CareFirst

Family of health care plans

PROVIDER MANUAL

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Chapter 1: Welcome to CareFirst

Introduction to CareFirst

Mission

As CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) continues to transform, upholding our values and ethics in support of our mission remain crucial to our success. It is through our daily conduct that each of us can thrive and be our best on behalf of the people we serve; living our values and modeling the behaviors that form an ethical and supportive culture.

Online Resources and Contact Information

Provider Link List

Please refer to the Provider Link List to help you navigate the provider website.

Provider Quick Reference Guide

Please refer to the Provider Quick Reference Guide for additional information and resources to help you do business with CareFirst.

How to Use this Manual

This manual provides information for your patients who are CareFirst members. It is meant to be your primary reference guide to conducting business with CareFirst. The information in the manual relates to all provider types. To help you navigate through the manual, look for icons that indicate the relevant provider type as shown below.


Ancillary


Institutional


Professional


All Provider Types

The information in this manual is organized by chapters and units within each chapter. Additionally, we have included links to helpful documents throughout the manual.

The entire manual can be downloaded as a searchable PDF document. Simply click on "View Entire Manual." Click on the magnifying glass, enter your keyword(s) in the search box to find the information you seek. Also, the table of contents has been hyperlinked, so you can easily navigate within the PDF.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. In the event that there is an inconsistency between your Participation Agreement and this Manual, your Participation Agreement controls.

If we make any procedural changes in our ongoing efforts to improve our service to you, we will update the information in this manual and notify you through email or BlueLink, our online provider newsletter. To be kept up-to-date with the most current information and alerted to changes, we strongly encourage you to sign up to receive our emails, which will let you know when the manual has been revised.

We welcome your feedback on the manual. If you have any comments or suggestions for additional improvements to the manual, please send them to providermanual@carefirst.com.

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-Service.

Note: References to the UB-04 claim form, its field locators and related billing instructions in this manual are intended to include UB-04 claim form, its successor form if it is replaced, and the equivalent electronic billing standard (ANSI 837) or another accepted standard format.

References to the CMS 1500 claim form, its field locator and related billing instructions in this manual is intended to include the CMS 1500 claim form, its successor form if it is replaced, and the equivalent electronic billing standard (ANSI 837) or another accepted standard format.

New Providers/Office Staff Begin Here

We encourage all new providers/office staff to review our on-demand training modules that serve as foundational knowledge to doing business with CareFirst. You will also find additional helpful training modules. If you have questions after reviewing these training sessions, please email providered@carefirst.com.

Social Determinants of Health

CareFirst serves three primary geographic regions: Maryland, D.C. and Northern Virginia. Within those three regions are smaller sub-regions. Annually, CareFirst analyzes social determinants of health in those geographic areas and identifies those most likely to directly impact the health and well-being of our members. Additionally, an assessment of these findings helps drive the CareFirst primary areas of focus for care coordination and the clinical programs that support our members' health.

A recent analysis identified the social determinants of health expected to have the greatest negative impact on our members and areas most in need of prevention and treatment efforts. Within our geographic regions and corresponding populations, poverty, crime, air quality, alcohol consumption and access to medical services presented some of the most significant social challenges impacting the health of CareFirst members. Each year, population and member experience data are assessed so that, as a health plan, we can determine needs and prioritize services. This data helps CareFirst focus healthcare resources and/or services to help improve member health.

Social determinants of health cause many challenges for members and may vary widely based on the area in which they live. This contributes to variations in health by region and in each of the areas we serve, with different geographic areas presenting different challenges. Chronic issues such as lack of access to healthy food, poverty, poor housing and lack of access to medical care all contribute to reduced health outcomes.

As a health plan, CareFirst is committed to offering programs and services designed to create the maximum positive impact and health outcomes for our members.

CareFirst
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Chapter 2: Product Descriptions

Overview

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) offer a comprehensive portfolio of health insurance products and administrative services to 3.4 million individuals and groups in Maryland, Washington, D.C. and Northern Virginia. This section explains the various types of policies our members may have.

BlueChoice Products

BlueChoice Health Maintenance Organization

BlueChoice is a health maintenance organization (HMO) product that requires the member to select a primary care provider (PCP) who provides routine care and coordinates specialty care through referrals. When members use in-network providers, they have the lowest out-of-pocket costs. If members need care from a specialist, the PCP provides a referral to a specialist. Some BlueChoice policies also have deductibles. Be sure to check member benefits through the self-service tools.

Referrals

Unless otherwise stated, all office services not rendered by a PCP require a written referral. A written referral is valid for a maximum of 120 days and limited to three visits except for standing referral situations.

Decisions to issue additional referrals rest solely with the PCP.

Additional information about covered services and benefits guidelines is available through the Medical Policy Reference Manual.

Note: Referrals are not needed for emergency and urgent care services.

- Lab and radiology services performed by CareFirst BlueChoice providers (a physician's order or prescription is required). Laboratory services should be directed to LabCorp.
- Gynecological and obstetrical care (except infertility services) as long as the care is provided by a CareFirst BlueChoice OB/GYN

Standing referrals

Members with conditions requiring long-term specialized care may receive a standing or condition management referral that applies to an authorized treatment period or period review.

BlueChoice Open Access

Members who have BlueChoice Open Access must follow the requirements of BlueChoice but have the flexibility to receive specialty care without a referral from their PCP.

BlueChoice Advantage

BlueChoice Advantage has the same requirements of BlueChoice. However, these members also have out-of-network coverage allowing members to see a non-participating provider, and there is no referral required to see a specialist.

BlueChoice Opt-Out Plus Open Access

Members who have BlueChoice Opt-Out Plus Open Access must follow the requirements of BlueChoice Open Access, but they also have out-of-network coverage and the ability to see a non-participating provider. If a member sees a non-participating provider, they may be subject to balance billing and filing their own claims in addition to higher out-of-pocket costs.

Preferred Provider Organization

BluePreferred Preferred Provider Organization

BluePreferred is a Preferred Provider Organization (PPO) product which allows members to seek care from our network of PPO providers, as well as from providers outside the PPO network through their out-of-network benefits. Members who utilize providers outside the PPO network will incur higher out-of-pocket expenses. The selection of a PCP and referrals are not required.

Exclusive Provider Organization

Exclusive Provider Organization (EPO) works much like the PPO. However, the member does not have out-of-network benefits. With the exception of emergency services, if they seek care from a provider outside the PPO network, their claims are denied.

HealthyBlue

HealthyBlue HMO, HealthyBlue 2.0, HealthyBlue Advantage and HealthyBlue PPO offer the same basic requirements and benefit structures of the products noted above. However, they also offer online tools and resources that give the member the flexibility to manage their healthcare and wellness goals.

Blue High Performance Network℠ (BlueHPN℠)

BlueHPN is a curated network that provides national access through other Blues' plans high-performing networks. In CareFirst's service area, BlueHPN products will use the BlueEssential network. If you are a participating BlueEssential provider, you may see BlueHPN and BlueEssential members and still be considered an in-network provider.

BlueHPN Products

BlueHPN plans will have in-network benefits only except for urgent and emergent care. Plans will use the PPO network for emergent care. Also, BlueChoice rules apply to the BlueHPN plans. For example, members must use LabCorp and receive a prior authorization for non-freestanding services.

Note: The University of Maryland Downtown Campus will be considered in-network for certain services only.

Federal Employees Health Benefit Plan/Federal Employee Program

Overview

All federal government employees and qualified retirees are entitled to health insurance benefits under the Federal Employees Health Benefits (FEHB) Program.

Federal employees are given a wide range of insurance options, from catastrophic coverage plans with high deductibles to HMOs. Some plans are offered nationwide while others offer coverage regionally.

The Federal Employee Program® (FEP®), also known as the Service Benefit Plan (SBP), has been part of the FEHB Program since its inception in 1960. For Maryland, Washington, D.C. and Northern Virginia, this fee-for-service plan is administered by CareFirst. More than 50 percent of all federal employees and retirees nationwide have chosen to receive their healthcare benefits through FEP. These members and their families receive health coverage through the local Blue Plan where they reside.

Note: Providers can find helpful tips in the FEP Cheat Sheet and the FEP Job Aid.

FEP Benefit Plan Options

In 2019, FEP introduced a new coverage option for the first time since the beginning of the FEHB Program – FEP Blue Focus. The options now available to federal employees and retirees include:

- The Standard Option PPO which allows FEP members to seek covered services from both preferred/in-network and non-participating providers. When members use preferred PPO providers, their out-of-pocket expenses, such as coinsurance and copayment amounts, will be less.
- The Basic Option PPO has a lower premium than the Standard Option and no deductibles, but members must use participating preferred providers to receive benefits.
- The FEP Blue Focus is also a PPO product that uses the same network as the Standard and Basic options with no out-of-network benefits, except in certain situations such as emergency care. The core benefits, which provide coverage for all essentials of good preventive health, are the base of the program. The core benefits are covered at little or no cost to members when they use the PPO provider.

Learn more about the benefit plans at https://www.fepblue.org/benefit-plans.

How to Identify an FEP Policy

Members who are part of Blue Cross Blue Shield Association (BCBSA) FEP can be identified by the following:

- The letter “R” in front of their member ID number instead of a three-letter alpha prefix
- The BlueCross BlueShield (BCBS) FEP logo on their ID card.
- A thin blue border around the FEP Blue Focus ID card perimeter, which distinguishes it from the Standard Option card, which has a solid white border, and the Basic Option card, which has shaded blue font. Samples of each card are shown below.

SAMPLE: Standard Option ID card

Front of card:

Back of card:

SAMPLE: Basic Option ID card

Front of card:

Back of card:

SAMPLE: FEP Blue Focus ID card

Front of card:

Back of card:

Verifying Eligibility and Benefits

Eligibility and benefits can be verified through CareFirst Direct and the Provider Integrated Voice Response (PIVR) for FEP services being rendered in Maryland, Washington, D.C. and Northern Virginia. Preferred providers are expected to utilize their self-service tools for eligibility, claim status, benefits, prior authorizations and remittance retrieval. Service representatives are available to assist with more complex issues and any information not available using the self-service tools such as the PIVR or the CareFirst Direct provider portal.

FEP Claim Submissions

Electronic transactions and online communications have become integral to healthcare. To support our paperless initiative and improve your claims processing experience, CareFirst strongly encourages participating and non-participating providers to submit claims electronically.

This applies to the following types of claims:

- Initial
- Corrected (Institutional and Professional only)
- Late Charge (Institutional only)
- Interim (Institutional only)
- Medicare Secondary (Institutional and Professional only)

Certain claims require additional documentation and cannot be submitted electronically. However, we urge you to take advantage of the convenience provided by filing electronically, whenever possible.

When you submit your claims electronically, you can track your claims submissions, help save on administrative costs and improve your claims process. If you currently do not submit claims electronically or need assistance, please contact one of our preferred clearinghouses.

Claims for FEP members should be submitted to the local Blue Plan where services were rendered. Each local plan is responsible for processing and paying claims for services received within that area. CareFirst participating providers should submit all claims for FEP members to CareFirst, except for the following:

- Lab providers should file FEP claims in the state where the lab tests were performed, not where the specimen is drawn. The provider location is determined by the mailing address.
- Durable Medical Equipment (DME) providers should file FEP claims in the state where the provider is located, not where the DME supplies are delivered. The provider locations are determined by the mailing address.
- Facilities (UB/8371 billers) must submit claims for FEP members to the facility's local Blue Cross plan.

