CareFirst
Family of health care plans

Benefit Exclusions and Limitations—BlueChoice Only

CareFirst BlueChoice, Inc. (CareFirst BlueChoice) only

This section provides information on Exclusions and Limitations for your CareFirst BlueChoice, Inc. (CareFirst BlueChoice) patients.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable.

If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify you through **email** and **BlueLink**, our online provider newsletter.

Specific requirements of a member's health benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits or claims status information, we encourage you to use one of our self-service channels; **CareFirst Direct** or **CareFirst on Call**. Through these channels, simple questions can be answered quickly.

Read and print the **Guidelines for Provider Self-Services**.

Covered services and benefit guidelines

It is the expectation that providers who perform laboratory or imaging tests, at any site, will obtain and/or maintain the appropriate federal, state, and local licenses and certifications; training; quality controls; and safety standards pertinent to the tests performed.

You should always obtain verification of benefits. Information regarding a member's specific benefit plan can be verified by calling **CareFirst on Call** or by visiting **CareFirst Direct**.

The information in this guide includes exclusion and limitation information related to CareFirst's BlueChoice products and may vary by jurisdiction or product. Check the medical policy reference manual and your contract.

Unless otherwise stated, all office services not rendered by a primary care provider (PCP) require a written referral, except for OB-GYN services and services rendered for members with the Open Access feature. Unless otherwise indicated, a written referral is valid for a maximum of 120 days and limited to three visits except for long-standing referral situations, and covered services rendered to CareFirst BlueChoice members with the Open Access feature.

Decisions to issue additional referrals rest solely with the PCP. Please refer to the administrative functions guide for additional referral information. The hospital must obtain prior authorization for inpatient hospital admissions, except in emergencies.

Additional information about covered services and benefits guidelines are available through the **Medical Policy Reference Manual**. If you have additional questions, contact provider services at 800-842-5975.

Abortion

An authorization is required to perform an abortion in a hospital setting. Authorization is not required if performed in a provider's office.

Note: Benefits for abortions are not available under all programs.

Allergy

Allergy services require a written referral from a PCP. A PCP may issue a long-standing referral for allergy services. Allergy consultation, injections, testing and serum are generally covered.

PCPs may administer allergy injections and must maintain appropriate emergency drugs and equipment on site.

Ambulance

Ambulance services involve the use of specially designed and equipped vehicles to transport ill or injured members. Benefits for ambulance services are provided for medically necessary ambulance transport. Services must be authorized, except for emergency situations.

Emergency ambulance services are considered medically necessary when the member's condition is such that any other form of transportation would medically conflict and would endanger the member's health. For more information, please refer to the **Medical Policy Reference Manual**.

Anesthesia

CareFirst BlueChoice provides benefits for anesthesia charges related to covered surgical procedures and for pain management. Authorization for anesthesia during surgery is included in the authorization for the surgery. For pain management services rendered in a provider's office, a referral from the PCP is required.

For more information about reporting anesthesia services, refer to the **Medical Policy Reference Manual**.

Away From Home Care®

The Away From Home Care program is sponsored by the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, and allows CareFirst BlueChoice members and their covered dependents to receive care from any Blue Cross and Blue Shield health maintenance organization (HMO) while away from home for at least 90 consecutive days or more.

Members from other Blue Cross and Blue Shield HMOs can enroll in CareFirst BlueChoice, select a PCP and receive a standard member ID card. Benefits may vary; it is important to contact provider services at 800-842-5975 or visit **CareFirst Direct** to verify coverage in the state. This program does not change CareFirst BlueChoice providers' normal office procedures.

Behavioral health/substance use disorder services

CareFirst BlueChoice members may self-refer for services by calling the number on the back of their member ID card. CareFirst BlueChoice members who choose to see a non-participating specialist still must contact CareFirst at 800-245-7013 to authorize services.

Visit the disease management section of **provider.carefirst.com** for more information on behavioral health services.

Cardiology

Radiological services covered under the member's medical benefit and performed in the cardiologist's office are limited to certain procedures. All other procedures must be performed by a CareFirst BlueChoice contracted radiology facility. Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply. See **procedure code exception charts**.

