and substance use disorder services by calling Blue Shield directly at (877) 263-9952. Members may also ask their PCP to call Blue Shield and make the arrangements for them.

Physician Services

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for members copayment for:

Infertility Services

Mental Health and Substance Use Disorder Services

Physician (Professional) Services

Pregnancy and Maternity Care

Preventive Health Services

Benefit Exclusion

Any physician service which:

- Is not a covered benefit of the Blue Shield HMO Plan.
- Includes dental and oral surgery services of any kind.
- Has not been provided or authorized by the member's PCP except when it is a covered by a:
    - Access+ or Trio+ *Specialist* visit, or
    - Maternity and gynecological physician service.

An Access+ or Trio+ *Specialist* visit does not include:

- Services which are not covered, not medically necessary, or provided by any provider other than the plan specialist providing the Access+ or Trio+ *Specialist* visit (such as podiatry and physical therapy), except for routine x-ray and laboratory services.
- Allergy testing, endoscopic procedures, infertility, emergency, or urgent services.
- Any diagnostic imaging, except routine X-rays.
- Injectables, chemotherapy, or other infusion drugs, other than vaccines and antibiotics.
- Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services.
- Women's preventive health, maternity, and gynecological physician services, or services for which the IPA/medical group routinely allows the member to self-refer without authorization from the PCP.

Physician Services

Examples of Covered Services

- Office visits with the PCP.
- Office visits/consultations with specialists when referred by the PCP.
- Office visits for asthma self-management training and education to enable a member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers, and peak flow meters.
- Access+ or Trio+ *Specialist* office visits/consultations.
- Nutritional counseling provided by the treating physician as part of an office visit, and nutritional counseling for the treatment of diabetes.

Examples of Non-Covered Services

- Office visits/consultations with specialists that are not referred by the PCP, or Blue Shield, except an Access+ or Trio+ *Specialist* visit and visits for maternity and gynecological physician services.
- Professional services that are an exclusion of the plan.
- Physician services performed by a close relative of the member, by a person who ordinarily resides in the member's home or by hospital officers, residents, interns, and others in training.
- All dental and routine oral surgery services to include but limited to extractions of teeth, biopsies of oral tissues, oral facial pain, trigger point injections for jaw joint problems, oral pathology services, oral medicine services, etc. performed by licensed dentists (DDS or DMD). The Blue Shield of California Dental Director will make the final determination as to whether or not a service is considered a medical issue or a dental issue.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code, Section 1367.695

HMO Benefit Guidelines for:

Mental Health and Substance Use Disorders

Preventive Benefit Policy

Pregnancy and Maternity Care

Benefit Coverage

Prenatal and postnatal physician office visits, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. All necessary inpatient hospital services for normal delivery, Cesarean section (C-section), complications of pregnancy and routine newborn circumcision.

The Newborns and Mothers Health Protection Act of 1997 requires health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal vaginal delivery. A minimum hospital stay for the mother and newborn child of 96 hours is required after a C-section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

Note: If the mother is not covered as a subscriber or spouse by the Blue Shield HMO plan, and the newborn qualifies as a dependent of the subscriber, newborn nursery charges are eligible for coverage for the first 31 days under the subscriber's inpatient hospital benefits, subject to standard coordination of benefit rules, as applicable. This coverage applies regardless of whether the newborn is added to the subscriber's plan.

California law requires coverage for a follow-up visit for the mother and newborn within 48 hours of discharge when prescribed by the treating physician, if the hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating physician, in consultation with the mother, shall determine if the visit shall occur at home, the contracted facility, or the physician's office.

Members may arrange for maternity physician services directly from an obstetrician/gynecologist (OB/GYN) who is in the same IPA/medical group as her primary care physician (PCP).

<u>OB Checkups (Facility-Based)</u>

Non-Emergent

The member is not responsible for any copayment as these services are considered diagnostic.

Emergent

The member is responsible for an emergency room copayment unless admitted within twelve hours.

Pregnancy and Maternity Care

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Pregnancy and Maternity Care

Benefit Exclusions

Services incident to or resulting from procedures for a surrogate mother who is not eligible under a Blue Shield health plan.

Services for a newborn of a dependent unless legally adopted by the subscriber and added to the plan.

Benefit Limitations

Certified nurse midwife services are covered only when available within the IPA/medical group network.

Pregnancy and Maternity Care

Examples of Covered Services

- Prenatal care
- Postnatal care
- Involuntary complications of pregnancy
- Inpatient Hospital services including labor, delivery, and postpartum care
- Elective newborn circumcision within 18 months of birth
- Abortion and abortion-related services, including pre-abortion and follow-up services
- Newborn screening for metabolic disorders and Alpha Fetoprotein Screening (AFP)
- Services provided by a certified nurse midwife when available within the IPA/medical group network
- Diagnostic testing
  - Amniocentesis
  - Blood test to determine pregnancy
  - Chorionic villus sampling (CVS)
  - Fetal contraction stress test (fetal monitoring)
  - Fetal non-stress test (fetal monitoring)
- Genetic counseling
- Lactation counseling by a licensed provider
- Ultrasound
- Diagnostic procedures

Examples of Non-Covered Services

- Amniocentesis that is not medically necessary or that is performed solely for sex determination
- Blood tests to determine paternity
- Experimental/investigational services

Pregnancy and Maternity Care

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Newborns

Health & Safety Code Section 1367.62

Prostheses

Benefit Coverage

Medically necessary prostheses for maintaining normal Activities of Daily Living, defined as “Mobility skills required for independence and normal everyday living. Recreational, leisure, or sports activities are not included.” Covered services include the initial fitting, replacement after expected life of the item, and repairs (regardless if due to damage). Supplies necessary for the operation and functioning of the prostheses are covered. Benefits are provided at the most effective level of care that is consistent with professionally recognized standards of practice.