Reminders for all:

- When obtaining prior authorization for baby, it should start from the baby's date of birth.
- If mom and/or baby stay beyond what is considered a normal/routine length of stay, prior authorization is required for both.
- Length of stay calculation starts on date of delivery.
- For more information on submitting mom and baby claims, refer to our Mother and Baby Claims – Billing Guide.

These rules apply to CareFirst covered members only. These rules do not apply to CareFirst Administrators, National Capital Area Accounts, NetLease accounts or Out-of-State/Blue Card accounts.

Facility Claims Quick Tip	
Number	**Type of bill**
111	Inpatient Hospital
131	Outpatient Hospital
2XX	Skilled Nursing Facility
3XX	Home Health Care
720	Dialysis Center
831	Ambulatory Surgical Center

Coordinating Benefits with Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease. The Traditional Medicare Plan (Traditional Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is the primary payor.

When the patient is enrolled in Traditional Medicare along with FEP, providers still need to adhere to their contract agreement for CareFirst. For example, you must continue to obtain prior approval for some prescription drugs and organ/issue transplants before we will pay benefits. However, you do not have to pre-authorize inpatient hospital stays when Medicare Part A is the primary payor.

When CareFirst FEP is the primary payor, we process the claim first. When the Traditional Medicare Plan is the primary payor, Medicare processes the claim first. In most cases, the claim will be coordinated automatically, and CareFirst will then provide secondary benefits for the covered charges.

- **Institutional claims for FEP members with Medicare Part B but no Medicare Part A:** This procedure applies to federal retirees who are not enrolled in Medicare Part A. In these situations, CareFirst is primary for Part A charges while Medicare is primary for Part B charges. In most cases, the Part B claims will cross over electronically to CareFirst. FEP requires all charges related to an episode of care are paid as one claim. The following guidelines will assist you in submitting FEP Medicare Supplemental claims:
  - Submit Part B charges to Medicare.
  - Once Medicare has processed, submit all charges as an inpatient claim (Type of Bill XXX7 is helpful) with the Medicare B Summary Notices to FEP.

- Any Part B services originally processed/paid by FEP will be voided (retracted) and all charges will be processed/reprocessed on the inpatient claim.
- For Washington, D.C. and Northern Virginia facilities only, a DRG payment is made (Medicare Part B payment is deducted from the full DRG amount and CareFirst pays the difference).

CVS Caremark® Drug Prior Authorization

The FEP Director's Office in conjunction with CVS Caremark has a pilot program known as Novologix® for certain prescriptions that require pre-authorization. Before submitting claims for drugs listed on the Novologix or Prior Approval Drug List, providers must seek pre-authorization through CVS Caremark. After CVS Caremark gives the provider an approval letter, a copy of the letter must be submitted with their claim (paper or electronic).

Telemedicine

FEP utilizes a vendor, Teladoc®, to provide telemedicine services.

Advance Benefit Determination

Providers may request an Advanced Benefit Determination (ABD) for certain services that do not typically require prior authorization. Services that may qualify for an ABD are as follows:

- High-dollar surgical procedures or high-dollar outpatient procedure greater than $10,000
- High-cost DME or Prosthetics billed at an amount greater than $5,000
- Outpatient procedures that include drugs with a single drug billed amount of $5,000 or greater provided in an office or outpatient setting (excludes those drugs requiring prior authorization by Novologix).

Note: If any of the above criteria is met and the service is not one listed in the CareFirst Provider Manual as needing prior authorization providers may contact CareFirst's provider services line to initiate an ABD request.

- Maryland: 800-854-5256
- Washington, D.C./Metropolitan Area: 202-488-4900

To initiate the request, you will be required to provide the following to the provider service associate:

- Provider's full name
- Provider office contact name
- Provider's phone number (to be used when the decision is made)
- Provider's fax number (to be used to send the official letters of decision)
- Provider's Tax ID Number
- Member's ID number
- Patient Name
- Patient Date of Birth
- Procedure Code(s)
- Diagnosis Code(s)

- Place of Service (e.g., inpatient hospital, outpatient hospital, etc.)
- Type of service for review (e.g., life threatening illness, high cost DME/prosthetics, outpatient procedure)

Please include the following required documents:

- A description of patient's history and medical necessity for service
- Related clinical documentation
- Literature supporting treatment protocols (if not standard protocol)

For More Information

For more information on the BCBS FEP, please visit www.fepblue.org.

Reminders

Providers are required to report the most appropriate place of service on claim submissions. To ensure proper processing and reimbursement for your claims, please make sure you are accurately selecting the appropriate place of service code for all claims submitted.

Federal Employee Program Prior Authorization Requirements

FEP has precertification and prior authorization requirements for all products.

Inpatient admissions

Prior authorization is required for in-patient hospital, residential treatment center and skilled nursing facility (SNF) admissions. The only exception to this process is routine maternity admissions, meaning those that do not exceed 48 hours for a vaginal delivery or 96 hours for a Cesarean delivery. The admission time of 48 hours or 96 hours does not begin until the baby is delivered. For maternity admissions exceeding these timeframes, notification is required within two business days.

FEP applies a $500 penalty if an authorization is not obtained for inpatient hospital admissions within the appropriate timeframe. However, the penalty is imposed on the provider in the form of reduced payment. In the event of an emergency inpatient hospital admission, notification is required within two business days.

Note: Basic Option and FEP Blue Focus plans **do not** have a benefit for SNF.

Other services requiring pre-authorization

Pre-authorization is also required for certain services for FEP members as indicated by the FEP medical policy.

For the FEP Blue Focus product, FEP applies a $100 penalty if an authorization is not obtained for any of the services listed in the chart below. The penalty is imposed on the provider in the form of reduced payment if a claim is received, and the service is determined to be covered and medically necessary based on medical review. The provider may not bill this amount to the member.

Services Requiring Prior Authorization	Standard and Basic	FEP Blue Focus
Genetic Testing		
BRCA screening or diagnostic testing	X	X
Large genomic rearrangements of the BRCA1 and BRCA2 genes screening or diagnostic testing	X	X
Genetic testing for the diagnosis and/or management of an existing medical condition		X
Surgical services		
Outpatient surgery for morbid obesity	X	X
Outpatient surgical correction of congenital anomalies	X	X
Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth	X	X
Gender reassignment surgery	X	X
Breast reduction or augmentation not related to treatment of cancer		X
Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)		X
Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation		X
Reconstructive surgery for conditions other than breast cancer		X
Rhinoplasty		X

Services Requiring Prior Authorization	Standard and Basic	FEP Blue Focus
Septoplasty		X
Varicose vein treatment		X
Other services		
Outpatient intensity-modulated radiation therapy (IMRT)	X	X
Cardiac rehabilitation		X
Cochlear implants		X
Prosthetic devices (external), including microprocessor-controlled limb prosthesis, electronic and externally powered prosthesis		X
Pulmonary rehabilitation		X
Radiology, high technology including: ■ Magnetic resonance imaging (MRI) ■ Computed tomography (CT) scan ■ Positron emission tomography (PET) scan **Note:** High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.		X
Specialty DME, rental or purchase, to include: ■ Specialty hospital beds ■ Deluxe wheelchairs, power wheelchairs and mobility devices and related supplies		X
Gene therapy and cellular immunotherapy, (e.g., CAR-T and T-Cell receptor therapy)	X	X
Air Ambulance Transport (non-emergency)	X	X

Services Requiring Prior Authorization	Standard and Basic	FEP Blue Focus
Outpatient sleep studies performed outside the home	X	
Applied behavior analysis (ABA)	X	X
All covered organ/tissue transplants, except kidney and corneal transplants	X	X
Blood or marrow stem cell transplants	X	X
Clinical trials for certain blood or marrow stem cell transplants	X	X
Transplant travel	X	X
Maternity care		X

Reimbursement for Injectables, Vaccines and Administration

Covered vaccines and injectables are reimbursed and administered according to an established fee schedule. Newly recommended vaccines are eligible for reimbursement as of the recommendation effective date made by any of the following:

- The U.S. Preventive Services Task Force
- The American Academy of Pediatrics
- The Advisory Committee on Immunization Practices

Note: Benefits for vaccinations and immunizations are contractually determined, including vaccines necessary for international travel as determined by the Centers for Disease Control. Providers should ensure that benefits are available prior to rendering these services.

General Exclusions – Services, Drugs and Supplies

Important note: Although we may list a specific service as a benefit, we will not cover the service unless we determine the service is medically necessary to prevent, diagnose or treat an illness, disease, injury or condition.

A list of FEP general exclusions can be located in the medical policies or in the Member's FEP SBP Brochure.

Helpful Hints

- Providers may appeal any part of a claim within six months of payment or denial.
- PPO claims must be submitted within 365 days of the first service date.

- Peer-to-peer is an option for the ordering or treating provider to discuss as denied pre-service request, not a denied claim.
- Service representatives are trained to handle many complex issues. In the event an inquiry needs to be researched or escalated, please request a reference number and timeframe for resolution. You can find the phone number for your service representative on your remittance notice.
- Many national accounts, processed through the National Account Service Company (NASCO) system, and members with federal employee program benefits, may defer to policies developed by the Blue Cross and Blue Shield Association. For these accounts, when there is no policy on a specific service, CareFirst's Medical Policy Reference Manual will apply.

All Provider Types

BlueCard® Program

Introduction: BlueCard Program Makes Filing Claims Easy

As a participating provider of CareFirst, you may render services to patients who are National Account members of other Blue Plans and who travel or live in CareFirst's service area.

This section describes the advantages of the program and provides information to make filing claims easy. This section offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims

What is the BlueCard Program?

Definition

BlueCard is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other BCBS Plans, domestic and international, to CareFirst.
CareFirst is your sole contact for claims payment, adjustments and issue resolution.

BlueCard program advantages to providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to CareFirst. CareFirst will be your only point of contact for all your claims-related questions.

Products included in BlueCard

A variety of products and claim types are eligible to be delivered via BlueCard; however not all Blue Plans offer all these products to their members

- Traditional (indemnity insurance)
- PPO

- EPO
- Point of Service (POS)
- HMO
  - HMO claims are eligible to be processed under the BlueCard Program
- Blue Cross Blue Shield Global® Core claims
- Stand-alone vision
- Stand-alone prescription drugs

Note: Stand-alone vision and stand-alone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the member's ID cards.

