CareFirst
Family of health care plans

8. BlueChoice®

To help you navigate through the manual, look for icons that indicate the relevant provider type as shown below.
Any content that is not marked with an icon applies to all provider types.

Ancillary Institutional Professional

Arranging for Care

Referral Process

Unless stated in member's contract, primary care providers (PCPs) must issue a written referral to a specialist for services rendered in the specialist's office. Verbal referrals are not valid. It is the PCP's responsibility to refer the member to a CareFirst BlueChoice®, Inc. (CareFirst BlueChoice) Health Maintenance Organization (HMO) participating specialist for care.

The member should not be instructed to call CareFirst BlueChoice for the referral.

Please include the following information as specified on the referral form:

- Member's name, date of birth and member identification (ID) number
- Your name, phone number and CareFirst BlueChoice provider ID number
- The specialist's name and CareFirst BlueChoice provider ID number
- The date the referral is issued and the valid until date
- The diagnosis or chief complaint (stating follow-up or evaluation is not sufficient)
- The number of visits allowed, limited to a maximum of three visits (if this is left blank or you write "as needed," the default number will be three visits)

Retain a copy of the referral for the member's medical record. The member will take a copy to the specialist. A copy should be filed in the PCP medical record.

Remember:

- Care rendered by non-participating practitioners for CareFirst BlueChoice members who do not have an out-of-network option must be approved by Care Management.
- Unless otherwise indicated, referrals are valid for 120 days from the date of issuance and are limited to a maximum of three visits. Please see the extended referral information below for exceptions.
- Members with the Open Access feature included in their coverage do not need a written referral to see an in-network practitioner.

Standing referrals

PCPs may issue a standing referral for a CareFirst BlueChoice member who requires specialized care over a long period of time. Members are allowed up to one year of unlimited specialist visits through an extended referral if all the following criteria are met:

- The member has a life-threatening, degenerative, chronic and/or disabling condition or disease requiring specialized medical care.
- The member's PCP determines, in consultation with the specialist, that the member needs continuing specialized care.
- The specialist has expertise in treating the member's condition and is a participating practitioner.

If necessary, the PCP may modify a standing referral to limit the number of visits or the period of time for which visits are approved. In addition, the referral may require regular communication between the specialist and the PCP regarding the treatment and health status of the member.

CareFirst BlueChoice also allows referrals to an allergist, hematologist or oncologist to be valid for up to one year. For any other life-threatening, degenerative, chronic and/or disabling condition or disease requiring specialized medical care, call case management at 410-605-2623 or 888-264-8648 for assistance.

Please confirm that the member understands to whom he or she is being referred, the number of visits allowed and the time limit for seeking specialist services.

Services Requiring a Written Referral

Most office visits to an in-network specialist/practitioner require a written referral.

Services Not Requiring a Written Referral

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

- Ambulatory surgery centers (ASCs)
- Participating Obstetrician/Gynecologist (OB/GYN) care when performed in an office setting
- Routine vision exams by participating Davis Vision optometrists
- In and outpatient mental health/substance use disorder services (see phone number on member's ID card)
- Visits to an urgent care center
- Services provided by a participating specialist in the hospital during the course of the member's hospitalization.
  Note: a referral is required for any follow-up care provided in the specialist's office following the discharge from the hospital
- Services provided by an in-network provider to members with the Open Access feature included in their coverage

Laboratory Services

LabCorp

LabCorp is the only national network lab that is in-network for BlueChoice members. Members can easily schedule appointments online through the LabCorp website. Please do not refer HMO members to a lab other than LabCorp because doing so can cause significant increases to their out-of-pocket expenses.

LabCorp requisition forms that include the member's ID number must be used when ordering lab testing or directing members to a drawing station. These 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.

Please note the requirements in the Benefit Exclusions and Limitations section below. Some exceptions may apply in rural areas or for unique services; please refer to the online provider directory.

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

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

Visit carefirst.com/qualityandaffordability for additional information related to national laboratories.

Specialists

Specialists should render care to CareFirst BlueChoice members only when they have a written referral from the PCP, except for members with the Open Access feature included in their coverage.

Entering Referral Information on a CMS-1500 Form

- Locator 17: Enter the name of the referring provider.
- Locator 17B: Enter the PCP NPI.
- Locator 23: Enter the referral number found on the CareFirst BlueChoice referral form (RE followed by 7 digits). If the PCP used a uniform consultation referral form, enter RE0000001.

Entering Referral Information on Electronic Claims

Contact your clearinghouse to confirm your billing process can accommodate entering the referral information as described above. Visit carefirst.com/electronicclaims for vendor contact information.

Note: Specialists may only perform services as indicated on the referral form. All other services require additional approval from the PCP.

