# Colorado Choice Health Plans
# NON-COVERED SERVICES LIST

The Services listed below contains some of the most common non-covered services but is **not all inclusive. Please call Customer Services at (719) 589-4995 or (800) 475-8466** if there is any question about what services are covered.

***Remember it is important to verify Benefits and Eligibility with Colorado Choice for all services.***

## SERVICES THAT ARE NOT COVERED

This list contains some of the most common non-covered services but is **not all inclusive. Please call** if there is any question about what services are covered.

| CATEGORY | SERVICES NOT COVERED | Comments |
|---|---|---|
| | | |
| Complementary and Alternative Medicine | Acupuncture, Chiropractic, Massage, etc. | Not a covered benefit. |
| Dental | All dental-related services including treatment of TMJ and most oral surgery | Some services covered with a dental rider. Call for details. |
| Developmental Disorders | All services except those related to specific congenital defects as mandated by law. | |
| Devices and DME | Deluxe items or comfort items | |
| Education | Education services other than diabetic education, nutrition therapy and tobacco cessation. | |
| Experimental or Investigational | All experimental or investigative services | Not a covered benefit. |
| Genetic testing | BRCA1 and BRCA2 | Others may be covered for treatment purposes. Call for benefit information. |
| Mental Health | All services for family, sexual, marital, or occupational counseling; and court-ordered care | Other Mental Health services are a limited benefit except for biologically-based illnesses |
| Obesity Treatment | Obesity related surgeries and treatment, including liposuction, surgery, and meds | |
| Ophthalmology | Vision testing or other vision services for non-medical conditions | Some services covered with a vision rider. Call for details. |
| Orthopedics | All experimental/investigational treatments | |
| Osteopathy | Manipulation therapy | Covered when provided by DO |
| Pharmacy | Please see formulary materials for list of excluded oral medications and allowed injectables | Generally only available for members with a pharmacy benefit. |
| Plastic or Cosmetic | Cosmetic services or surgery of any kind unless part of reconstruction following medical illness or trauma with referral or breast reconstruction post- mastectomy for breast cancer. | |
| Podiatry | Routine podiatric care including treatment of flat feet, nail trimming, corns, and calluses. | **Exception:** Medicare members with diabetic neuropathy may receive foot eval and treatment every 6 months with referral |
| | | |
| Reproductive Services | Infertility treatment | Only diagnostic services are covered and this is a limited benefit. |
| Screening Services | In general, screening services not recommended by the US Preventive Services Task Force not covered | Includes thermography and whole body CT scans. Call if any clarification needed. |

# Colorado Choice Health Plans
# NOTIFICATION & PREAUTHORIZATION LIST

**It is important to verify Benefits and Eligibility with Colorado Choice for *all* services.** The Services listed below may be governed by Colorado Choice Medical Policies, which may impact coverage decisions. **All admissions and any procedure or service costing $500 or more require preauthorization** unless otherwise specified below.

Preauthorization is required ***before*** the service is provided in non-emergent situations. Retroactive requests will be denied unless there are extenuating circumstances. All preauthorizations should be requested using Colorado Choice's request form. Supporting documentation (e.g., notes and lab or radiology findings) should be sent for all planned admissions and additional services as noted below. Documentation may be required in other cases based on Colorado Choice Medical Department review.

***For notification or preauthorization:***
**Phone:** 719.589.3696 **Medical Fax:** 719.589.4995 **Online:** www.cochoice.com

## SERVICES REQUIRING NOTIFICATION

| SERVICE | COMMENTS |
|---|---|
| Admissions – **all** unplanned medical and surgical inpatient admissions | Notification is the responsibility of the contracting facility providing the service |
| Observation Stays resulting from ER visit | Notification is the responsibility of the contracting facility providing the service. |
| Observations Stays, unanticipated after surgery or other procedure | Notification is the responsibility of the contracting facility providing the service. |
| Obstetric care, routine | In normal, uncomplicated pregnancy, one ultrasound is considered routine. Additional ultrasounds require preauthorization. |

## SERVICES REQUIRING PREAUTHORIZATION

**Any procedure or service costing $500 or more** requires preauthorization unless otherwise specified below. This list may not be all-inclusive. Services **must be provided by participating providers**. **Please call** if you are uncertain whether a referral is necessary or a particular provider is participating.