Chemotherapy

Chemotherapy services rendered in a specialist's office require a written referral from the PCP. The PCP may issue a long-standing referral. Services rendered in a hospital setting must be authorized by CareFirst BlueChoice.

Chiropractic services

Chiropractic services require a written referral from the PCP, except when rendered to CareFirst BlueChoice members with the Open Access feature included in their coverage. Benefits may be limited to spinal manipulation for acute musculoskeletal conditions of the spine for individuals over the age of 12 years. Refer to the spinal manipulation and related services, policy 8.01.003, in the **Medical Policy Reference Manual** on our website. Copayments for specialty office visits apply and there are limitations on number of visits, which vary by contract. See **procedure code exception charts**.

Dental care

Discount Dental is a free discount program offered to all CareFirst BlueChoice Medical HMO (CHMO) members at no additional cost. Members have access to any provider who participates in the CHMO discount dental program and can receive discounts on dental services through this program. Because it is a discount program and not a covered benefit, there are no claim forms, referrals or paperwork to complete. Members must show their CareFirst BlueChoice member ID card and pay the discounted fee at the time of service to save.

Durable medical equipment (DME) and prosthetics

Authorization is required for services related to prosthetics and certain other DME items. Authorization is also required when the contracted provider supplies all DME equipment and supplies for diagnoses other than asthma and diabetes. For members with asthma and/or diabetes, the attending provider is responsible only for a written prescription to the participating DME provider.

Visit **carefirst.com/preauth** for a full list of codes requiring prior authorization.

Note: To verify a member's level of coverage, use CareFirst on Call at or visit CareFirst Direct.

Immediate needs

CareFirst BlueChoice PCPs, physical therapists, podiatrists, orthopedists and chiropractors can provide certain medical supplies in their office when these supplies/devices are rendered in conjunction with an office visit. No separate authorization is needed; however, member benefits must be verified prior to providing supplies, as medical benefit limitations, policies and procedures still apply.

Search for immediate needs supplies in the **Medical Policy Reference Manual**. Choose the applicable policy and view the provider guidelines section of the policy for detailed information for supplying an immediate need.

If you choose not to supply an immediate need item to a member, then you must refer the member to a contracted DME supplier. Contracted DME providers must distribute all other supplies not considered an immediate need. Find a list of current DME suppliers in our online **provider directory**.

Emergency services

CareFirst defines a medical emergency as a serious illness or injury that in the absence of immediate medical attention could reasonably be expected by a prudent layperson (one who possesses an average knowledge of health and medicine) to result in any of the following:

- Placing the member's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any body part or organ

Members should call 911 for all life-threatening emergencies. CareFirst members may contact their PCP or FirstHelp for instructions or medical advice. If the member's medical condition seems

less serious, the provider may elect to direct the member to receive care at one of the following locations:

- The PCP's office
- Another participating provider's office (written referral may be required)
- An urgent care center

Copayments are generally required for emergency services; however, the copayment is waived if the member is admitted to the hospital.

Note: All providers are contractually obligated to be available by telephone 24 hours a day, seven days a week for member inquiries. The use of recorded phone messages instructing members to proceed to the emergency room during off-hours is not an acceptable level of care for CareFirst members and should not be used by CareFirst participating providers.

Endocrinology

Radiological services covered under a member's medical benefit and performed in the endocrinologist's office setting are limited to certain procedures.

All other radiological procedures must be performed by a CareFirst contracted radiology facility. See **procedure code exception charts**.

Gastroenterology

Laboratory services covered under a member's medical benefit and performed in the gastroenterologist's office setting are limited to certain procedures. All other laboratory services must be performed by LabCorp. See **procedure code exception charts**.

Hearing aid devices

In general, CareFirst's payment for hearing aids is limited to the hearing aid allowed benefit, or, the dollar amount CareFirst allows for the particular hearing device in effect on the date the service is rendered. Due to the wide variation in hearing aid device technology, the hearing aid allowed benefit amount does not always cover the full cost of the hearing aid device(s) the member selects. If the member selects a hearing aid device(s) where the full cost is not covered by the hearing aid allowed benefit, the member will be fully responsible for paying the remaining balance for the hearing aid device(s) up to the provider's charge.