Copayment

See the members’ *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Other Services

Surgically Implanted Devices
Orthotics, Prosthetics (external)
Durable Medical Equipment

Benefit Exclusions

- Dental implants
- Routine maintenance
- Backup or alternate items
- Lost or broken: Dentures (full or partial), orthodontic retainers, fixed dental bridgework, removable orthodontic aligners, Obstructive Sleep Apnea oral appliances (within the warranty period of 5 years), TMJ appliances, oral obturators, radiation shields used to cover the face and jaws during radiation treatment, and oral medicament carriers
- Any and all dental “prosthodontic” appliances

Benefit Limitations

- Payment authorization will be provided for the least costly item that will meet the patient's medical needs
- Surgically implanted accommodative lenses (e.g., Crystalens) that correct the post cataractomy eye and allow ciliary muscles to accommodate the optic lens for presbyopia are not covered. Such accommodative lenses are not medically necessary as the standard intraocular lens restores the eye to a functional state

Prostheses

Examples of Covered Services

- Artificial eye
- Artificial hand
- Artificial leg
- Additional replacement devices to allow for growth and development
- Breast prosthesis after mastectomy and mastectomy bra (paid at surgical level of benefits and not subject to plan copayment for prostheses)
- Blom-Singer and artificial larynx prostheses following a laryngectomy

Examples of Covered Surgically Implanted Prosthetic Devices

- Breast implant after mastectomy
- Cochlear implants
- Hip prosthesis (pins, screws, rods)
- Pacemaker and supplies
- Prosthetic eye
- Blom-Singer and artificial larynx prostheses

Examples of Non-Covered Services

- Dental implants
- Any and all dental prosthetic devices to include, but not limited to, fixed bridgework, dentures (full or partial), facial-jaw prosthesis provided primarily for cosmetic reasons
- Accommodative intraocular implants (e.g., Crystalens)
- Investigational or Experimental prosthetic devices

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Second Opinion Consultation

Benefit Coverage

A second opinion consultation that is initiated at the request of an HMO member, primary care physician (PCP), plan specialist, or other plan licensed health care provider is covered, subject to plan benefit limitations and exclusions.

A second opinion consultation is provided by an appropriately qualified health care professional who is a PCP or specialist acting within his or her scope of practice and who possesses a clinical background including training and expertise, related to the particular illness, disease, condition, or conditions associated with the request for second opinion.

A second opinion consultation is considered to be a covered service including, but not limited to, the following conditions:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

  Note: When the member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the member's ability to regain maximum function, the second opinion shall be authorized or denied as soon as possible to accommodate the member's condition not to exceed 72 hours from receipt of the request.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the member requests a second opinion.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate length of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.

Second Opinion Consultation

Benefit Coverage *(cont'd.)*

Second Opinions - Primary Care Physician

If the member is requesting a second opinion about care from their PCP, the second opinion shall be provided by an appropriately qualified health care professional of the member's choice within the same IPA/medical group as their PCP, as arranged by the IPA/medical group.

The IPA/medical group is responsible for obtaining a second opinion outside of the IPA/medical group network if an appropriately qualified licensed health care professional is not available in the IPA/medical group.

Second Opinions - Specialist

If the member is requesting a second opinion about care from a specialist or other licensed health care provider outside of their assigned IPA/medical group, Blue Shield will authorize a second opinion by an appropriately qualified health care professional of the member's choice within the Blue Shield HMO network.

If there is no participating plan provider within the HMO network who meets the standards specified, then Blue Shield must authorize a second opinion by an appropriately qualified health professional outside of the Blue Shield HMO provider network.

Second Opinion Consultation

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician Outpatient/Consultation

Physician Inpatient/Consultation

Benefit Exclusions

Second opinion consultations regarding infertility are not a benefit for IFP members.

Benefit Limitations

Second opinion consultations for requests regarding care from the assigned PCP must be referred by the member's PCP and approved through the contracted IPA/medical group authorization process. Generally, members will be provided one second opinion consultation if requested. This is in addition to any consultations that the PCP or attending physician may determine are medically necessary.

Second Opinion Consultation

Exceptions

Members may arrange an Access+ or Trio+ *Specialist* visit with a plan specialist in the same IPA/medical group as the PCP without a referral when the IPA/medical group participates as an Access+ or Trio+ Provider.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Consultations

Infertility Services

Mental Health and Substance Use Disorder

Blue Shield HMO IPA/Medical Group Procedures Manual

Skilled Nursing Facility (SNF)

Benefit Coverage

Two types of services are covered under the Skilled Nursing Facility (SNF) Services benefit:

- Medically necessary skilled nursing services are covered when authorized and provided in a skilled nursing facility.
- Medically necessary hospice services are covered when authorized and provided in a facility for Individual and Family Plan (IFP) members in the latter stages of a terminal illness as determined by a plan physician. See the *HMO Benefit Guideline* for *Hospice Care.*

A total of 100 days per calendar year is covered for these services. (*Note*: For Blue Shield HMO group members, hospice services provided by a participating hospice agency do not count toward the 100 days per calendar year maximum for Skilled Nursing Facility services. See the *HMO Benefit Guideline* for *Hospice Care.*

A skilled nursing facility (SNF) is defined as a facility licensed by the California Department of Public Health (CDPH) as a “Skilled Nursing Facility” or similar institution licensed under the laws of any other state territory, or foreign country.

Copayment

See the members’ *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Skilled Nursing Facility (SNF)

Benefit Exclusions

- Services for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for custodial, maintenance or domiciliary care, rest, or to control or change a person's environment.
- Convenience items such as telephones, TVs, guest trays, and personal comfort items.
- Services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain.
- Services in connection with private duty nursing, except as medically necessary and authorized.
- Services for psychiatric hospitalization, psychiatric professional services delivered in conjunction with hospitalization, inpatient psychotherapy, or psychological testing.
- SNF coverage for custodial and domiciliary care, homemaker services, personal and comfort items, and private duty nursing.
- Confinement in a SNF that does not require daily skilled nursing observation or treatment.
- Confinement in a SNF for social services reasons.
- Lost dental appliances, routine dental services, oral surgery services (for example extractions of teeth), dental cleanings, broken dental appliances, and any dental palliative treatments.
- Any dental services provided by itinerant dentists and dental hygienists who visit the SNF on an "on-call" basis or have a regular schedule in the SNF.