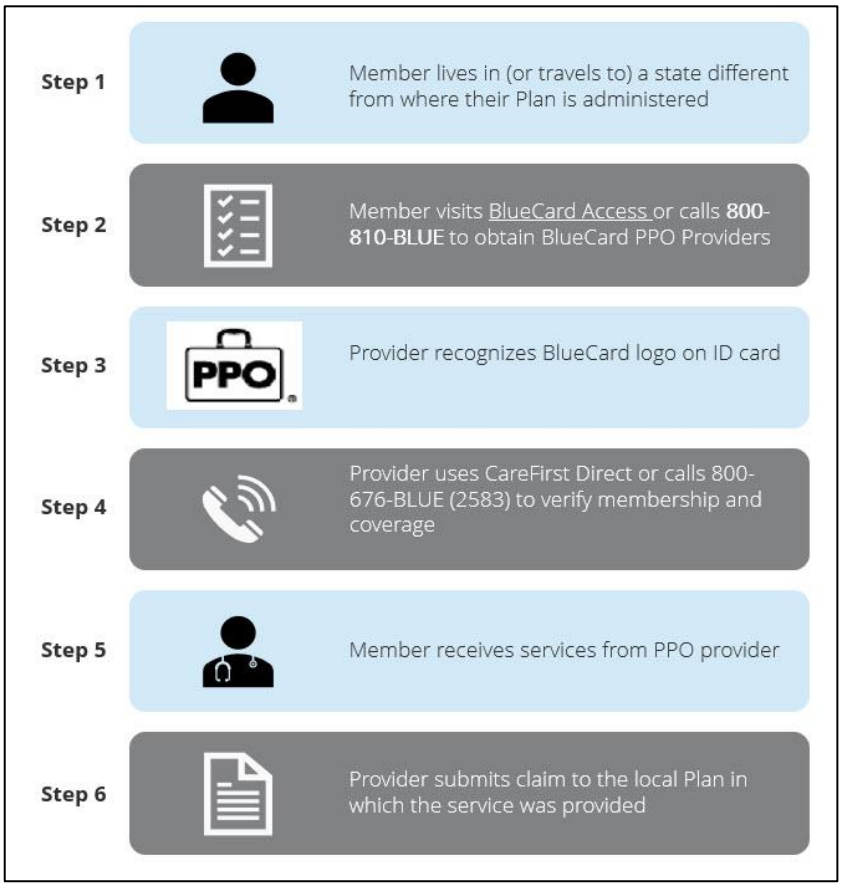
Products excluded from BlueCard

The following claims are excluded from the BlueCard Program:

- Standalone dental
- Vision delivered through an intermediary model (using a vendor)
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- The Federal Employee Program (FEP)

Note: Please follow CareFirst billing guidelines when submitting BlueCard claims.

How the BlueCard Program Works



In the example above, a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another plan's service area, in this example, Maryland:

- If the member was traveling in Maryland.
- If the member resided in Maryland and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, the member can obtain the names and contact information for BlueCard PPO providers in Maryland by calling the BlueCard Access Line at 800-810-BLUE (2583). The member can also obtain information on the Internet, using the BlueCard National Doctor and Hospital Finder available at www.bcbs.com.

Note: Members are not obligated to identify participating providers through either of these methods, but they are responsible for going to a PPO provider if they want to access PPO in-network benefits.

When the member makes an appointment and/or sees a Maryland BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility Line at 800-676-BLUE (2583) or by using CareFirst Direct. The provider also may obtain this information via a Health Insurance Portability and Accountability Act (HIPAA) electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, CareFirst.

After rendering services, the provider in Maryland files a claim locally with CareFirst. CareFirst forwards the claim to BlueCross BlueShield of Tennessee and adjudicates the claim according to the member's benefits and the provider's arrangement with CareFirst. When the claim is finalized, BlueCross BlueShield of Tennessee issues an explanation of benefit (EOB) to the member, and CareFirst issues the explanation of payment or remittance advice to its provider and pays the provider.

How to identify members: member ID cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

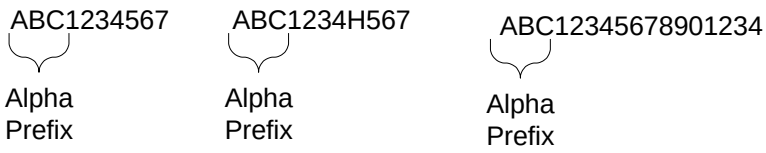
The main identifier for out-of-area members is the prefix. The ID cards may also have a:

- PPO in a suitcase logo, for eligible PPO members.
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network.
- Blank suitcase logo.
- An BlueHPN in a suitcase logo with the Blue High Performance Network℠ (BlueHPN℠) name in the upper right or lower left corner, for BlueHPN EPO members.

Important facts concerning member IDs:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

Examples of ID numbers:



As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Verify with the member that the ID number on the card is not their Social Security Number. If it is, call the BlueCard Eligibility line 800-676-BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Remember that member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

How to identify members: prefix

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue Plan or National Account to which the member belongs and confirms a patient's membership and coverage.

To ensure accurate claim processing, capture all ID card data. If the information is not captured correctly, you may experience a delay with claim processing. Do **not** make up prefixes.

Note: Do not assume that the member's ID number is their social security number. All Blue Plans replaced social security numbers on member ID cards with an alternate, unique identifier. A sample ID card is listed below.

BlueCard ID Cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase or an BlueHPN in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to CareFirst's PPO provider contract.

Please note: EPO products may have limited benefits out-of-area. You can find any benefit limits on the back of the EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic. Providers will be reimbursed for covered services in accordance with your CareFirst contract.

The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional or HMO coverage, you will be reimbursed according to your CareFirst contract.

Some Blue ID cards don't have any suitcase logo on them:

- The ID cards for Medicaid.
- SCHIP, if administered as part of State's Medicaid.
- Medicare Complementary and Supplemental products, also known as Medigap.

Government-determined reimbursement levels apply to these products.

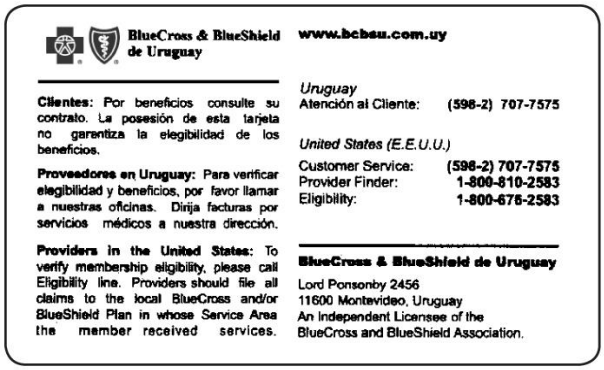
While CareFirst routes all these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's plan via the established electronic crossover process.

How to identify international members

Occasionally, you may see identification cards that are from members of international licensees or that are for international-based products. International Licensees products are provided through GeoBlue and the Blue Cross Blue Shield Global Core™ portfolio; however, always check with CareFirst as the list of international licensees and products may change.

ID cards from these licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and copayment) and file their claims to CareFirst. See below for sample ID cards for international members and products.

Example of an ID card from an international licensee:



Examples of ID cards for international products

Illustration A – GeoBlue:

Illustration B – BlueCross BlueShield Global Core portfolio:

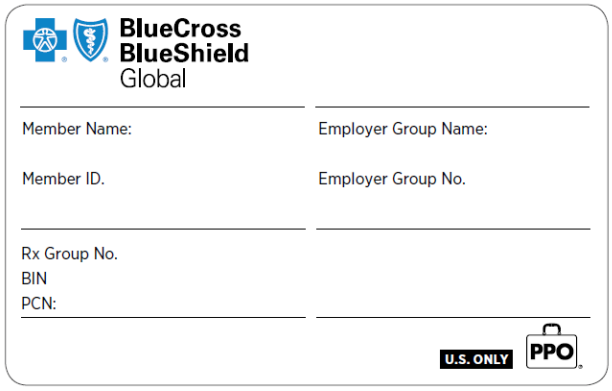
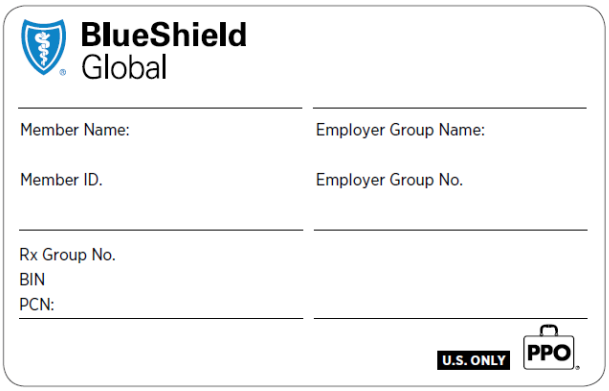
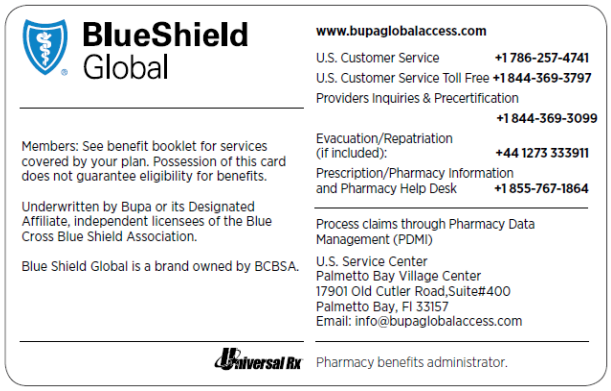


Illustration C – Shield-only ID card:





Note: In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross Branded products are not available. The ID cards of members in these territories will display the Blue Shield Global Core logo.

Canadian ID cards

Note: The Canadian Association of Blue Cross Plans and its member plans are separate and distinct from the BCBSA and its member plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard Program.

Please follow the instructions of the Blue Cross plans in Canada on the ID cards for servicing their members. The Blue Cross plans in Canada are:

- Alberta Blue Cross
- Manitoba Blue Cross
- Medavie Blue Cross
- Ontario Blue Cross
- Pacific Blue Cross
- Quebec Blue Cross
- Saskatchewan Blue Cross

Source: http://www.blucross.ca/en/contact.html

Consumer Directed Healthcare and healthcare debit cards

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision using member support tools, provider and network information and financial incentives.

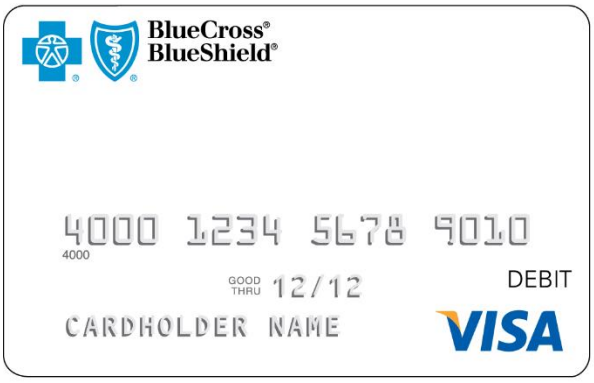
Members who have CDHC plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are stand-alone debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

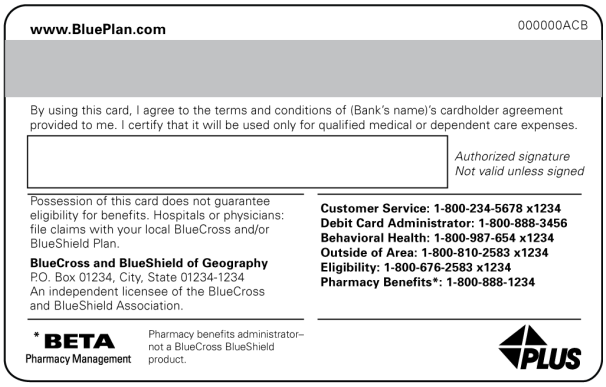
- Reduce bad debt.
- Reduce paperwork for billing statements.
- Minimize bookkeeping and patient account functions for handling cash and checks.
- Avoid unnecessary claim payment delays.

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

Below is a sample stand-alone healthcare debit card:



Below is a sample combined healthcare debit card and member ID card:



The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Helpful Tips:

- Using the member's current member ID number, including the prefix, carefully determine the member's financial responsibility before processing payment. Check eligibility and benefits electronically through CareFirst Direct or by calling 800-676-BLUE (2583).
- All services, regardless of whether you've collected the member responsibility at the time of service, must be billed to CareFirst for proper benefit determination and to update the member's claim history.
- Please do not use the card to process full payment up front. If you have any questions about the member's benefits, please contact 800-676-BLUE (2583). For questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Limited benefits products

Verifying Blue patients' benefits and eligibility is important, now more than ever, since new products and benefit types entered the market. Patients may have traditional Blue PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e., $1million or more), and you may now see patients whose annual benefits are limited to $50,000 or less.