Hematology/oncology

Intravenous therapy or chemotherapy services administered in a provider's office will be reimbursed directly to the provider. The PCP may issue a long standing referral. Laboratory services covered under a member's medical benefit and performed in the hematologist's/oncologist's office setting are limited to certain procedures. All other laboratory services must be performed by LabCorp. See **procedure code exception charts**.

Hemodialysis

Authorization from care management is required for inpatient, outpatient or home hemodialysis services, unless the services are performed in a contracted, freestanding facility. If hemodialysis services are rendered in a contracted, freestanding facility, the attending provider is responsible for a written prescription or order.

Home health services

Care management coordinates directly with the provider and/or hospital discharge planning personnel and will authorize and initiate requests for home health services when appropriate.

Home infusion therapy

CareFirst has contracted with designated intravenous therapy providers. These services require authorization from care management.

Hospice care

Members with life expectancies of six months or less may be eligible for hospice care. Prior authorization should be requested via **CareFirst Direct**.

House Calls

When a provider determines that a house call is necessary for treating a CareFirst member, a copayment is required from the member. Based on provider's specialty, collect the appropriate copayment listed on the member ID card. A referral from the PCP is required for a specialist to visit the home for CareFirst BlueChoice members.

Laboratory services

LabCorp and Quest Diagnostics are the national laboratories for CareFirst and are a cost effective choice when referring patients. Members can easily schedule appointments online through **LabCorp** and **Quest Diagnostics** websites.

LabCorp

(Available for health maintenance organization (HMO) and preferred provider organization (PPO) members)

Quest Diagnostics

(Available for PPO members only)

LabCorp is the only network national lab that BlueChoice (HMO) members can use. Please do not refer HMO members to Quest Diagnostics.

The required laboratory requisition forms must accompany lab specimens collected in the provider's office. The requisition form must include the member ID number exactly as it appears on the ID card. Also, indicate the member's insurance company as CareFirst BlueChoice. Members may also be referred to designated drawing sites with the required laboratory requisition forms, which can be obtained by contacting **LabCorp**.

Providers who perform laboratory services in their office should maintain the appropriate level of clinical laboratory improvement amendment (CLIA) certification.

Note: Specialists in CareFirst BlueCross BlueShield networks are required to use LabCorp for outpatient laboratory services that are not included in the appropriate procedure code exception charts.

Nephrology

Laboratory services covered under a member's medical benefit and performed in the nephrologist's office setting are limited to certain procedures. All other laboratory services must be performed by LabCorp.

Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply. See **procedure code exception charts**.

Nutritional services

Professional nutritional counseling is defined as individualized advice and guidance given to people at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, and about options and methods for improving nutritional status. This counseling is provided by a registered licensed dietitian or other health professional functioning within their legal scope of practice.

Medical nutrition therapy, provided by a registered dietitian, involves the assessment of the person's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Refer to medical policy operating procedure 2.01.050A for additional information on professional nutritional counseling and medical nutritional therapy (CPT 97802–97804).

For additional information on preventive medicine counseling services to address issues such as diet and exercise, refer to the the **CareFirst Preventive Services Guidelines**.

Obstetrics & gynecology

Obstetrical care may be provided by a participating OB/GYN without a written referral from a PCP. The hospital must contact care management the day of delivery or the next business day to obtain the necessary authorization for the facility.

Note: Any admission for pre-term labor or other obstetrical complications requires an additional authorization. If the newborn requires additional services or an extended stay due to prematurity or any complications of birth, a separate authorization will be required.

Reporting for obstetrical services

For additional information about reporting maternity services, visit our **Medical Policy Reference Manual** and search global maternity care (4.01.06A).

Obstetrical radiology/laboratory services

Obstetrical ultrasounds covered by the member's medical benefit and performed in the OB/GYN's office setting are limited to:

- One baseline fetal ultrasound for diagnosis codes V22-V22.2 or 650 and,
- Any medically necessary diagnostic fetal ultrasound

Other radiology, laboratory and other noted services covered under the member's medical benefit and performed in the OB/GYN's office setting are limited to certain procedures. See **procedure code exception charts**.