Benefit Limitations

Inpatient skilled nursing facility services are covered up to 100 days per calendar year. Skilled nursing facility services and hospice services (for IFP members only) rendered in a facility both apply toward the 100 day per calendar year benefit.

Skilled Nursing Facility (SNF)

Exceptions

Rehabilitation services rendered in a SNF apply toward the Rehabilitation benefit.

Examples of Covered Services

- Intense and complex care needs that require skilled nursing facility care.
- Wound management that requires dressing changes with prescription medication such as for decubitus ulcers (Stage III and IV) requiring aseptic techniques twice daily or more often.

Examples of Non-Covered Services

- SNF care primarily for administration of routine oral medications, eye drops, and ointments.
- SNF care primarily for general maintenance care of colostomy or ileostomy.
- SNF care primarily for assistance in dressing, eating, and going to the toilet and other activities of daily living.

Skilled Nursing Facility (SNF)

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Hospice Care

Mental Health and Substance Use Disorders

Blue Shield HMO IPA/Medical Group Procedures Manual

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Coverage

Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jawbones, including adjacent tissues are a benefit only to the extent that these services are provided for or included in the plan as delineated below:

- Treatment of pre-malignant or malignant tumors (neoplasms) of the gingiva (gums), teeth, or soft and hard tissues of the oral cavity and associated oral structures. Required documentation for services are radiographs (when requested), extra/intra oral photographs, and medical pathology reports.

  Note: Surgical removal of lesions in the soft and hard tissues of the mouth as a direct or indirect result of poor oral hygiene, dental caries, teeth, or pulpal necrosis (e.g., periapical lesions, dental cysts, dental abscesses, and gum abscesses,) are not a benefit under this plan. Pathology reports and biopsies of tissues from the mouth by dental pathologists for non-malignant, malignant, or pre-malignant lesions are not a benefit of this medical plan as these are covered under a member's dental plan.

  Note: A neoplasm is defined as an abnormal mass of tissue characterized by excessive growth that is uncoordinated with that of the surrounding tissue and persists in the same excessive manner after cessation of the stimuli that initiated the change; also called a tumor. (Melloni's Illustrated Medical Dictionary, 4th Edition).

- Emergency palliative treatment or damage to the natural teeth and adjacent structures caused directly (solely) by an accidental injury or trauma to the mouth.

  Note: The goal and definition of emergency palliative is the immediate treatment to dentally or medically stabilize the teeth or oral structures that is the direct result of an accident and/or to manage or treat acute, intractable (severe) oral pain or swelling; it is not necessarily the definitive restoration of teeth or oral structures. This benefit does not include services for pain, swelling, or damage to the natural teeth that are/is not accidental (for example resulting from chewing or biting) or chronic conditions of the mouth and teeth due to neglect or poor oral hygiene. Covered services are limited to the immediate, medically necessary services for the initial, palliative medical stabilization (first aid) of the member's teeth and associated oral structures to prevent a more serious medical condition from occurring. Submission of pre- and post-accident radiographs of the site will be required when requesting services. For additional information, see the *HMO Benefit Guideline* for *Accidental Injury to Natural Teeth-Basic Plan*.

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

- Medically necessary, non-surgical treatment of Temporomandibular Joint Syndrome (TMJ) or Temporomandibular Disorders (TMD) dysfunction (for example splint and physical therapy). The treatment is a benefit when clinical evidence is provided showing there is definitive pathology/disease to the TMJ articulating disk, condyles, and fossa and not just secondary pain or discomfort (soreness or tenderness) to the joint or the myo-facial/myo-fascial tissues surrounding the joint from bruxism or clenching of the teeth (the mere presence of jaw joint clicking, pain to the muscles of mastication, pain-tenderness to the area of the jaw joints, clenching, nocturnal teeth grinding, limited jaw opening, pain to the face, headaches, neck aches, is, in-of-itself, not sufficient clinical documentation to arrive at a diagnosis of TMJ pathology or disease). The provider must provide unambiguous clinical documentation, to include X-rays showing the condition of the teeth and the TMJ joint complex, distinguishing actual pathology/disease to the jaw joint articulating disk (for example arthritis, displacement of the articulate disc, changes to the morphology of the jaw condyles, etc.) versus pain/discomfort secondary to parafunctional oral habits.

  Note: When a TMJ/TMD appliance is medically necessary to address a jaw joint problem, only one oral appliance is needed to manage the TMJ discomfort because the vast majority of TMJ problems occur at night while the patient is sleeping. If desired, the approved TMJ appliance can also be worn during the day as well. If the TMJ appliance gets in the way when speaking or eating during the day, the patient can simply remove the appliance and put it back in your mouth when you are done speaking or eating. The need for a daytime TMJ appliance is therefore not medically needed.

  Note: A flat plane TMJ oral appliance to maintain the jaw condyles in a specific location in the TMJ joint space (fossa) after the acute TMJ pain subsides is essentially an oral appliance used to separate the teeth to minimize the effects from clenching or grinding (usually at night) and viewed as a dental appliance and not a benefit of the medical plan. In the event the TMJ returns, the patient can simply put the approved TMJ appliance back in the mouth and wear it until the TMJ pain subsides. The current literature suggests that wearing an oral appliance after the TMJ discomfort resolves for long periods of time is not recommended as it can lead to changes to the bite (occlusion).

  Note: In a publication from the US Government www.nidcr.nih.gov/health-info/tmd, "Many TMDs last only a short time and go away on their own."

Benefit Coverage *(cont'd.)*

Note: Treatment of bruxism, obstructive sleep apnea related bruxism and nocturnal clenching of the teeth, or any parafunctional oral habits as the primary etiology of pain or discomfort to the muscles of mastication or inflammation to the jaw joints, are not covered in this plan as these are considered by Blue Shield to be dental issues.

Note: Oral appliances sometimes referred to as morning aligners to prevent a TMJ issue from developing when using an oral appliance to manage obstructive sleep apnea are not a benefit since there is no reliable-consistent medical evidence that such appliances are medically necessary because the patient must be certified by the provider to be TMJ disease free before an oral appliance for obstructive sleep apnea is provided as a benefit.

- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment of the TMJ failed (the Provider must provide documentation that conservative treatments, to include the use of medications and any oral appliances were attempted and why the treatments failed).

- Medically necessary treatment of maxilla and mandible (jaw joints and jaw bones) caused by an accident.

- Trigger point injections of various types of pain and anti-inflammatory medications for the relief of pain, inflammation, soreness, and tenderness to the muscles of mastication (muscles used to operate the jaws) and temporo-mandibular joints are a benefit under the medical policy. Treatment request for the administration of trigger point injections to the muscles of mastication, cluster headaches, and the jaw joint capsule must meet the criteria outlined in the Blue Shield Medical Policy on the Trigger Point and Tender Point Injections. Only a physician (MD or DO) may administer the medications to the trigger point per Blue Shield Medical Policy.

- Oral appliances are a benefit under the medical policy for the management of obstructive sleep apnea (OSA) when the submitted documentation meets all the criteria in Blue Shield's Medical Policy on the Diagnosis and Management of Obstructive Sleep Apnea for oral appliances. In general, a physician must order and evaluate the sleep study. If a diagnosis of obstructive apnea is made and member has tried and is not able to use a positive air pressure device to manage their sleep apnea, then a prescription must be provided by the referring sleep specialist medical doctor to a dentist to construct an oral appliance to manage the obstructive sleep apnea.

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

The attending dentist must submit the following documentation for review to Blue Shield for an oral appliance:

- A prescription for an oral appliance from a sleep specialist medical doctor.
- A current sleep study meeting the criteria for sleep studies pertinent Blue Shield Medical Policy.
- A report on the periodontal condition of the member to include the submission of a current periodontal pocket depth charting of the dentition and submission of current full mouth radiographs when requested. The medical policy (Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome) states the member must be free (absence) of periodontal disease.
- A report on the temporomandibular joint (TMJ) of the member. The member must be free (absence) of any TMJ symptoms before an oral appliance is provided not after an oral appliance is provided. Upon request, the provider must provide radiographs of the jaw joints for review. For the purpose of this *HMO Benefit Guidelines*, bruxism and clenching causing discomfort to the jaw joints fall under this TMJ criteria.
- A current sleep survey (e.g., Epworth Sleep Scale) demonstrating clinically significant OSA.
- A letter of medical necessity.
- An affidavit of positive air pressure intolerance
- A letter clearly indicating the oral appliance is custom constructed by a dentist.
- A letter clearly indicating the member is not involved with any manner of orthodontic treatment.
- Completion of the Oral Appliance Therapy Worksheet form. The form must be signed by the attending dentist who certifies the information provided to Blue Shield is true.

Note: Replacement of oral Appliances for TMJ and Obstructive Sleep Apnea (OSA): Generally, replacement of an oral appliance, whether for OSA or TMJ is not a benefit of the medical plan during the warranty period of the appliance (generally 5 calendar years after initial delivery of the appliance). After the warranty period, the provider must submit photographs of the appliance, and a letter of medical necessity explaining WHY the appliance is no longer useable for review. For OSA, the provider must also provide documentation of the member's compliance with the oral appliance, a new sleep study if the previous sleep study is older than 5 years old, the current status of the periodontium and status of the TMJ, a sleep study showing the oral appliance is effective in managing the member's OSA symptoms.

Benefit Coverage *(cont'd.)*

- Orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is medically necessary to correct skeletal deformity and function and not for cosmetic reasons or to balance the appearance of the face with the jaws (e.g., chin surgery). Refer to the Blue Shield Medical Policy on Orthognathic Surgery on necessary documentation when requesting services.

  Note: To expedite claims and pre-certifications or claims for orthognathic surgery, Blue Shield request providers submit CURRENT radiographs, cephalometric radiographs, cephalometric analysis, intra-oral photographs, full facial photographs, and photographs of the jaw showing the jaw issue including post orthodontic treatment radiographs and photographs of the teeth and jaws. In addition, a letter of medical necessity should accompany the treatment request to include a statement in the letter indicating that orthodontic treatment is not needed or treatment has been completed Blue Shield uses exclusively the Steiner Cephalometric Analysis Protocol to evaluate orthognathic treatment requests. Providers are requested to submit ONLY the values for SNA, SNB, ANB, SN-GoGn, horizontal overjet, overbite, and the fossa-cusp relationship of the first upper and lower permanent molars (to evaluate transverse discrepancies). Submission of any cephalometric analysis other than the Steiner Analysis will cause delays in processing the treatment request or have the treatment request returned to the provider requesting a Steiner Analysis and the specified angles outlined in this paragraph. Treatment request with missing documentation will delay processing of a treatment request or have the treatment request returned to the provider.

- Orthognathic surgery requests to include all manner of soft and hard tissue surgery to the oral cavity to manage obstructive sleep apnea must be accompanied by necessary radiographs (when requested), intra-oral photographs (when requested), jaw, and facial photographs (when requested).

- For surgery requests for obstructive sleep apnea, documentation of positive air pressure treatment failure, a signed affidavit of positive air pressure intolerance, a current sleep study, documentation of oral appliance compliance and subsequent oral appliance treatment failure, letter of medical necessity, current cephalometric radiographs, and cephalometric analysis (when requested). Refer to the Blue Shield Medical Policy on the Surgical Management of Obstructive Sleep Apnea for further information.

  Note: Surgery for the management of obstructive sleep apnea (OSA) is a benefit of the medical plan. The criteria to qualify for surgical correction of OSA requires documentation the member attempted to use and failed Continuous Positive Airway Pressure (CPAP) therapy for an adequate period of time to manage their OSA symptoms) and also attempted to use and failed a custom-made oral appliance to manage their OSA for an adequate period of time.

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

Note: The oral appliance must meet all current Blue Shield medical criteria for oral appliance to manage obstructive sleep apnea as delineated in the Blue Shield Medical Policy Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome.

Note: If a member indicates they are unable to use an oral appliance due to jaw joint pain or discomfort, they must provide medical documentation from a Board Certified Dental Sleep Specialist certifying the patient is unable to benefit from an oral appliance due to jaw joint pain.