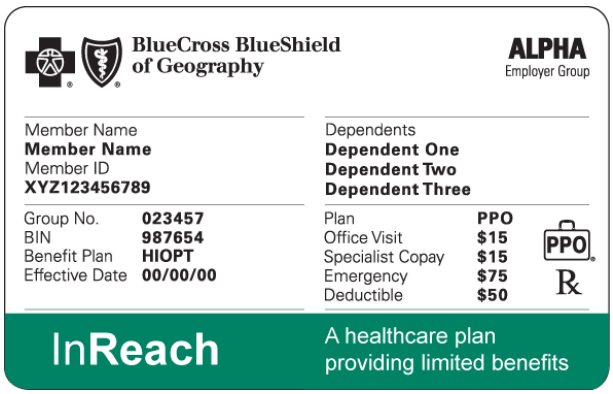
Currently CareFirst doesn't offer such limited benefit plans to our members; however, you may see patients with limited benefits who are covered by another Blue Plan.

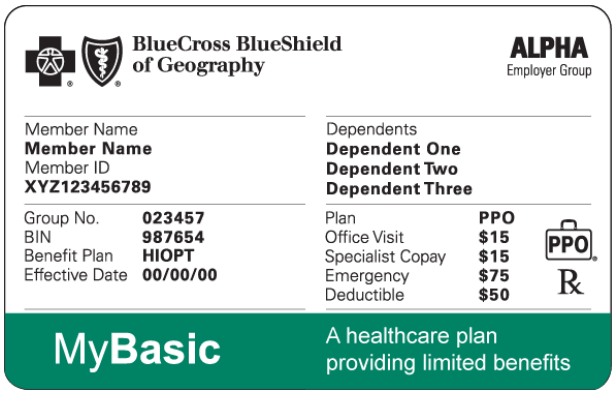
How to recognize members with limited benefits products

Members with Blue limited benefits coverage (i.e., annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as InReach or MyBasic.
- A green stripe at the bottom of the card.
- A statement either on the front or the back of the ID card stating this is a limited benefits product.
- A black cross and/or shield to help differentiate it from other identification cards.

An example is listed below:





How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient's ID card, and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility and collect any patient liability.

You may do so electronically by using CareFirst Direct eligibility inquiry or may call the 800-676-BLUE (2583) eligibility line for out-of-area members.

Both electronically and via phone, you will receive patient's accumulated benefits to help you understand the remaining benefits left for the member.

Use these helpful tips below to verify the patient's benefits:

- In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, always verify eligibility and benefits electronically with CareFirst Direct or by calling 800-676-BLUE (2583). You will receive the member's accumulated benefits to help you understand their remaining benefits.
- If the cost of service extends beyond the member's benefit coverage limit, please inform your patient of any additional liability they might have.
- If you have questions regarding a Blue Plan's limited benefits ID card/product, please contact CareFirst.

If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

What should I do if the patient's benefits are exhausted before the end of their treatment?

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts of the number of treatments are the member's liability.

Who do I contact if I have additional questions about Limited Benefit Plans?

If you have any questions regarding Limited Benefits Products, contact CareFirst. You can find our contact information in the Provider Quick Reference Guide.

Coverage and eligibility verification

For BlueCard members, submit an electronic inquiry through CareFirst Direct or call BlueCard Eligibility 800-676-BLUE (2583) to verify the patient's eligibility and coverage:

- CareFirst Direct: You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and Midnight CDT, Monday through Saturday.
- Phone: Call BlueCard Eligibility 800-676-BLUE (2583)
    - English and Spanish speaking phone operators are available to assist you.
    - Blue Plans are located throughout the country and may operate on a different time schedule than CareFirst. You may be transferred to a voice response system linked to customer enrollment and benefits outside that plan's regular business hours.
    - The BlueCard Eligibility line is for eligibility, benefit and pre- authorization inquiries only. It should not be used for claim status. See the Claims Filing section for claim filing information.

Utilization review

You should remind patients that they are responsible for obtaining pre-authorization/pre-certification for outpatient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract. Refer to the Provider Financial Responsibility section below. In addition, members are held harmless when pre-service review is required and not received for in-patient facility services (unless an account receives an approved exception).

Participating providers must:

- Notify the member's Blue Plan within 48 hours when a change or modification to the original pre-service review occurs; and
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

General information on pre-authorization/pre-certification information can be found on the Out-of-Area member Medical Policy and Pre-Authorization/Pre-Certification Router at carefirst.com/preauth utilizing the three-letter prefix found on the member ID card.

You may also contact the member's plan on the member's behalf. You can do so by:

- Calling BlueCard Eligibility 800-676-BLUE (2583) and asking to be transferred to the utilization review area.
    - When pre-authorization/pre-certification for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles pre-authorization/pre-certification. You will choose from four options depending

on the type of service for which you are calling (Medical/Surgical, Behavioral Health, Diagnostic Imaging/Radiology and Durable/Home Medical Equipment and Supplies (D/HME)).

- If you are inquiring about both eligibility and pre-authorization/pre-certification through 800-676-BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-authorization/pre-certification area.

- Submit an electronic pre-authorization request through CareFirst Direct.
- The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining pre-authorization/pre-certification, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure an existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

Electronic provider access

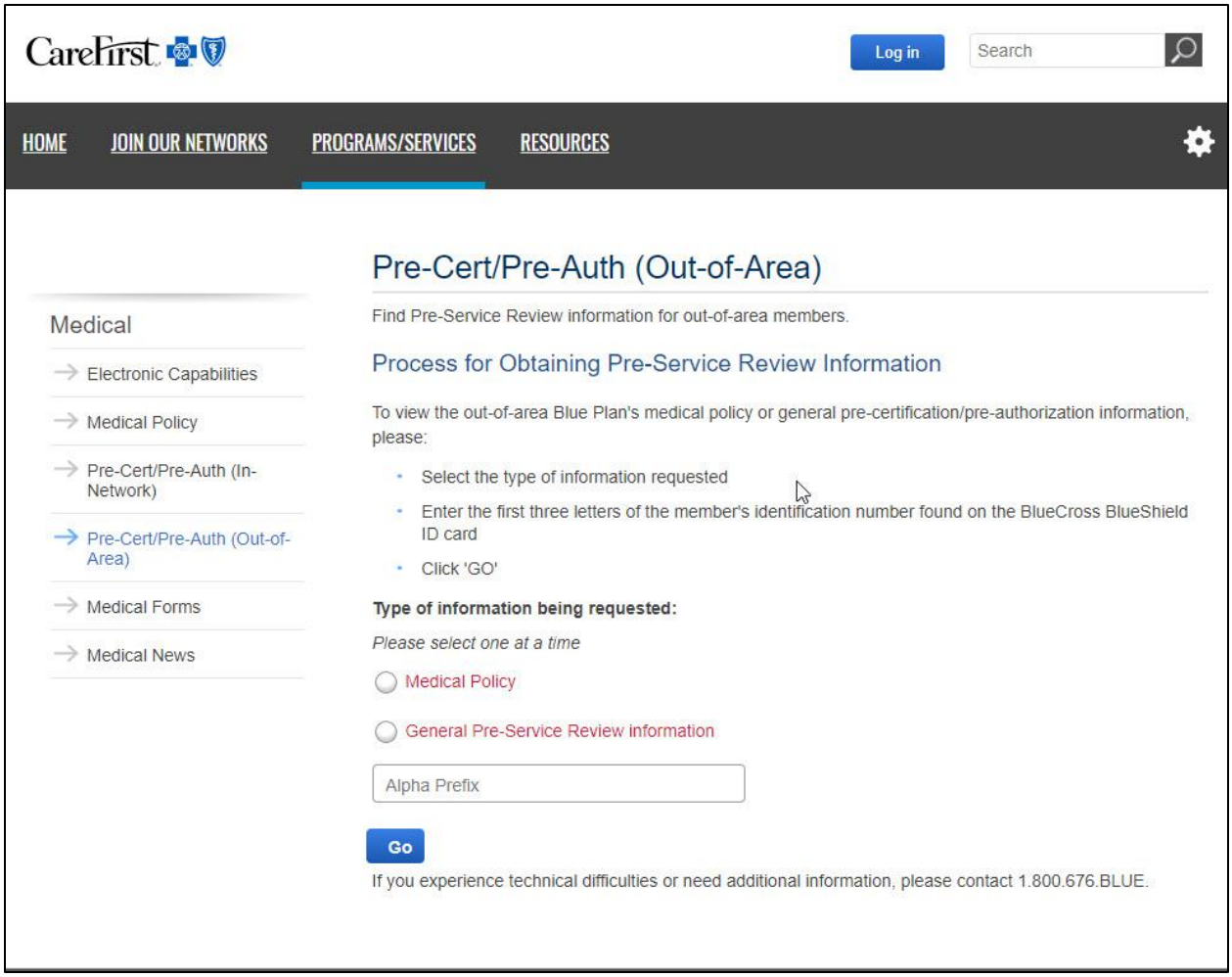
Electronic Provider Access (EPA) gives providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes.

EPA enables providers to use their local Blue Plan provider portal (CareFirst Direct) to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The availability of EPA varies depending on the capabilities of each Home Plan. Some Home Plans have electronic pre-service review for many services, while others do not. The following describes how to use the EPA and what to expect when attempting to contact Home Plans.

Using the EPA Tool

The first step for providers is to go to CareFirst Direct and log-in. Then select the menu option, ***Pre-Service Review for Out-of-Area Members (includes notification, pre-certification, pre-authorization and prior approval.)***



Next, you will be asked to enter the prefix from the member's ID card. The prefix is the first three characters that precede the member ID.

Note: You can first check whether pre-certification is required by the Home Plan by either:

- Sending a service-specific request through CareFirst Direct.
- Accessing the Home Plan's pre-certification requirements pages by using the medical policy router as noted above.

Entering the member's prefix from the ID card automatically routes you to the Home Plan EPA landing page. This page welcomes you to the Home Plan portal and indicates that you have left CareFirst's portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of the Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to guide you through conducting an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The Home Plan landing page may look similar across Home Plans but will be customized to the particular Home Plan based on the electronic pre-service review services they offer.