Amniocentesis/CVS

An authorization from CareFirst is required if the amniocentesis is performed in a hospital setting. If the amniocentesis is performed in the office setting, care management authorization is not necessary. All specimens must be submitted to LabCorp for processing for BlueChoice members. Some exceptions may apply on the Eastern Shore.

Chorionic villus sampling (CVS) procedures require an authorization from care management, whether performed in a hospital or in your office. All specimens must be submitted to LabCorp for processing, unless procedure is performed in a hospital setting. Some exceptions may apply in Western Maryland or a CareFirst BlueChoice contracted radiology facility.

Genetic testing/counseling (excludes amniocentesis)

Genetic testing and counseling performed in a specialist's office requires a written referral from the PCP, unless the specialist is an OB/GYN. Genetic testing and counseling performed in a setting other than a participating providers's office will require an authorization from care management. All lab work must go to **LabCorp** for processing. Some exceptions may apply on the Eastern Shore. Please contact **CareFirst on Call** or visit **CareFirst Direct** to verify a member's level of coverage.

Maternal and child home assessment

A postpartum home visit is available for a maternal and child home assessment by a home health nurse. The home visit may be performed as follows:

- In less than 48 hours following an uncomplicated vaginal delivery
- In less than 96 hours following an uncomplicated C-Section
- Upon provider request

CareFirst must authorize the postpartum home visit.

The postpartum home visit will consist of a complete assessment of the mother and baby. Tests for phenylketonuria (PKU) or bilirubin levels are also included if ordered by the provider. If more visits are medically indicated, an additional authorization from care management will be required.

Infertility services

Tests that relate to establishing the diagnosis of infertility (i.e., semen analysis, endometrial biopsy, post-coital and hysterosalpingogram (HSG)) do not require an authorization from care management when performed in an office setting. All specimens must go to **LabCorp** for processing.

Always schedule these tests with LabCorp prior to rendering these services.

Treatment of infertility, including artificial insemination and In-Vitro Fertilization (IVF), requires authorization from CareFirst in all settings. Treatment of infertility when performed in a specialist's office requires a written referral from the PCP. Some members may not have infertility benefits (for either diagnosis or treatment) as part of their health coverage. Contact **CareFirst on Call** or visit **CareFirst Direct** to verify a member's coverage.

Prior authorization may be required for all infertility/IVF prescription medications. CVS/Caremark administers this process and creates a central point of contact for providers, members and pharmacies. To begin the authorization process, call 855-582-2038.

Laboratory, radiology and other noted services covered under a member's medical benefit and performed in the office setting are limited to certain procedures. See **procedure code exception charts**.

All other laboratory and radiology services must be performed by **LabCorp**.

Gynecologic services

CareFirst BlueChoice members may self-refer to participating OB/GYNs for services performed in an office setting. A written referral is not required from the PCP. If a nurse practitioner is a part of the OB/GYN practice, a written referral is not required if the diagnosis and procedure is related to OB/GYN services. Care management authorization may be required for gynecologic services performed outside the office setting.

Mammograms

All mammograms must be performed in a CareFirst BlueChoice contracted, freestanding radiological center. Some exceptions apply on the Eastern Shore. The PCP or attending provider is responsible for written prescription/order for the radiological center. Refer to the **provider directory** for facilities.

Contraceptive Services

IUD/Diaphragm

Member benefits generally cover provider services in connection with the insertion of an IUD or fitting of a diaphragm. The IUD or diaphragm itself might not be a covered benefit for some members, and the member may be financially responsible for this component of the service.

If covered, the IUD charges can be submitted to CareFirst BlueChoice. The diaphragm can be obtained by the member at a participating pharmacy with a prescription from the provider. The diaphragm is a covered benefit only for members with prescription drug benefits whose benefits do not include contraceptive limitations.