Note: The member cannot simply refuse CPAP and an oral appliance to qualify for surgery for OSA. Unacceptable medical documentation an oral appliance failed to manage symptoms of OSA include the following: 1) Movement of teeth by the oral appliance, 2) Jaw joints are sore after using the oral appliance, 3) The member unconsciously removes the oral appliance during the night, 4) The member drools excessive amounts of saliva during the night, 5) The member's teeth hurt when using an oral appliance, and 6) The oral appliance failed to control snoring.

Note: An oral appliance for OSA, like any oral appliance, takes several months for the patient's mouth to adapt to and become accustomed to wearing and using.

Note: An oral appliance for OSA is considered successful when it manages the average AHI to mild levels.

- Medically necessary dental or orthodontic services that are an integral part of covered reconstructive surgery for cleft palate/lip procedures. Orthodontic services not associated with cleft palate/lip procedures are not a benefit under this plan.

- General anesthesia (GA) administered in a hospital or surgery center for dental care. The general anesthesia must be required due to clinical status, medical necessity, developmental issues, or underlying medical condition of patient and consistent with the Blue Shield Medical Policy on Dental Anesthesia and all State of California Regulations pertaining to the appropriate use of this treatment modality. Not a benefit are services of mobile dental anesthesia teams that provide general anesthesia and sedation services in dental offices because the facility or dental office generally do not meet the minimum State of California Regulations for the administration of a general anesthetic in an outpatient treatment facility.

  Note: A mobile anesthesia service is not legally authorized to waive the Dental Board of California's criteria for the provision of general anesthesia service in a treatment facility not possessing a valid GA facility permit.

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Coverage *(cont'd.)*

- Documentation, when requesting treatment for any dental, oral structures, and jaw shall always include necessary current radiographs (not just a radiographic report), and medical pathology reports when applicable. When necessary, include pre-accident radiographs, intra and extraoral photographs must be provided for review.

  Treatment of the teeth, jaws, and jawbones covered under the Basic Plan must be reviewed and pre-authorized (except after an accident to the teeth or jaws).

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Office Visits/Consultations/Surgery

Inpatient Hospital Services

Outpatient Hospital Services

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Exclusions

- Routine dental services (e.g., fillings, preventive dental services, root canals, surgical root canal treatment, routine removal of teeth to include 3rd molars, all gum surgery, bone grafts to support loose teeth or implants, bone grafts to prepare the mouth for implants or dentures, devices to manage night-time teeth grinding or clenching, devices to control pain to the chewing muscles or jaw joints, full or partial dentures, any dental treatment that is not the direct result of an accident/trauma/disease/medical treatment, any dental treatment vicariously associated with a systemic condition or disease, a disease state or associated medical treatment, dental treatment caused ostensibly by poor oral hygiene or drug use, facial prosthesis, crowns, fixed dental bridges, splinting teeth together, bone grafts to fill-in empty tooth sockets, radiation shields, oral or facial medicament carriers, orthodontia to include interceptive or preventive orthodontia, dental X-rays, three dimensional X-rays (CBCT X-rays), oral medicine, oral pathology, dental-facial photographs, dental models, pediatric dentistry, habit control devices, any and all treatments usually provided by dentists to include dental specialists, etc.).
- Oral appliances constructed to prevent parafunctional habits (athletic mouthguards, appliances for bruxism, thumb sucking appliances, etc.).
- Oral appliances to fill in holes in the mouth or missing parts of the jaw bones not due to cleft lip, cleft palate, or oral cancer.
- Oral appliances used to hold medications in or against structures of the mouth, jaws, tongue, face, and soft tissues of the oral cavity (sometimes referred to as medication stents or splints).
- Oral appliances used for weigh loss treatment.
- The services of oral pathologists, oral radiologists, oral facial pain specialists, dental anesthesiologists, and oral medicine specialists.
- Definitive dental treatment caused by or following an accident or trauma to the mouth (directly or vicariously).
- Dental treatment to restore teeth damaged ostensibly by poor oral hygiene, dental neglect, and/or the combination of poor oral hygiene-dental neglect and the vicarious effects of systemic, genetic, inherited, congenital, drug related, and iatrogenic conditions or procedures to the mouth and dentition (for example, dry mouth caused by Sjogren's Syndrome, damage to the teeth from bulimia, damage to the teeth from the use of illicit drugs, damage to the teeth from gastric reflux disease, damage to the teeth from mouth breathing and etc.).

Benefit Exclusions *(cont'd.)*

- Visits to hospital emergency departments or urgent care clinics for the alleviation or treatment of dental pain associated with dental caries (cavities), soft tissue (gum) inflammation, chipped or fractured teeth due to chewing, clenching, bruxism, biting, neglect, broken orthodontic wires or brackets, loose teeth, and/or poor oral hygiene.
- Services performed on the teeth, gums associated oral structures, periodontal structures, alveolar bone, any treatment(s) to prepare the mouth for dentures/dental implants, dental orthotics, dental orthosis and prosthesis, requests for biopsies of oral tissues (hard and soft), and dental-oral related abscesses, and cysts, including related hospitalization.
- Any extractions of teeth to include third molars, extraction of teeth for orthodontic reasons, and extractions of supernumerary teeth.
- Anesthesia (general anesthesia, intravenous sedation, oral conscious sedation, or nitrous oxide gas) administered in the dental office that does not meet the criteria outlined in the Blue Shield Dental Anesthesia Medical Policy and the current regulations pertaining to the administration of sedative agents by the California Dental Board.
- Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason (except medically necessary dental or orthodontic services that are an integral part of covered reconstructive surgery for cleft palate/lip procedures), including treatment to alleviate TMJ.
- Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures.
- Dental implants and any dental procedures associated with or a prelude to the future placement of a dental implant (endosteal, subperiosteal, or transosteal).
- Removing dental implants and any associated procedures required to treat the dental or oral structures as the result of a failing implant(s).
- Alveolar ridge surgery of the jaws if performed primarily to treat natural bone recession associated with loss of teeth and/or the normal aging process, diseases related to the teeth, gums, or periodontal structures or from natural or from prosthetic teeth.
- Bone or soft tissue grafts placed into or around the tooth or bone sockets of the jaws after extractions of teeth.
- Bone grafts around dental implant bodies.