Provider financial responsibility for pre-service review for BlueCard members

CareFirst participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

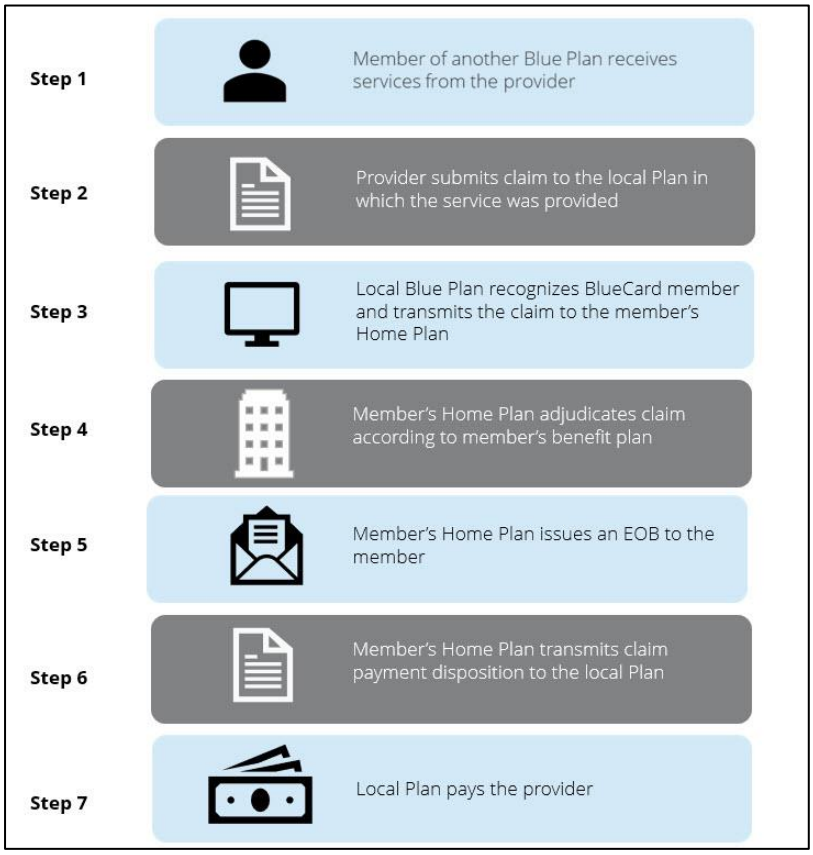
- Notify the member's Blue Plan within 48 hours when changes or modifications to the original pre-service review occurs
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue Plan for pre-service review or for a change or modification of the pre-service review will result in a penalty (per the member's contract) or denial of the claim information for in-patient facility services. The BlueCard member must be held harmless and cannot be balance-billed if required pre-service review has not occurred, unless the member signed a written consent to be billed prior to rendering the service.

Claims Filing

How claims flow through BlueCard

Below is an example of how claims flow through BlueCard:



After the member of another Blue Plan receives services from you, file the claim with CareFirst. We will work with the member's plan to process the claim, and the member's plan will send an EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract and based on the members benefits and coverage.

Use these helpful tips to improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically through CareFirst Direct or by calling 800-676-BLUE (2583). Be sure to provide the member's prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate any payment you collected from the patient on the claim.
    - On the 837 electronic claim submission form check field AMT01=F5 patient paid amount; on the CMS 1500 locator 29 amount paid; on UB92 locator 54 prior payment; on UB-04 locator 53 prior payment.
- Submit all Blue claims to CareFirst. Be sure to include the member's complete ID number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member ID numbers cannot be processed.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, slows down the claims payment process and creates confusion for the member.
- Check claims status by using CareFirst Direct.

Medicare Advantage claims: overview

Medicare Advantage (MA), also known as Medicare Part C, is the program alternative to standard Medicare Part A and Part B fee-for-service coverage, generally referred to as Traditional Medicare.

MA offers Medicare beneficiaries several product options (like those available in the commercial market), including HMO, PPO, POS and private fee-for-service (PFFS) plans.

All MA plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, MA organizations may also offer a Special Needs Plan, which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

MA plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage — by calling 800-676-BLUE (2583) or submitting an electronic inquiry — for all MA members prior to providing service, since the level of benefits, and coverage rules, may vary depending on the MA plan.

Below are the types of MA Plans:

Medicare Advantage HMO

An MA HMO is a Medicare managed care option in which members typically receive a set of pre-determined and pre-paid services provided by a network of physicians and hospitals. Generally (except in

urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by MA plan.

Medicare Advantage POS

An MA POS program is an option available through some Medicare HMO programs. It allows members to determine — at the point of service — whether they want to receive certain designated services within the HMO system or seek such services outside the HMO's provider network (usually at greater cost to the member). The MA POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

An MA PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. MA PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue MA PPO members have in-network access to Blue MA PPO providers.

Medicare Advantage PFFS

An MA PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The MA Organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance-billing may be permitted in limited instances where the provider is a network provider, and the plan expressly allows for balance billing.

MA PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any MA PFFS member without having a contract with CareFirst.
- If you do provide services, you will do so under the terms and conditions of that member's Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan, and we advise that you review them before servicing MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the plan's terms and conditions. You may choose to render services to an MA PFFS member on an episode of care (claim-by-claim) basis.
- Submit your MA PFFS claims to CareFirst.

Medicare Advantage Medical Savings Account (MSA)

MA MSA is a Medicare health plan option made up of two parts. One part is an MA MSA Health Insurance Policy with a high deductible. The other part is a special savings account where MA deposits money to help members pay their medical bills.

Ancillary claims

Ancillary providers include Independent Clinical Laboratory (Lab), D/HME and Specialty Pharmacy providers. File claims for these providers as follows and refer to the detailed claims filing charts here:

- Independent Clinical Lab
  - The plan whose state the specimen was drawn based on the location of the referring provider.
- D/HME
  - The plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy
  - The plan in whose state the ordering physician is located.

Note: If you contract with more than one plan in state for the same product type (i.e., PPO or Traditional), you may file the claim with either plan.

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of the member ID card or calling 1-800-676-BLUE (2583), prior to providing any ancillary service.
- Providers that utilize outside vendors to provide services (ex. sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. You can find a list of in-network participating providers online by using the Find a Doctor Tool.

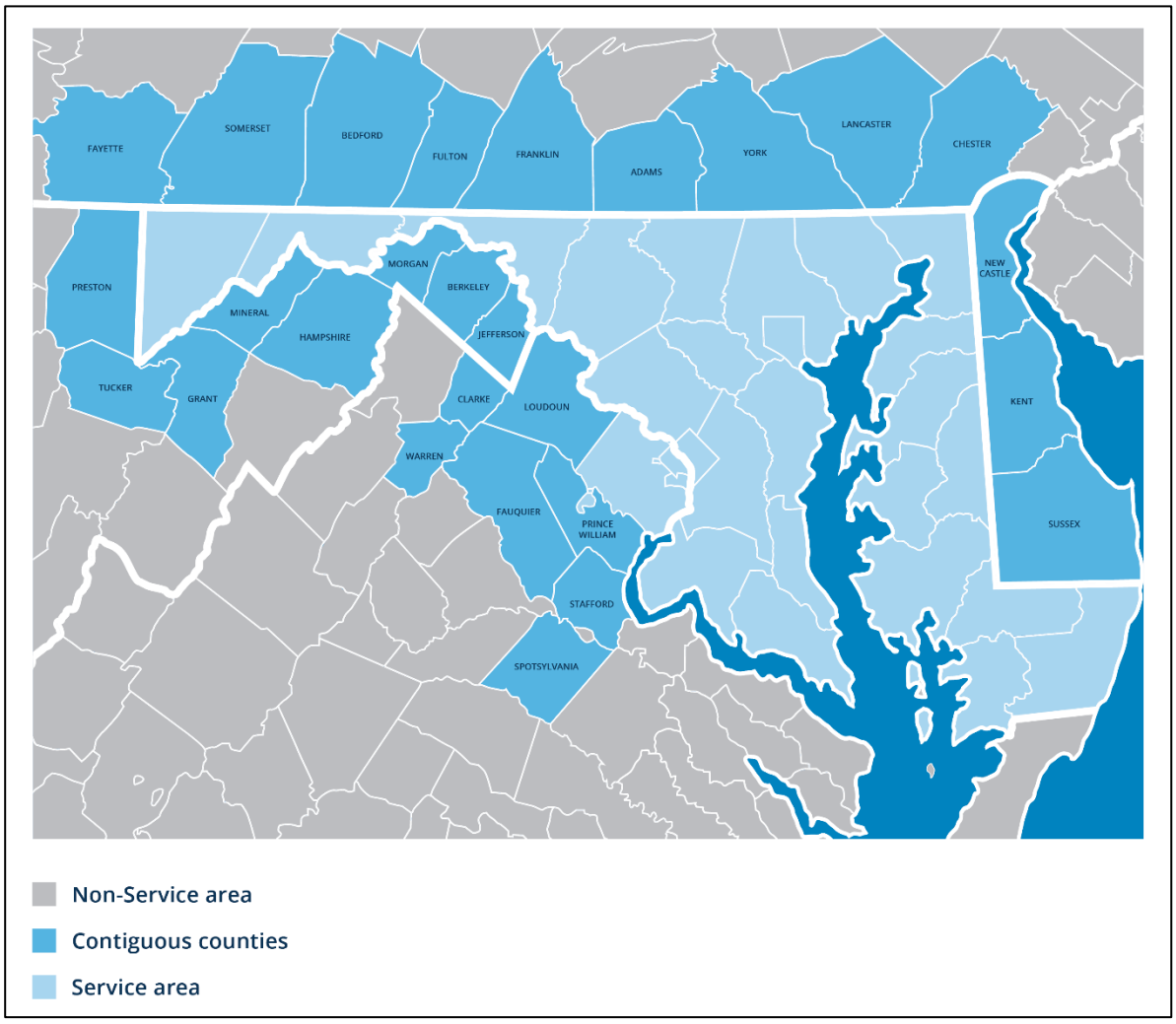
Air ambulance claims

Claims for air ambulance services must be filed to the Blue Plan where the point of pickup ZIP code is located.

Note: If you contract with more than one plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either plan.

- The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Where possible, providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of the member ID card or calling 800-676-BLUE (2583).
- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits. You can find a list of in-network participating providers online by using the Find a Doctor Tool.
- Members are financially liable for air ambulance services not covered under their benefit plan. If is the provider's responsibility to request payment directly from the member for non-covered services.

Contiguous counties/overlapping service areas



Contiguous Counties

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract, which may include:

- Provider location (i.e., which plan service area is the providers office located).
- Provider contract with the two contiguous counties (i.e., is the provider contracted with only one or both service areas).
- The member's home plan and where the member works and resides (i.e., is the member's home plan with one of the contiguous counties plans).
- The location of where the services were received (i.e., does the member work and reside in one contiguous county and see a provider in another contiguous county).

Overlapping service areas

Submitting claims in overlapping service areas is dependent on what plan(s) the provider contracts within that state, the type of contract the provider has (ex. PPO, traditional) and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either plan.
- If you have a PPO contract with one Blue Plan, but a traditional contract with another Blue Plan, file the out-of-area Blue Plan member's claim by product type.
    - For example, if it's a PPO member, file the claim with the plan that has your PPO contract.
- If you contract with one plan but not the other, file all out-of-area claims with your contracted plan.

Medical records

Blue Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

- As part of the pre-authorization process — if you receive requests for medical records from other Blue Plans prior to rendering services, you will be instructed to submit the records directly to the member's plan that requested them. This is the only circumstance where you would not submit them to CareFirst.
- As part of claim review and adjudication — these requests will come from CareFirst in the form of a letter, fax, email or electronic communication requesting specific medical records and include instructions for submission.

BlueCard medical record process for claim review

- An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
- A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously but received a remittance advice indicating records were still needed, please contact CareFirst to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
- If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact CareFirst to determine if the records are needed from your office.
- Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful ways you can assist in timely processing of medical records

- If the records are requested following submission of the claim, forward all requested medical records to CareFirst.
- Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by CareFirst.
- Please submit the information to CareFirst as soon as possible to avoid further delay.
- Only send the information specifically requested. Frequently, complete medical records are not necessary.
- Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Adjustments

Contact CareFirst if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

Appeals

Appeals for all claims are handled through CareFirst. We will coordinate the appeal process with the member's Blue Plan, if needed.

Claim payment

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple EOBs. CareFirst's standard time for claims processing is 30 days from the date of receipt or sooner. However, claim processing times at various Blue Plans vary.
- If you do not receive your payment or a response regarding your payment, please check CareFirst Direct or CareFirst on Call to check the status of your claim.
- In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, CareFirst may ask you for the information or give the member's plan permission to contact you directly.