Depo-Provera®

Depo-Provera® is generally covered for the prevention of pregnancy when administered in the provider's office. Depo-Provera® can be obtained at a participating pharmacy with a prescription from the provider. DepoProvera® is a covered benefit only for members with prescription drug benefits, whose benefits do not include contraceptive limitations. Refer to the following chart for a quick reference regarding OB/GYN services.

OB/GYN services quick reference guide

Services	Care Management Authorization Required?	Comments
Abortions	Yes, if performed in a hospital setting. No, if performed in office or freestanding radiology center. Must verify member's benefits.	Not covered by all plans, must verify the member's benefits.
Amniocentesis	Yes, if performed in a hospital setting.	
Chorionic Villus Sampling (CVS)	Yes, in any setting.	Lab work must go to LabCorp*, unless performed in a hospital setting.
Depo-Provera	No.	Must be administered in the physician's office. Medication is available for eligible members through a prescription drug benefit.
Genetic Testing	Yes, if performed in a hospital setting. No, if performed in the office.	
Gynecologic Surgical Procedures	Yes, if performed in a hospital setting.	
Hysteropsalpingogram (HSG)	No.	Must be performed at a contracted free-standing radiology center.
Infertility Testing	Yes, if performed in a hospital setting.	Must verify the member's benefits.
IUD/Diaphragm Insertion	No.	Cost of IUD/diaphragm may be member's financial obligation. Diaphragm is available for eligible members through a prescription drug benefit.
Maternity Services	Yes, if performed in a hospital setting.	Must call to authorize and to notify of actual admission date.
Mammograms	No.	Must be performed at a contracted free-standing radiology** center.

* Some exceptions apply in western Maryland.

** Some exceptions apply on the Eastern Shore.

Oral surgery

Radiological services covered under a member's medical benefit and performed in the oral surgeon's office setting are limited to certain procedures. See **procedure code exception charts**. All other radiology services must be performed by a CareFirst BlueChoice contracted radiology facility.

Orthopedics

(Includes hand and pediatric orthopedics)

Radiological services covered under a member's medical benefit and performed in the orthopedist's office setting are limited to certain procedures. See **procedure code exception charts**. All other radiology services must be performed by a CareFirst BlueChoice contracted radiology facility.

Physical, occupational and speech therapy

A PCP, neurologist, neurosurgeon, orthopedist or physiatrist must issue a written referral to a participating therapist for up to three visits for rehabilitative physical therapy (PT), occupational therapy (OT) or speech therapy (ST). After the first visit, the therapist should submit their findings from the evaluation and a treatment plan to the referring provider.

Note: A written referral is not required for members with the Open Access feature included in their BlueChoice coverage.

- Coverage for rehabilitative PT, OT and/or ST services is provided to enable a member to regain a physical, speech or daily living skill lost as a result of injury or disease
- Coverage for habilitative PT, OT and/or ST services is provided to enable a member to develop or gain a physical, speech or daily living skill that would not have developed without therapy
- Effective Jan. 1, 2018: Habilitative Services should be reported using the appropriate Category I CPT code appended with the CPT modifier 96 (habilitative services).
- When applicable, habilitative PT, OT and ST may require outpatient pre-treatment authorization program (OPAP) authorization. Contact **CareFirst on Call** or visit **CareFirst Direct** to identify members who require authorization for habilitative services

Members covered by self-funded plans may require authorization from OPAP to continue treatment beyond the first three visits. Contact **CareFirst on Call** or visit **CareFirst Direct** to identify members who require OPAP authorization.

Podiatry

The PCP must provide a written referral to the specialist for podiatric services. Benefits will only be provided for routine foot care services when it is determined that medical attention is needed because of a medical condition affecting the feet, such as diabetes. Radiological services covered under a member's benefit and performed in the podiatrist's office setting are limited to certain procedures. See **procedure code exception charts**. All other radiology services must be performed by a CareFirst BlueChoice contracted radiology facility.

Note: A written referral is not required for members with the Open Access feature included in their BlueChoice coverage.

Prescription drugs

CareFirst has several formulary options. The formularies are reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals who make sure the drugs on the formulary are safe and clinically effective.