| CATEGORY | SERVICE | Comments |
|---|---|---|
| Admissions | **All** planned or scheduled inpatient medical and surgical admissions including acute, rehab, and skilled nursing facility. | Must submit notes. |
| Ambulance or Air Transport | **Non-emergent** transport or transfer | Generally not covered |
| Cardiac Procedures | EP studies and ablations; Pacemaker checks. See "Diagnostic Procedures" for cardiac tests requiring preauthorization. | |
| Consultations | All consultations | No pre-authorization is required to see **participating (contracted)** providers. All procedures, other than routine labs and x-rays, require preauthorization |
| Dental | All dental related services | Generally not covered without a dental rider |
| Devices and DME | Durable medical equipment | All DME requires pre-authorization with the following exception: Referral not needed for bilirubin bed for newborn at initial d/c |
| | Oxygen and related supplies<br>Prosthetics and orthotics | |
| Diagnostic Procedures | Arteriogram | |
| | CT scans | Must submit notes |
| | Cardiac stress test | |
| | Carotid doppler | |
| | Echocardiogram | |
| | EEG, EMG, and NCV | |
| | Endoscopy (other than colonoscopy and | |

## SERVICES REQUIRING PREAUTHORIZATION

**Any procedure or service costing $500 or more** requires preauthorization unless otherwise specified below. This list may not be all-inclusive. Services **must be provided by participating providers**. **Please call** if you are uncertain whether a referral is necessary or a particular provider is participating.

| CATEGORY | SERVICE | Comments |
|---|---|---|
| Diagnostic Procedures (cont'd) | flex sig) | |
| | Event Monitors ≥ 7 days duration | |
| | MRIs | Must submit notes. |
| | Myelogram | |
| | Nuclear cardiology | |
| | PET or SPECT scans | Must submit notes |
| | Sleep studies | |
| | Ultrasound - 3D and 4D | |
| Dialysis | All services | |
| Education | Diabetes Education | Up to 10 hours on initial diagnosis and 2 hours annually afterward. |
| | Other services such as tobacco cessation or nutrition therapy | Contact CCHP Medical Department for plan limitations and pre-authorization requirements. |
| Hematology and Oncology | Cancer treatment including chemo, radiation, stem cell, bone marrow transplant, and surgery | Submit treatment plan as soon as known to facilitate rapid approval of necessary services. |
| Home Services | Home care | Must submit notes |
| | Home infusion services | Refer to formulary materials |
| | Medical foods or enteral nutrition | Generally not a covered benefit |
| | Total parenteral nutrition | Must submit notes |
| Injections and Infusions | Epidural injections | Must submit notes. |
| | Medical injectables | Must submit notes. Most require pharmacy benefit. |
| | Infusion pumps, including insulin | Must submit notes |
| Mental Health | All services | Limited benefit except for biologically-based illnesses |
| Ophthalmology | All vision related services.<br>***Exception:*** No referral needed for cataract surgery performed by a contracted provider/facility. | Most services, unless associated w/specific medical condition, not covered without a vision rider. |
| Out-of-Network Services | Any service | Generally not a covered benefit. Only approved if medically necessary **AND** not available in-network. |
| Outpatient Services | Any procedure or surgery costing >$500 | Call Colorado Choice if there are any questions about whether a service requires preauthorization |
| | Hyperbaric oxygen therapy | Submit notes |
| | Wound care services and supplies | Submit notes |
| Pharmacy | Please see formulary materials for list of medications requiring prior authorization | Generally only available for members with a pharmacy benefit. |
| | | |
| Plastic or Cosmetic Surgery | All services that are potentially cosmetic. | Generally not a covered benefit unless for breast reconstruction post- mastectomy for breast cancer. |
| Podiatry | All procedures | Routine foot care is generally not covered. |
| Rehabilitation | Physical, speech, and occupational therapy | Must submit notes. Limited benefit. |
| Screening Services | Bone density measurement | **Criteria:** No scan in previous 2 years **AND**<br>1. Female ≥ 65 years of age **OR**<br>2. Hyperparathyroidism **OR**<br>3. Multiple myeloma **OR**<br>4. Vitamin D deficiency **OR**<br>5. Chronic steroid use **OR**<br>6. Documented osteoporosis |
| | | |
| Transplants | All services including evaluation | Must submit notes/plan. |