Claim status inquiry

CareFirst is your single point of contact for all claim inquiries. Claim status inquiries can be done by utilizing CareFirst Direct or CareFirst on Call.

Calls from members and others with claim questions

If other Blue Plan members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's plan should not contact you directly regarding claims issues, but if the member's plan contacts you and asks you to submit the claim to them, refer them to CareFirst.

All Provider Types

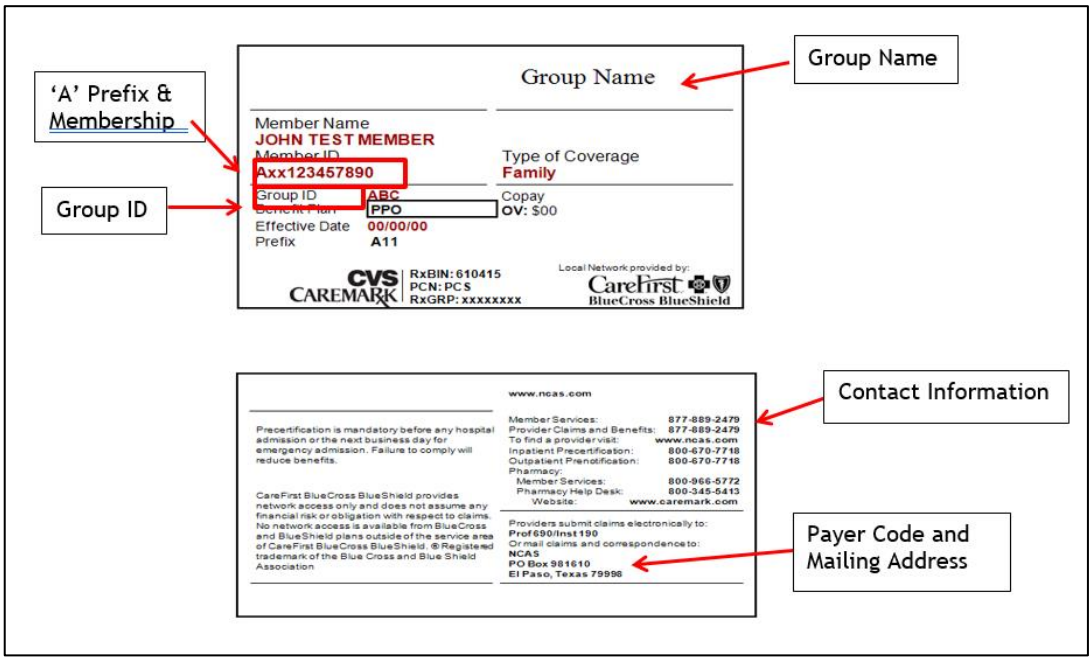
Network Lease/Third Party Administrators

Network Lease

CareFirst jointly administers, with third-party administrators (TPAs), self-insured employers, and health and welfare funds, the Network Lease claims product. This product enables employers to utilize the CareFirst network of providers while still being able to design and administer their health benefits. CareFirst is actively involved and responsible for collecting and pricing claims, training and maintenance of the provider networks. The TPAs are responsible for issuing ID cards, handling claims adjudication, benefit and claims inquiries, correspondence, appeals, etc. Participating providers agree to accept the CareFirst allowance as payment in full for services rendered, less any deductibles and coinsurance amounts.

Member identification

The member will have a unique ID card with the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund). The prefix on the ID card begins with an "A" followed by two numeric characters. EOBs, checks and vouchers will usually have the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund).



Claims submission

Providers should submit claims electronically following the instructions that appear on the reverse side of the member's ID card.

Electronic claims

- Should be submitted to CareFirst.
- Professional providers should use payer code 580.
- Institutional providers should use payer code 190.

The above payer codes should be used for submission of claims for all members with an "A" prefix. Contact your clearinghouse for specific details on how to submit the payer code correctly. Some clearinghouses may use a different format that is then translated and sent to CareFirst.

Paper claims

- Should be submitted to the TPA using the address on the back of the ID card.
- The address will differ for each TPA.
- The member's "A" prefix should be included on the claim form along with the member's ID number in the following locations:
  - Professional claims submitted on a HCFA 1500 – Box 1a.
  - Institutional claims submitted on a UB-04 – Field 60.
- The member's group number should be included in the following locations:
  - Professional claims submitted on a HCFA 1500 – Box 11.
  - Institutional claims submitted on a UB04 – Field 62.

Correspondence

Correspondence should be submitted directly to the TPA using the address on the back of the member's ID card. This address will differ for each TPA.

Claim status and service inquiries

To obtain information about benefits, claim status, claim adjudication, deductibles or coinsurance:

- Contact the TPA's phone number on the back of the member's ID card, or
- Refer to the CareFirst TPA Prefix List for contact information.

Note: National Claims Administrative Services network lease groups (A11) should refer to www.ncas.com or the back of the member's ID card for contact information.

CFA, LLC dba CareFirst Administrators and National Claims Administrative Services

CFA, LLC dba CareFirst Administrators

CFA, LLC dba CareFirst Administrators is a wholly owned subsidiary of CareFirst, Inc. CFA is Blue-Branded and operates under an independent license from the BCBSA. CFA provides administrative services to self-funded employer groups whose plans are governed by the Employee Retirement Income Security Act of 1974. This allows members to take advantage of local plan networks for out-of-area services. Products are customized using the BCBS national network of providers.

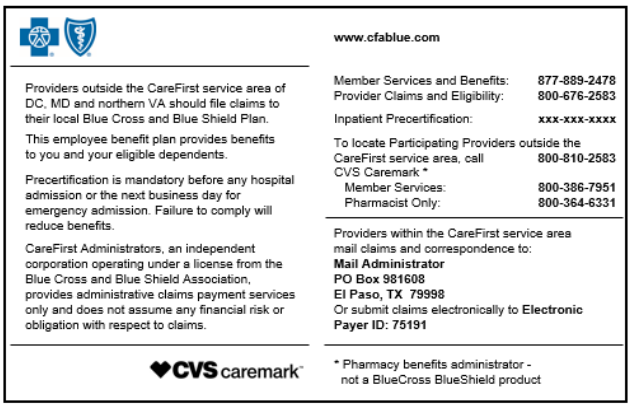
CFA provides administrative services only and does not assume any financial risk or obligation with respect to healthcare benefit claims for the self-insured portion of the plan. Though CFA offers access to

the CareFirst provider network, specific requirements of member's health benefits vary and may differ than the procedures outlined in this manual.

For specific patient eligibility and benefit information, CFA offers a member health ticket online. Providers should refer to this information for details on their patient. The health ticket includes some of the member's responsibilities such as their copays, deductibles, out-of-pocket and retail pharmacy amounts. The member health tickets for CFA members can be located by accessing www.cfablue.com or https://www.cfacustomer.com/Default.asp.

CFA also has an interactive voice response system (IVR), 877-889-2478 that providers can access for patient benefits, eligibility and claims information. Providers can also use CareFirst Direct or CareFirst on Call for eligibility and claim status.

CFA members' identification cards carry the CFA logo. Contact information for claims and correspondence is listed on the back of the card.



Claims should be submitted electronically using payer code 75191. Correspondence and paper claims should be submitted to:

CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998

For more information, refer to www.cfablue.com.

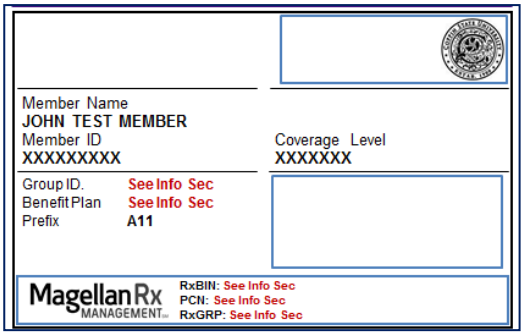
NCAS

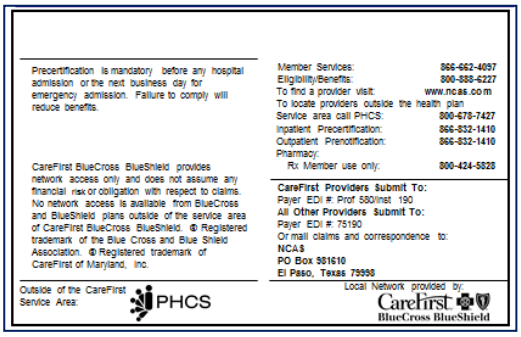
National Claims Administrative Services (NCAS) is part of CFA, LLC dba CareFirst Administrators. NCAS is a non-blue branded national TPA for companies headquartered throughout the United States with members who have access to the CareFirst provider network. CareFirst shares administrative duties with the employer groups or TPA.

NCAS is responsible for benefits eligibility and claims processing. For specific patient eligibility and benefit information, NCAS offers a member health ticket online. Providers should refer to this information for details on their patient. The member health tickets for NCAS members can be located by accessing www.ncas.com or at https://www.ncascustomer.com/Default.asp.

NCAS has an IVR, 877-889-2479, that providers can access for patient benefits, eligibility and claims information. NCAS membership information is not available through the CareFirst Direct portal.

CFA members' ID cards will have a dual logo that shows both CareFirst and the TPA. Contact information and mailing addresses are listed on the back of the card.





Claims for NCAS should be submitted electronically using payer code 580 for professional claims and payer code 190 for institutional claims. Correspondence and paper claims should be mailed to:

NCAS
P.O. Box 981610
El Paso, TX 79998

For more information, visit www.NCAS.com.

CareFirst
Family of health care plans

Chapter 3: Provider Network Requirements

Administrative Functions

Credentialing

Professional Providers

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) contract with independently practicing licensed healthcare practitioners who provide services covered under the member's plan's medical benefits. The practitioner must be licensed in the state where the member receives the service and must be within the CareFirst service area, which includes Maryland, Washington, D.C. and Northern Virginia.

Eligible professional providers

- Medical Doctor
- Osteopath
- Podiatrist
- Chiropractor
- Optometrist
- Nurse Practitioner
- Nurse Midwife
- Nurse Anesthetist
- Registered Nurse Clinical Specialist
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Psychologist
- Lactation Consultant (licensed healthcare practitioner)
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Counselor
- Licensed Alcohol and Drug Counselor
- Licensed/Registered Dietician/Nutritionist
- Licensed Art Therapist (Maryland only)
- Licensed Board-Certified Behavior Analyst (Maryland and Virginia only)
- Licensed Masters Social Worker
- Licensed Graduate Marriage and Family Therapist
- Licensed Graduate Social Worker
- Licensed Graduate Professional Counselor
- Naturopath (Maryland and Washington, D.C. only)
- Acupuncturist
- Music Therapist
- Athletic Trainer (Virginia only) **other criteria apply*

Professional provider credentialing

Providers wishing to participate in CareFirst's provider networks are required to submit a completed credentialing application and copies of credentials.

Eligible professional providers with supervision

CareFirst allows the following licensed professionals listed below to submit a credentialing application only if a supervisor is listed. This cohort has completed all masters-level educational requirements for their target license type, is actively completing clinical supervision from a qualified supervisor at a frequency and duration commensurate with their caseload.

Qualified clinical supervisors are independently licensed providers actively credentialed and contracted with CareFirst individually and/or under a contracted behavioral health group or facility.