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Exclusions *(cont'd.)*

- Treatment for damage to the natural teeth that is not the direct result of accidental injury to the teeth and jaws. The vicarious effects of an accident to the mouth or teeth that may cause a tooth or teeth to become non-vital or become loose well after an accident are not a benefit of this medical plan. For example, a tooth that is bumped by accident and years later a root abscess appears on the tooth.

- Treatment to teeth as the result of bruxism, clenching, neglect, caries (cavities), poor oral hygiene, bulimia, the use of illicit drugs, damage to the teeth from any and all parafunctional habits, the natural effects of aging to the teeth and jaws, tooth mobility, biting unusual objects or items, and the vicarious effects of dry mouth from natural aging, radiation to the mouth for cancer, medication use, systemic-congenital-genetic conditions).

- Replacement of existing partial removable or full denture(s) in case of accident, damage, or loss due to a hospital, ambulance or clinic visit.

- Replacement or restoration of existing fixed dental bridges, dental implants, teeth, fillings, in case of accident, damage, or loss due to a hospital, ambulance or clinic visit.

  Note: Dental treatment to restore teeth caused directly or indirectly by procedures performed by medical staff, (e.g., intubation procedures for general anesthesia), medical transportation, loss or damaged dental appliances caused by medical staff are not a benefit of this plan. Such concerns need to be brought to the attention of the attending physician or nursing staff of the medical clinic or hospital.

- Any dental services provided after the initial, palliative medical stabilization of the member's oral/dental structures following an accident.

- Swellings (inflammatory edema), infections, pain, hypertrophy (over-growth) to the gingiva due to poor oral hygiene, food impaction, medication use, chronic gingivitis, or periodontitis are not a benefit of this plan. When and where appropriate radiographs and photographs will be required to submit a claim or request pre-certification for treatment.

- Surgical orthodontics to include the extraction of teeth incidental to orthodontic treatment, the surgical placement of orthodontic anchors, bollard plates to distract the growth or trajectory (direction) of the upper or lower jaws, exposing teeth, exposing the crowns of teeth to aid in the placement of an orthodontic bracket, removing remaining deciduous teeth in the dental arches, up-righting a tooth or teeth, expansion of the palate, and etc.

- Removable orthodontic treatments prescribed by a dentist.

Teeth, Jaws, and Jawbones – Basic Plan

Benefit Limitations

Coverage for dental anesthesia (and associated facility charges) required by member's clinical status or underlying medical condition is limited to members who:

- Are less than seven years of age, or
- Developmentally disabled, regardless of age (medical documentation required by the member's physician), or
- Whose health is compromised and for whom general anesthesia is medically necessary, regardless of age (medical documentation required by the member's physician).

  Note: The use of itinerate (mobile) dental anesthesia teams in an outpatient treatment facility to perform general anesthesia services, not previously licensed to provide general anesthesia by the California State Dental Board, do not meet the California State Dental Board regulations for a physical facility anesthesia permit from the Dental Board to administer a general anesthetic, intravenous sedation, oral sedation, etc. and are therefore not a benefit under this medical plan.

Exceptions

Maxillofacial prosthesis replacing all or part of a jaw to restore function and when it is not primarily a cosmetic procedure. Medical quality photographs of the jaws and face are required when requesting services of this type.

Examples of Covered Services

- Medically necessary splint therapy of the temporomandibular joint (TMJ) when there is clinical documentation of disease-pathology to the articulating joint disk.
- Surgical and arthroscopic treatment of TMJ if conservative medical treatment has failed (thorough clinical documentation must be provided to include current joint radiographs).
- Orthognathic surgery to correct skeletal deformity (surgery to reposition the upper and/or lower jaw). Not a benefit is orthognathic surgery that does not significantly improve the function of the jaws and/or associated structures or is primarily provided to improve the esthetics of the jaw and/or face of the member. Dental or orthodontic services that are an integral part of covered reconstructive surgery for cleft palate/lip procedures.
- Treatment of malignant and pre-malignant tumors (neoplasms) of the soft tissues of the mouth (gums) and malignant or pre-malignant tumors (neoplasms) of dental origin of the jaws.

Teeth, Jaws, and Jawbones – Basic Plan

Examples of Covered Services (*cont'd.)*

- General anesthesia administered for dental care and associated facility charges (when the member meets specified clinical criteria). Refer to the Blue Shield Dental Anesthesia Medical Policy.
- Initial, immediate, emergency services to medically stabilize the jaws, soft tissue, jaw joints, jaws after an accident.

  Note: Definitive dental treatment to restore the dentition, soft tissues, hard tissues, and broken dental appliances after emergency services were provided to stabilize the teeth/jaws/airway/gums are not a benefit of this plan.
- Orthognathic and soft tissue surgery to manage obstructive sleep apnea (refer to the Blue Shield Medical Policy for Surgical Management of Obstructive Sleep Apnea).

Examples of Non-Covered Services

- Endodontics (all root canal treatments).
- Prosthodontic services (dentures, fixed dental bridges, crowns, dental implants, etc.).
- Oral medication carriers (prosthetic oral appliances constructed to hold medications in the mouth, teeth, face, and jaws).
- Oral medicine, oral radiology, and oral pathology services.
- Periodontal services (all gum treatment services).
- Orthodontia.
- Surgical orthodontic treatment (e.g., surgical rapid expansion of the palate).
- Placement and removal of bone anchors and bone plates to assist in orthodontic treatment.
- Routine dental extractions of non-restorable or diseased teeth.
- Extraction of teeth for orthodontic reasons.
- Extractions of impacted 3rd molars.
- Surgical services to drain soft or hard tissue cysts and abscesses.
- Treatment of periodontal disease or periodontal surgery for inflammatory conditions such as gingivitis or acute necrotizing ulcerative gingivitis.
- Preventive dental care (e.g., fluoride varnish, dental sealants, preventive dental restorations).