Authorizations

Services Requiring an Authorization

When an admitting physician calls the hospital to schedule an inpatient or outpatient procedure, he/she must provide the hospital with the following information:

- The name and telephone number of the admitting physician or surgeon
- A diagnosis code
- A valid Current Procedural Terminology (CPT®) code and/or description of the procedure being performed

The hospital will then request the authorization from CareFirst BlueChoice. An authorization is required for the following services pending verification of eligibility requirements and coverage under the member's health benefit plan:

- Any services provided in a setting other than a physician's office, except for lab and radiology facilities, and freestanding ambulatory surgery/care centers (ASCs)
- All inpatient hospital admissions and hospital-based outpatient ambulatory care procedures
- All diagnostic or preoperative testing in a hospital setting
- Chemotherapy or intravenous therapy in a setting other than a practitioner's office and billed by a hospital

- Durable medical equipment (DME) for certain procedure codes—view the list of codes requiring prior authorization at carefirst.com/preauth
- Follow-up care provided by a non-participating practitioner following discharge from the hospital
- Hemodialysis (unless performed in a participating free-standing facility)
- Home healthcare, home infusion care and home hospice care
- Inpatient hospice care
- Nutritional services (except for diabetes diagnosis)
- Prosthetics when billed by an ancillary provider or supply vendor
- Radiation oncology (except when performed at contracted freestanding centers)
- Skilled nursing facility care
- Treatment of infertility
- Attended sleep studies

For more information on pre-certification or pre-authorization, visit carefirst.com/preauth.

Medical Injectables

Certain medical injectables require prior authorization when administered in an outpatient hospital and home or office settings. Intravenous immune globulin and select autoimmune infusions can be administered in the outpatient hospital setting only if medical necessity criteria are met at the time of prior authorization. This requirement applies to all CareFirst products. The complete list of medications that require prior authorization is available at carefirst.com/preauth > Medications.

You should request prior authorization:

- **Online:** Log in at carefirst.com/provider https://provider.carefirst.com/providers/login/solo-provider.pageand click the Pre-Auth/Notifications tab to begin your request.

Necessary Information

The following information is required to request an authorization for medical injectables:

- Member's name, address and telephone number
- CareFirst BlueChoice member ID number
- Member's gender and date of birth
- Member's relationship to subscriber
- Attending physician's name, ID number, address and telephone number
- Admission date and surgery date, if applicable
- Admitting diagnosis and procedure or treatment plan
- Other health coverage, if applicable

Services Not Requiring Authorization

Any service performed at a participating freestanding ASC does not require prior authorization. When members are referred appropriately to ASCs, healthcare costs can be reduced.

CareFirst offers a wide range of accredited ASCs that are appropriate in various clinical situations.

To find a facility or other network provider, visit Find a Doctor or Facility.

Emergency Hospital Admissions

When ER professionals recommend emergency admission for a CareFirst BlueChoice member, they should contact the member's PCP or specialist, as appropriate. The member's physician is then expected to communicate the appropriate treatment for the member. The hospital is required to contact CareFirst by following the authorization process below.

In-Area Authorization Process

The hospital is responsible for initiating authorization for all emergency admissions.

CareFirst must receive the authorization request within 48 hours after an emergency admission or on the next business day following the admission, whichever is longer. This includes any medical/ surgical or obstetrical admissions.

Medical information for acute hospital care must be received by telephone on the next business day after the request for authorization is made. If the member has been discharged, the hospital has five business days to provide medical information. Failure to provide the requested information may result in a denial of authorization due to lack of information.

Out-of-Area Authorization Process

In the case of an out-of-area emergency admission, the hospital is responsible for obtaining the authorization.

Hospital Services

Inpatient Hospital Series—Elective Authorization Process

- The hospital is responsible for initiating all requests for authorization for an inpatient admission through CareFirst Direct. However, when the admitting physician calls the hospital to schedule an inpatient procedure, they must provide the hospital with the following information:
  - A diagnosis code
  - A valid CPT code and/or description of the procedure being performed
  - The name and telephone number of the admitting physician or surgeon
- The hospital must receive a call from the admitting physician at least 15 business days prior to any elective admissions. Request review timelines vary, and are based on applicable NCQA, state and federal requirements. An exception to this policy is applied when it is not medically feasible to delay treatment due to the member's medical condition. The admitting physician's office may be contacted by CareFirst BlueChoice if additional information is needed before approving the authorization.
- Failure to notify the hospital within this time frame may result in a delay or denial of the authorization.

- CareFirst will obtain the appropriate information from the hospital and either forward the case to the clinical review nurse specialist (CRNS) or certify an initial length of stay for certain specified elective inpatient surgical procedures. The CRNS must review a request for a preoperative day. The utilization management specialist (ICN) monitors admissions of plan members to hospitals anywhere in the country.
- If the admission date for an elective admission change, CareFirst must be notified by the hospital as soon as possible, but no later than one business day prior to the admission. Lack of notification may result in a denial of authorization.

Preoperative Testing Services

Preoperative laboratory services authorized in the hospital setting are as follows:

- Type and cross matching of blood
- Laboratory services for children under the age of eight

All other preoperative testing must be processed and/or performed by in-network freestanding providers.