Behavioral Health Supervisory Credentialing	
Professional Type	**Qualified Clinical Supervisor**
Licensed Master Social Worker (LMSW)	Licensed Clinical Social Worker (LCSW) Psychologist (PhD or PSYD) Psychiatrist
Licensed Graduate Marriage and Family Therapist (LGMFT)	Licensed Clinical Marriage and Family Therapist (LCMFT) Psychologist (PhD or PSYD) Psychiatrist
Licensed Graduate Professional Counselor (LGPC)	Licensed Clinical Social Worker (LCSW) Psychologist (PhD or PSYD) Psychiatrist
Registered Psychology Associate (RPA)	Licensed Professional Counselor (LPC) Psychologist (PhD or PSYD) Psychiatrist
Licensed Graduate Art Therapist	Licensed Professional Counselor (LPC) Psychologist (PhD or PSYD) Psychiatrist

How to apply

CareFirst encourages the use of the Council for Affordable Quality Healthcare (CAQH) ProView® application. CAQH ProView is an online credentialing application that streamlines data collection by using a standard form. New practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website.

Once you have completed your application (CAQH will email you notification that your application is complete), and you have authorized CareFirst to access your data, go to http://www.carefirst.com/caqhquestionnaire, complete and submit the online form. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

The practitioner's credentialing information is verified to confirm that our credentialing criteria is met. This includes, but is not limited to:

- Valid, current, unrestricted licensure
- Valid, current, Drug Enforcement Agency and Controlled Dangerous Substance registration, if and as applicable, for each state where the practitioner practices
- Appropriate education and training in a relevant field
- Board certification, if applicable
- Review of work history
- Active, unrestricted, admitting privileges at a participating network hospital, except as otherwise agreed to by CareFirst in its sole discretion
- At least 20 office hours per week to see patients
- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
- Attestation to ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use.
- Current malpractice insurance coverage with minimum limits as indicated below:

Malpractice Insurance Coverage					
Number of practitioners in practice	**Medical practices primary layer**	**Medical practices excess layer**	**Mid-level behavioral primary layer**	**Mid-level behavioral excess layer**	**PT/OT/ST primary layer only**
1	$1M/$3M Individual	N/A	$.5M/$1.5M Individual	N/A	$1M/$3M Shared (up to 24)
2–5	$1M/$3M Shared	N/A	$.5M/$1.5M Shared	N/A	$1M/$3M Shared (up to 24)
6–10	$2M/$6M Shared	N/A	$1M/$3M Shared	N/A	$1M/$3M Shared (up to 24)
11-24	$2M/$6M Shared	$5M Shared	$1M/$3M Shared	$3.25M Shared	$1M/$3M Shared (up to 24)
	$1M/$3M Shared	$10M Shared	$.5M/$1.5M Shared	$7.5M Shared	

Malpractice Insurance Coverage					
25–50	$2M/$6M Shared	$10M Shared	$1M/$3M Shared	$5M Shared	Individual Consideration
	$1M/$3M Shared	$15M Shared	$.5M/$1.5M Shared	$10M Shared	
51+	Individual Consideration	Individual Consideration	Individual Consideration	Individual Consideration	Individual Consideration

If all credentialing criteria is met, the CareFirst Medical Director refers the practitioner to the Credentialing Advisory Committee (CAC) for a recommendation to approve the application. If credentialing criteria is not met, the Medical Director may deny the application or defer to the CAC for their recommendation. The Medical Director may request additional information from the practitioner. Practitioners will be notified in writing upon approval or denial. If the application is denied, the practitioner is afforded the opportunity to submit a written appeal within 30 days. The decision based on the appeal is final.

If the practitioner is part of a group practice, the practice will be notified of the termination of that provider. Since all members of a group practice must be approved for participation, the practice may be terminated if the terminated practitioner remains with the group practice.

Note: To avoid confusion and unexpected out-of-pocket expenses for members, all providers in the same practice must participate in the same provider networks.

To ensure that CareFirst has obtained correct information to support credentialing applications and made fair credentialing decisions, providers have the right, upon request, to review this information, to correct inaccurate information and obtain the status of the credentialing process. Requests can be made by calling 877-269-9593 or 410-872-3500.

Institutional and Ancillary Providers

CareFirst contracts with the following organizational and ancillary providers who meet CareFirst requirements.

Eligible institutional and ancillary providers

- Medical
  - Birthing Center
  - Freestanding Ambulatory Surgery Center (ASC)
  - Freestanding Dialysis
  - Home Health
  - Hospice
  - Hospital
  - Rehab Hospital

- Skilled Nursing Facility
- Lithotripsy

- Behavioral health
  - Ambulatory
  - Residential/Inpatient
- Alcohol Rehabilitation
  - Ambulatory
  - Residential/Inpatient
- Drug Rehabilitation
  - Ambulatory
  - Residential/Inpatient
- Durable Medical Equipment (DME)

Locum Tenens

A locum tenens practitioner is a healthcare practitioner who is practicing temporarily to substitute for another practitioner. When a locum tenens practitioner is requesting participation with CareFirst, they must apply and be accepted for participation. Refer to the "How to Apply" section for providers listed above.

A locum tenens practitioner can participate in the CareFirst provider networks for six months or less.

Recredentialing

After initial credentialing and contracting, CareFirst recredentials its practitioners every three years. If you keep your CAQH ProView profile to-to-date, you won't need to do anything for recredentialing.

Ongoing Monitoring of Sanctions

Between recredentialing cycles, CareFirst monitors state licensing boards and other sources for sanctions and disciplinary actions. Reports are reviewed by the CareFirst Medical Director who may request further review by the CAC. The Medical Director may request additional information from the practitioner.

For more information on our credentialing process, visit carefirst.com/professionalcredentialing.

Adding a New Practitioner to Your Existing Group Practice

Practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website. If the CAQH ProView application is already complete, make sure it includes the new practice affiliation information. Once complete, go to carefirst.com/provider > click Join Our Networks > click How to Apply > Select the CareFirst Questionnaire. Follow the prompts to add the practitioner to the practice and click submit.

CareFirst will receive your updated information electronically and begin the process to add your new practitioner. You will receive written notification of the practitioner's acceptance, provider number and effective date of participation.

Access and Availability

CareFirst's services are assessed against network availability and network accessibility standards of care. This assessment determines how CareFirst maintains an adequate network of practitioners to provide appropriate access to primary care, behavioral healthcare and specialty care to meet the needs and preferences of members.

Appointment Wait Times – Network Accessibility Standards

Members should be able to schedule an appointment for the care they need within the specified time frames. For more information, visit the "Appointment Wait Times" page under Legal/Mandates.

Network accessibility standards – Maryland (Commercial plans)	
Appointment type	**Time frame**
Medical Urgent Care	24 hours
Behavioral Health Urgent Care (including behavioral health and substance use disorder services)	48 hours
Routine Primary Care	14 calendar days
Preventive Visit/Well Visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent behavioral health/substance use disorder services	10 calendar days

Network accessibility standards – DC (Commercial plans)	
Appointment type	**Time frame**
First appointment with a new or replacement PCP	Within 7 business days
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use treatment	Within 7 business days

Network accessibility standards – DC (Commercial plans)	
First appointment with a new or replacement provider for Prenatal Care treatment	Within 15 business days
First appointment with a new or replacement provider for Specialty Care treatment	Within 15 business days

Provider Data Accuracy

Accurate provider data is essential to doing business with CareFirst. The information we have for you is displayed in our print and online provider directories. This enables our members, your patients, to find you, determine if you participate with their plan and are accepting new patients and contact you to schedule an appointment at their preferred office location. If the information we have for you is not correct, your patients may not be able to find you and may consider other providers instead.

CareFirst conducts regular audits of the directory to ensure the accuracy of provider information. We are also subject to audits by regulatory agencies. If we are unable to confirm the accuracy of your information in our directory, you may be assessed an administrative fee.

As an in-network provider, you need to keep your information updated in two places:

- **CareFirst Directory Data:** CareFirst's self-service tool is not integrated with CAQH ProView. Federal law requires all providers to attest and/or update their directory information at least every 90 days with CareFirst directly. For more information on how to access and utilize CareFirst's self-service tool, review the Update Your Practice Info page.
- **CAQH ProView Application:** Once you are registered with CAQH, please continue to review, and make regular updates any time your credentialing information changes (or at least once each quarter). You will be sent a reminder from CAQH to review, update, and attest your data. For more information about CAQH ProView, visit proview.caqh.org.

In addition, it is important you also keep your data updated in NPPES. NPPES stands for National Plan and Provider Enumeration System, and is the database used by NPI number holders and the Centers for Medicare and Medicaid Services (CMS). The NPPES registry is updated regularly; therefore, any changes you make to your CareFirst provider directory information should also be reviewed and updated as appropriate in NPPES. For more information, go to NPPES (hhs.gov).

Institutional and Ancillary Provider Credentialing

CareFirst credentials institutional and ancillary providers prior to contracting and every three years thereafter. Prior to contracting, CareFirst confirms that such providers are in good standing with state and federal regulatory bodies and confirms that the providers have been reviewed and approved by an appropriate accrediting body. If the provider is not accredited, CareFirst may conduct an on-site quality assessment as part of the credentialing process. View our credentialing requirements.

How to apply

Complete a Request for Information Application and a Facility Data Sheet for each location along with all required credentialing documents. Submit the completed forms and required credentialing documents to:

CareFirst BlueCross BlueShield
Attention: Institutional Contracting
Mail Stop CG-51
10455 Mill Run Circle
Owings Mills, MD 21117-0825

Fax: 410-505-2765

Email: Institutional.Credentialing@CareFirst.com.

Note: Home infusion therapy providers and medical specialty pharmacies wishing to apply can call 410-872-3515.

For more information regarding the credentialing process, click here to find frequently asked questions and view the Institutional/Ancillary credentialing requirements or the DME credentialing requirements.

Practice Transformation

What is Practice Transformation?

Practice transformation has traditionally been used to describe the process of implementing the Patient Centered Medical Home (PCMH) Model of Care[1]. The Joint Principles of the Patient-Centered Medical Home were developed in 2007, and in 2008, the NCQA began a formal program of medical home accreditation.

However, the term is now also being used more broadly to encompass the concepts of data-driven quality improvement, comprehensiveness and care coordination, with an emphasis on high-value, evidence-based care.

In the broadest sense, practice transformation means improving healthcare delivery to achieve the Triple Aim of population health, reduced healthcare costs, and patient satisfaction. Practice transformation includes foundational key components:

- **Payment transformation,** which aligns financial incentives with high-value care.
- **Engaged leadership** that prioritizes a continuous process of organizational learning and data-driven improvement.
- **Interdisciplinary, team-based care** that focuses on increasing staffing ratios with expanded roles for non-physician members. Using a team-based approach allows providers to practice at the top of their license, which reduces burnout and increases access to care.
- **Comprehensiveness and care coordination,** which are essential elements of population health management. Practices have a responsibility to connect high-needs patients with all the services and resources they require, which may involve providing the services internally or coordinating with external care teams.