Examples of Non-Covered Services *(cont'd.)*

- Treatment of pain of dental origin or structures associated with the teeth due to dental caries (cavities), chipped or fractured teeth due to biting or chewing, and poor oral hygiene.
- Routine dental care (even if related anesthesia and associated facility charges are covered).
- Replacement of existing partial removable or full denture(s) in case of accident, damage, or loss from or due to hospital or clinic visit.
- Replacement of fixed dental bridges, dental implants, restoration of teeth, etc. following a hospital or clinic visit.
- Dental X-rays used for the detection of caries (cavities), impacted 3rd molars, and the ectopic eruption of teeth.
- Three dimensional X-rays for orthodontics, root canal treatment, gum surgery, detection of cavities and etc.
- Oral appliances made to stop or prevent parafunctional habits (thumb sucking appliances, tongue thrusting appliances, lip biting appliance, etc.). This includes any training and education in the use of such appliances.
- Flat plane appliances to be worn after TMJ discomfort subsides (considered to be a dental appliance to prevent parafunctional habits).
- Daytime TMJ appliances constructed essentially for the convenience of the patient.
- Morning aligners to be used for a short time in the morning after using an oral appliance for obstructive sleep apnea.
- Special orthodontic type devices to manage snoring or obstructive sleep apnea (e.g., Daytime-nighttime appliances (DNA), or advanced light force (ALF) appliances).
- Removing a dental implant, curetting around the bone, and treating the infection as a result of the failing dental implant.
- Facial and jaw radiation shields constructed by a dentist.
- Removal of teeth prior to anticipated radiation therapy.
- Definitive treatment or restoration of the dentition, jaws, soft tissues from the vicarious effects of an accident, cancer surgery, xerostomia, drug use (legal or illegal), and radiation treatment.

Teeth, Jaws, and Jawbones – Basic Plan

Examples of Non-Covered Services *(cont'd.)*

- Complete, partial, or definitive restoration of the dentition due primarily from the effects of poor oral hygiene to include the vicarious effects of radiation treatment, cancer surgery, orthognathic surgery, xerostomia, systemic/ genetic/inherited/congenital conditions, and the use of medications/drugs (legal or illegal) on the dentition.

  Note: For example, dental treatment to restore teeth from the vicarious effects of xerostomia on the teeth from Sjogren's Syndrome is not a benefit of this medical plan because the primary etiology of the dental problem is poor oral hygiene, not visiting a dentist on a regular basis and/or not following through on the recommendations of the patient's dentist not the systemic condition. This is only one example; however, this policy applies to any and all medical conditions that may cause xerostomia).

- Restoration of teeth due to use of certain antibiotics in childhood and heavy fluoride use or exposure.

- Restoration of teeth due to environmental exposure to acidic compounds, such as stomach acid, vinegar-based diets, drinking carbonated soft drinks, chewing sour candies, breathing acidic vapors, etc.

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Health & Safety Code Section 1367.71

HMO Benefit Guideline for:

Accidental Injury to Natural Teeth-Basic Plan

Transplant Services

Benefit Coverage

Hospital and professional services are covered in connection with the following human organ, bone marrow/stem cell transplants when: 1) The recipient is a member; 2) The procedure is medically necessary and not experimental or investigational for specific diagnosis or condition; 3) The service is pre-authorized by Blue Shield Medical Care Solutions Transplant Team and; 4) The service is performed at a Blue Shield approved Major Organ/Bone Marrow Transplant Facility:

- Bone Marrow
- Stem Cell
- Cord Blood
- Kidney and Pancreas (for kidney only see below)
- Heart
- Heart/Lung
- Lung
- Liver
- Small Bowel
- Multi Organ Transplants

The IPA/medical group is responsible for medical necessity review of and authorization for the following transplants:

- Cornea
- Kidney
- Skin

No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.

Services to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Transplant Services

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments for:

Physician-Outpatient

Physician-Inpatient

Inpatient Hospital Services

Outpatient Hospital Services

Benefit Exclusions

All transplants of organs other than the human organs listed above are excluded. All transplants that are not medically necessary or are considered experimental/investigational are excluded. Donor costs for a member when the recipient is a non-member are excluded.

Benefit Limitations

- Organ transplant services and organ procurement services are only covered when the recipient is a Blue Shield HMO member.
- Major organ/bone marrow transplant services must be performed at Blue Shield Major Organ/Bone Marrow Transplant Facility.
- Hematopoietic Cell Transplantation, including Autologous Stem Cell Transplantation, Allogeneic Stem Cell Transplantation, or Cord Blood Transplantation used to support high-dose chemotherapy, are covered when such treatment is medically necessary and is not experimental or investigational.

Exceptions

None

Transplant Services

Examples of Covered Services

Human organ transplant services for:

- Bone Marrow
- Stem Cell
- Cord Blood
- Kidney and Pancreas (for kidney only see below)
- Heart
- Heart/Lung
- Lung
- Small Bowel
- Liver
- Multi Organ Transplants
- Cornea
- Kidney
- Skin Organ Transplant

Examples of Non-Covered Services

- Transplants determined not to be medically necessary or considered to be experimental/investigational for a specific diagnosis

Transplant Services

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

Blue Shield Medical Policy

Blue Shield HMO IPA/Medical Group Procedures Manual

Urgent Care Services

Benefit Coverage

Blue Shield defines urgent care as treatment provided within the primary care physician's (PCP) service area to prevent serious deterioration of a member's health due to unforeseen illness, injury, or complications of an existing medical condition. In an urgent situation, treatment cannot reasonably be delayed.

Urgent Services are defined as those covered services rendered outside of the PCP's service area (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury, or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the member returns to the PCP's service area.

Out-of-area follow-up care is defined as non-emergent medically necessary out-of-area services to evaluate the member's progress after an initial emergency or urgent service.

Urgent care within the PCP's service area is a covered benefit when:

- The member first contacts their PCP and care is rendered or referred by the PCP. This includes services rendered in an urgent care clinic when instructed by the PCP or assigned IPA/medical group, or
- The assigned IPA/medical group has provided the member with advance instructions for obtaining care from an urgent care clinic within the PCP's service area.