A Quick Reference Guide when Arranging for Care

Care Services	
Service	How to arrange for care
Obtain Benefits	CareFirst Direct
Inpatient/Outpatient Hospital Authorization	Hospital is required to obtain authorization at least 15 business days prior to admission **Note:** Request review timelines vary, and are based on applicable NCQA, state and federal requirements.
Inpatient Emergency Authorization	Hospital is required to obtain authorization within 48 hours or next business day following the admission, whichever is longer.
Authorization may be obtained by	CareFirst Direct
Care Management Referral Line	410-605-2623 888-264-8648
Member's Customer Service Line	Refer to member's ID card

Benefit Exclusions and Limitations

Covered Services and Benefit Guidelines

Providers who perform laboratory or imaging tests, at any site, are expected to 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 manual includes exclusion and limitation information related to CareFirst's BlueChoice products and may vary by jurisdiction or product. Check the Medical Policy Reference Manual for more information.

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

Abortion Care

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

Note: Benefits for abortion care are not available under all health benefit plans.

Allergy

Allergy services require a written referral from a PCP. A PCP may issue a long-standing referral for allergy services.

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 not be medically appropriate 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.

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 carefirst.com/clinicalresources and click on *Disease Management* 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, number 8.01.003, in the Medical Policy Reference Manual. 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 members at no additional cost. Members have access to any provider who participates in the 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 and Prosthetics

Authorization is required for services related to prosthetics and certain other DME items. Authorization is also required when the participating DME provider supplies 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 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

Members should call 911 for all life-threatening emergencies. CareFirst members may contact their PCP or the 24-Hour Nurse Advice Line 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 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 may be 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.

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 in the Medical Policy Reference Manual 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 CareFirst Preventive Services Guidelines.

Obstetrics and 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.

Refer to Payment Policy PP CO 080.01 for Global Obstetrical Services.

Reporting for obstetrical services

For additional information about reporting maternity services, visit our Medical Policy Reference Manual and search global maternity care (4.01.006A).

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 Z33.1, Z33.3, Z34.00-Z34.03, Z34.80-Z34.83, Z34.90-Z34.93, Z36.0-Z36.9, Z3A.00-Z3A.49, 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 certain procedures. See procedure code exception charts.

Amniocentesis/chorionic villus sampling

An authorization from CareFirst is required if the amniocentesis is performed in a hospital setting. If the amniocentesis is performed in an office setting, Care Management authorization is not necessary. All specimens must be submitted to LabCorp for processing for BlueChoice members.

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 the procedure is performed in a hospital setting.

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 provider's office will require an authorization from Care Management. All lab work must go to LabCorp for processing. Please contact CareFirst on Call or visit CareFirst Direct to verify a member's level of coverage.

As a reminder, rendering participating providers must confirm that an approved authorization is on file before rendering services. Please see the "Member to be Held Harmless" section in Chapter 3.

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 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® [22] 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. The PCP or attending provider is responsible for written prescription/order for the radiological center. Refer to the provider directory for facilities.

Contraceptive services

Intra-Uterine Device/Diaphragm

Member benefits generally cover provider services in connection with the insertion of an Intra-Uterine Device (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

[22] CVS is an independent company providing pharmacy benefit management services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

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. Depo-Provera 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
Abortion Care	Yes, if performed in a hospital setting. No, if performed in office or freestanding facility. Must verify member's benefits.	Not covered by all plans, must verify the member's benefits.
Amniocentesis	Yes, if performed in a hospital setting	
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, in any setting for most services.	For more information, visit https://provider.carefirst.com/providers/news/2019/02/take-action-before-ordering-genetic-tests/.
Gynecologic Surgical Procedures	Yes, if performed in a hospital setting.	
Hysterosalpingogram	No.	Must be performed at a contracted free-standing radiology center.

Services	Care Management Authorization Required?	Comments
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 **Note:** Authorizations are not required for inpatient delivery stays less than 48 hours for a vaginal birth or 96 hours for a c-section. Refer to the in-network Pre-Cert/Pre-Auth webpage for more information.	Must call to authorize and to notify of actual admission date.
Mammograms	No.	Must be performed at a contracted free-standing radiology center.

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 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
- 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.

Prescription Drugs

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

The prescription drugs found on the formularies 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 Portalhttp://carefirst.com/providerlogin or call CVS Caremark 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 certain procedures. See procedure code exception charts. All other radiology services must be performed by CareFirst BlueChoice contracted radiology facility.

Note: CareFirst BlueChoice expects 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 certain procedures. See procedure code exception charts.

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/Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Procedure Code Exception Charts

The procedure codes listed here show the effective dates for codes in 17 specialty areas. Certain services covered under the member's medical benefit and performed in a specialist's office setting are limited to the codes listed. Please refer to your current CPT or HCPCS code book for specific code descriptions. All other procedures must be performed by a CareFirst BlueChoice contracted facility. Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply.

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