The prescription drugs found on the formulary are divided into tiers. These tiers may include zero-dollar cost-share, generics, preferred brand, non-preferred brand, preferred brand specialty, and non-preferred brand specialty drugs. A member's cost-share is determined by the tier the drug falls into:

- Tier 1: generic drugs ($)
- Tier 2: preferred brand ($$)
- Tier 3: non-preferred brand ($$$)
- Tier 4: preferred brand specialty ($$$$)
- Tier 5: non-preferred brand specialty ($$$$)

To ensure members are receiving the most appropriate medication for their condition(s), certain medications may require prior authorization or are subjected to quantity limits or step therapy.

To access a formulary, visit **carefirst.com/rx** and click *Drug Search*.

To request a prior authorization, login through the **Provider Portal** or call your PBM at 888-877-0518 for specialty drugs, or 855-582-2038 for non-specialty drugs.

Pulmonology

Laboratory services covered under a member's medical benefit and performed in the pulmonologist's office setting are limited to certain procedures. See **procedure code exception charts**. All other laboratory services should be performed by LabCorp.

Radiology services

Outpatient radiology procedures rendered at a participating freestanding radiology facility do not require a written referral from the PCP. Providers must provide the member with a prescription or order.

Radiological services and other noted codes covered under a member's medical benefit and performed in the PCP's or specialist's office are limited to the following procedures. All other radiology services must be performed by CareFirst BlueChoice contracted radiology facility.

It is the expectation of CareFirst and CareFirst BlueChoice that all providers who perform laboratory or imaging tests, at any site, obtain and/or maintain the appropriate federal, state, and local licenses and certifications; training; quality controls; and safety standards pertinent to the tests performed.

Rheumatology

Radiological services covered under a member's medical benefit and performed in the rheumatologist's office setting are limited to certain procedures. See **procedure code exception charts**. All other radiological procedures must be performed by a CareFirst BlueChoice contracted radiology facility.

Routine office visits

Annual health examinations, well child visits and other services for the prevention and detection of disease are covered benefits. CareFirst BlueChoice promotes preventive health services and has adopted preventive health recommendations applicable to our members. Examinations solely for the purposes of employment, insurance coverage, school entry and sports or camp admission are generally not covered and should be charged in full to the member. Immunizations required solely for foreign travel are generally not covered.

Transplants

Transplants and related services must be coordinated and authorized by care management, depending on the member's contract. Coverage for related medications may be available under either the prescription drug program or medical benefits.

Urgent care services

A member may require services for urgent, but non-emergency, conditions. Direct the member to an urgent care center; a written referral is not required.

Urology

Radiology, laboratory services and other noted codes covered under a member's medical benefit and performed in the urologist's office setting are limited to certain procedures. See **procedure code exception charts**. All other radiology and laboratory services must be performed by a CareFirst BlueChoice contracted radiology facility or LabCorp.

Vision Care

Medical

With CareFirst BlueChoice, a written referral from the member's PCP is required for ophthalmologic and optometric services related to medical diagnoses. Vision services covered under the member's medical benefit and performed in the ophthalmologist's or optometrist's office are limited to the following procedures.

Services related to the treatment of a medical or surgical condition of the eye are included under the medical portion of the contract. The appropriate CPT code must be used to bill for these services. See **procedure code exception charts**.

Note: A written referral is not required for members with the Open Access feature included in their coverage.

Routine vision and eyewear

Davis Vision is our contracted vendor for routine vision care. Routine vision services, including refractions and eyewear, performed by Davis Vision contracted providers do not require a written referral from the PCP.

Some contracts may include a standalone vision endorsement. These types of endorsements cover basic routine vision services such as refractions, eyeglasses and contact lenses. Services included in the routine eye exam include but may not be limited to:

- Complete case history
- Complete refraction
- External examination of the eye
- Binocular measure
- Ophthalmoscopic examination
- Tonometry when indicated
- Medication for dilating the pupils and desensitizing the eyes for tonometry
- Summary and findings

Routine vision services should be billed using standard CPT/HCPCS procedure codes.

Wellness discount program

Blue365 is a program that offers health and wellness discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. This program is not a part of the member's benefits.

Members can visit **carefirst.com/wellnessdiscounts** for more information.