Urgent Services outside of the PCP's service area are a covered benefit when:

- Within California - Services are provided by a Blue Shield participating provider or a non-participating provider. If possible, the member should call Blue Shield Member Services for assistance in receiving urgent care services through a Blue Shield of California Plan Provider.
- Outside California but within the USA - Services are provided through a BlueCard participating provider or a non-participating provider.
- Outside California and outside of the USA - Services are provided through a BlueCard Worldwide Network participating provider or a non-participating provider.

Urgent Care Services

Benefit Coverage *(cont'd.)*

For assistance locating Urgent Services providers outside of California and within the United States, the member can call toll-free (800) 810-BLUE (2583) 24 hours a day, 7 days a week. For assistance locating Urgent Services providers outside of the United States, the member can call collect (804) 673-1177, 24 hours a day.

Out-of-area follow-up care is defined as medically necessary services following an initial emergency or urgent service to stabilize the patient's condition. Out-of-area follow-up care is covered through a Blue Shield or BlueCard participating provider or a non-participating provider. However, authorization by the Blue Shield HMO is required for more than two out-of-area follow-up outpatient visits or for care that involves a surgical or other procedure or inpatient stay. The Blue Shield HMO may direct the patient to receive extended follow-up care from their PCP.

If urgent services or out of area follow-up care are not available through a Blue Shield or BlueCard participating provider, any member who received services from a non-Blue Shield or non-BlueCard provider must submit a claim to Blue Shield. The services will be reviewed retrospectively by the plan to determine whether the services were for medically necessary urgent treatment.

Urgent Care Services

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverag*e for member copayments for:

Physician - Outpatient

Office Visits/Consultations/Surgery

BlueCard Worldwide

Benefit Exclusion

- Urgent care that is not provided or authorized by the PCP when the member is located within the member's service area.
- More than two unauthorized follow-up urgent care visits when the member is located outside of the member's service area.
- Unauthorized outpatient care that involves a surgical or other procedure or inpatient stay.
- Any dental services and treatments except the initial, emergency, palliative first aid care to medically stabilize the mouth, jaws, teeth, soft tissues of the mouth immediately following an accident. Dental treatment at an urgent care facility for toothaches, gum bleeding, gum pain/infections, chipped teeth, orthodontic problems, jaw joint problems, repair of any oral appliances, and mouth swelling due to a dental problem are not a benefit at an urgent care facility.

Benefit Limitations

Not applicable.

Urgent Care Services

Examples of Covered Services

Evaluation of:

- High or persistent fever
- Symptoms of infection
- Traumatic injury

Examples of Non-Covered Services

- Ongoing treatment, such as chemotherapy
- Routine services
- Out-of-area follow-up care that is not medically necessary following an emergency or urgent care visit
- Out-of-area follow-up care in excess of two outpatient visits that was not authorized by Blue Shield HMO
- Out-of-area follow-up care that involves any surgical procedure or inpatient stay unless prior authorized by Blue Shield HMO

References

Evidence of Coverage

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Emergency Services

Out-of-Area Services

Vision Care (VPA Optional Benefit)

Benefit Coverage

Blue Shield HMO offers optional vision plans through Blue Shield's Vision Plan Administrator (VPA) to group members. The plan provides payments based on prevailing fees not to exceed amounts calculated under the VPA's Schedule of Allowances. Covered benefits vary by plan and may include the following services:

- Comprehensive eye examination
- Pair of standard lenses
- Standard frames up to the amount specified by the plan
- Contact lenses
- Medically necessary contact lenses

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusions

- Services and supplies in connection with special procedures such as orthoptics or vision training except when medically necessary, and subnormal vision aids (e.g., magnifying glass).

References

Blue Shield HMO Evidence of Coverage and Disclosure Form Vision Plan Benefits Supplement

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Vision Screening – Basic Plan

Benefit Coverage

Vision screening by the primary care physician (PCP) for group plan members through the age of 18 to determine the need for an eye examination for refractive error is covered.

For IFP members, vision screening by the PCP through the age of 16 to determine the need for an eye examination for refractive error is covered.

Diagnostic tests and treatment for medical conditions associated with the eye are covered under medical/surgical benefits, subject to contract terms and conditions.

Copayment

See the members' *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* for member copayments.

Benefit Exclusion

Excluded eye services include but not limited to:

- Eye examinations for refractive error
- Vision screening performed by someone other than the PCP
- Lenses and frames for eyeglasses and contact lenses
- Surgery to correct refractive error (such as, but not limited to, radial keratotomy and refractive keratoplasty)
- Orthoptics or vision training except when medically necessary

Benefit Limitations

Covered benefits are limited to vision screening for group plan members through the age of 18 and IFP members under the age of 18; eye exams to for refractive error are not covered. Only vision screening conducted by the PCP is covered.

Vision Screening – Basic Plan

Exceptions

Contact lenses are covered when medically necessary to treat eye conditions such as keratoconus and keratitis sicca.

Examples of Covered Services

Vision screening by the PCP is covered for group plan members through the age of 18 and IFP members under the age of 18.

Examples of Non-Covered Services

- Vision screening not provided by the PCP
- Eye refractions
- Lenses and frames for glasses

References

Combined Evidence of Coverage and Disclosure Form

IFP Evidence of Coverage and Health Service Agreement

HMO Benefit Guidelines for:

Vision Care - VPA Optional Benefit

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Nutrition Supplements
See Home Health Care Services

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See Ambulatory Surgeries/Procedures

Oral Surgery
See Teeth, Jaws, and Jawbones – Basic Plan; Dental – Blue Shield HMO Plans (DHMO)

Organ Transplants
See Transplant Services

Orthodontia
See Teeth, Jaws, and Jawbones – Basic Plan; Dental – Blue Shield HMO Plans (DHMO)

Orthognathic Surgery
See Teeth, Jaws, and Jawbones – Basic Plan

Orthopedic Shoes
See Orthoses

Orthoptic Therapy
See Vision Care – VPA Optional Benefit

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