[1] https://pcmh.ahrq.gov/page/defining-pcmh

Based on the NCQA PCMH Model, key elements of transformed practices include:

- **Increased staffing ratios:** This allows providers to practice at the top of their license.
- **Morning huddles:** The whole team meets to plan for the day together.
- **Co-location:** Providers are near or accessible to team members to improve efficiency and communication.
- **Stable "teamlets":** Providers are paired with the same nurse and medical assistant every day to improve team functioning.
- **Empanelment:** Patients ideally see the same provider. Size of provider panels are thoughtfully determined and carefully managed.
- **Standing orders:** Medical assistants can use standing orders to order preventive screening and point-of-care tests independently. Registered nurses can use standing orders to do protocol-based management of warfarin, hypertension and diabetes.
- **Documentation support:** Medical assistants can be trained to provide documentation support, increasing providers' facetime with patients and reducing clinician administrative load.
- **Workflow mapping:** Workflows are carefully analyzed, optimized and standardized.
- **Health coaching:** Medical assistants can be trained to help facilitate patient behavior change by using structured motivational interviews.
- **Expanded hours:** This reduces ER and urgent care use and makes services more accessible and convenient for patients.
- **Virtual care:** Technology that supports the use of telemedicine that increases accessibility and convenience for patients.

Practice and Payment Transformation at CareFirst

Implementing the transformation activities necessary to become formally accredited as an NCQA PCMH Program requires a substantial time and monetary investment that practices may not be willing or able to undertake.

CareFirst has many resources that can assist practices with this transformation, whether their goal is aligning office workflows with NCQA recommendations or facilitating collaboration across the healthcare system to improve continuity of care.

Our initial focus was enabling transformation within primary care. In recent years, we have expanded our efforts to other areas, such as specialty practices and hospital systems, while also developing new payment models.

The following sections are intended to briefly summarize our efforts to date and provide strategies for successful transformation.

Primary care

In 2011, CareFirst began its own PCMH Program to improve health outcomes and value for our members. In 2019, we initiated separate Adult and Pediatric PCMH Programs to meet the needs of these two diverse populations.

Our PCMH Program provides PCPs with significant clinical expertise, analytical resources, and financial incentives to help transform their practices. Each enrolled practice receives the following:

- A care coordinator who is a registered nurse.
- Access to a suite of clinical support programs.
- A practice consultant trained to identify and implement transformation opportunities.
- Robust performance data available online 24/7.

Practices receive an increased fee for participating in the PCMH Program and a portion of any savings generated while maintaining a high quality of care. Twelve years in, CareFirst estimates that our PCMH Program has avoided over $1.6 billion compared to expected healthcare costs. To learn more and find examples of primary care transformation strategies, visit the CareFirst PCMH homepage.

Specialty care

Founded in 2017, CareFirst's Specialty Consulting Team is responsible for educating specialists on the utilization trends for their CareFirst patient population. The purpose is to bring price sensitivity to the market in order to facilitate quality care provided in the most cost-effective manner. To accomplish this, the Specialty Consulting Team contains subject matter experts who can identify clinical and operational best practices. The consultants understand the clinical disease progression for episodes that account for the highest dollars spent in the CareFirst service area. By combining data analytic tools, clinical and operational best practices, these consultants ultimately transform practices, providing better outcomes at a lower cost for our members.

The Specialty Consulting Team manages a database of utilization trends that assess providers on cost efficiency for which they provide care. Each specialist is compared to their peers in a granular, case-mix adjusted manner. Two third party vendor software programs are utilized in an annual ranking on cost efficiency, by grouping claims related to a given diagnosis or procedure into episodes. Key methodologies, including minimum threshold criteria and industry standard outlier control, are applied to collect the most sufficient sample size. This data is updated on an annual basis and provided to PCPs in the PCMH Program to guide decisions on when and where to refer patients. Please note, the data provided is cost only. Quality of care determinations are left to the referring provider.

Examples of transformation strategies for specialty care practices:

- Identify lower cost settings for procedures and testing when clinically appropriate.
- Align with CareFirst's pharmacy formulary to prescribe more cost-effective prescriptions.
- Understand the frequency with which providers should see patients with chronic diseases.
- Collaborate and communicate with providers in the medical community co-managing patient population ("Clinical Compact").
- Evaluate the initial consultation process to identify clinically appropriate tests prior to ordering/meeting the patient.
- Share data on risks and outcomes for certain high-risk services (e.g., elective c-section).
- Provide clinical support programs for patients who need additional services.
- Educate physicians on technology and resources readily available to help manage their patient population.
- Share cost data on all services clinically related to an episode of care and share information to help providers make cost-effective decisions while maintaining the quality of care provided.

Implementing the above strategies is likely to positively impact specialists' CareFirst Cost Ranking.

Health systems

A large portion of costs for CareFirst members are concentrated within a few large hospitals and health systems. Engaging these organizations in practice and payment transformation is key to improving population health across Maryland, Washington, D.C. and Northern Virginia.

CareFirst has equipped health systems with additional resources to enable transformation activities. In addition to field-based practice consultants, CareFirst has a team of enterprise managers serving a similar role for leadership of most large, engaged health systems in our network. CareFirst has also invested in utilization management specialists to provide additional on-site support with transitional care and discharge planning at our largest volume hospitals.

Regular meetings between CareFirst enterprise managers and health system executives help give leadership a closer view of their value-based care progress, as well as opportunities to implement transformation strategies that improve outcomes. Health system executive sponsorship is key to improving access and affordability of healthcare to CareFirst members.

Examples of transformation strategies for health systems:

- Modify site of service and other cost inefficiencies commonly found in specialist groups and other ambulatory services.
- Leverage robust CareFirst claims data to prescribe lower cost medications, close gaps in care, understand cost rankings of employed specialists and reduce variance in program performance across providers and practice sites.
- Facilitate collaboration among care coordinators to reduce duplication and strengthen continuity of care.
- Integrate with a two-way data sharing platform to improve quality reporting performance, decrease records requests and achieve a complete view of existing patients including visits outside of the system.
- Link a portion of physician payment to performance; move incentives from volume to value.
- Evolve value-based care arrangements; health systems are the ideal adopters of emerging payment models given infrastructure and experience.

Preparing for value-based care

Practice transformation enables organizations of any type to be successful in value-based care arrangements. CareFirst has historically used a fee-for-service reimbursement model. Moving forward, we will introduce value-based care reimbursement models for select areas of our network based after extensive research and solicitation of feedback from the provider community.

Value-based care focuses on development of efficient care pathways and clinical care team optimization to support improvements in health outcomes that demonstrate increased value. In addition to the practice transformation strategies mentioned above, there are several activities any organization can do to prepare for value-based care.

- Conduct a value-based payment readiness assessment to identify organizational strengths and weaknesses.
- Introduce a governance structure with a clearly defined vision and goals that are agreed upon by clinical leadership and communicated to all clinicians and administrators.

- Optimize electronic health records and other data tools to analyze and understand patient population from a cost and outcomes perspective.
- Develop evidence-based strategies to contain costs while maintaining or improving quality.
- Utilize care management and other preventative services in addition to evaluation and management visits.
- Implement a team-based care approach that includes daily huddles.

Provider Score

In addition to the credentialing requirements described above, CareFirst will utilize practice-specific profile scores that use data to evaluate practices in quality and member experience, cost efficiency, and relationship health. CareFirst may use these profile scores as a factor in creating new networks, likely beginning in June 2020. To learn more about the measures and methodology, please email profilescore@carefirst.com.

Role of the PCP — BlueChoice Only

Providers in the following medical specialties are recognized as PCPs:

- General practice
- Family practice
- Internal medicine
- Pediatrics
- OB/GYNs (MD only)
- Geriatrics
- Nurse Practitioners (NP)

In a managed care program, a strong patient-PCP relationship is the best way to maintain consistent quality medical care. Your role as the PCP is a physician manager who coordinates all aspects of a member's care.

Each CareFirst BlueChoice member selects a PCP upon enrollment and receives an individual member ID card with the name of the PCP on the card.

If a member chooses to change PCPs, the member must call the selected provider's office to confirm they still participate with CareFirst BlueChoice and that their new PCP is accepting new patients. The member then notifies member services of this change. Notification can also be done online at carefirst.com/myaccount.

Requests received on or before the 20th of the month will be effective the first day of the following month. Requests received after the 20th will be effective on the first day of the second month following the request.

For example: Changes received by January 20 will be effective February 1. Changes received on January 21 will be effective March 1. New cards will be issued after the PCP change is processed.

If you no longer wish to be a CareFirst BlueChoice member's PCP, you must verify you are the patient's current PCP and notify provider services in writing prior to notifying the member. Additionally, you must give the patient 30 days' notice prior to their release. A member services representative will help the member select a new PCP.

OB/GYNs as PCPs

Only members in Maryland can select OB/GYNs specialists as their PCP. A CareFirst BlueChoice participating OB/GYN who agrees to act as PCP for a female member should give the member a letter of intent stating your decision to serve as their PCP.

The letter should include your CareFirst BlueChoice provider number and the member's ID number and should be returned by the member to member services.

Back-up Coverage

When you are not available to provide service to patients, you must arrange effective coverage through another practitioner who is a PCP in the CareFirst BlueChoice network. The covering practitioner must indicate on the paper claim form that they are covering for a particular provider, and include the doctor's name, when submitting the claim to CareFirst BlueChoice.

After Hours Care

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week so you can appropriately respond to members and other providers concerning after hours care. 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 BlueChoice members and should not be used by CareFirst BlueChoice participating physicians. Refer to Payment Policy PP CO 200.01 After Hours Office Visits – Professional.

Open/Closed Panel

As stated in the physician Participation Agreement, you may close your panel to new members with at least 60 days prior written notice to provider information and credentialing.

If you wish to accept a new member into a closed panel, you must notify provider information and credentialing in writing. Written notification is also required when you elect to re-open your panel to new members.

Requests for opening and closing a panel can be made via the provider portal at carefirst.com/provider.

Requests for opening and closing a panel may also be faxed on your letterhead to 410-872-4107 or 866-452-2304.

Written notifications should be mailed to:

Mail Administrator
P.O. Box 14763
Lexington, KY 40512

Reduction, Suspension or Termination of Privileges

All practitioners who participate in CareFirst's networks are subject to the terms of your Participation Agreement with CareFirst. The Participation Agreement specifically provides for the enforcement of a range of sanctions up to and including termination of a practitioner's network participation for reasons related to the quality of care rendered to members, as well as for breaches of the Participation Agreement itself.

After review of relevant and objective evidence supplied to or obtained by CareFirst, our Medical Director may elect to reduce, suspend or terminate practitioner privileges for cause. When a potential problem with quality of care, competence or professional conduct is identified and there is imminent danger to the health of a member, the Medical Director may immediately terminate the practitioner's participation. Actions, other than termination of participation, include:

- Implementation of a corrective action plan
- Implementation of a monitoring plan
- Closure of PCP panels (CareFirst BlueChoice only)
- Suspension with notice to terminate
- Special letter of agreement between the practitioner and CareFirst outlining expectations and/or limitation of range of services the practitioner may supply to members.

To make final determinations, the Medical Director seeks advice from the Credentialing Advisory Committee (CAC) and may appoint other practitioners as ad hoc members to the CAC to offer specialized expertise in the medical field that is the subject of the case or issue presented. As part of its investigation, the Committee may use information that may include chart review of outpatient and inpatient care, complaint summaries, peer/staff complaints and/or interviews with the practitioner.

The Medical Director or credentialing manager notifies the practitioner in writing of the reason(s) for the termination and/or sanction, their right to appeal the determination, and the appeal process. The practitioner may appeal the decision by submitting a written notice with relevant materials they consider pertinent to the decision within 30 days of being notified of the decision. The practitioner forfeits their right to appeal if they fail to file an appeal within 30 days of receiving notification of the decision.

Pursuant to the local jurisdiction's regulations, CareFirst notifies the relevant licensing boards within 10 days when it has limited, reduced, changed or terminated a practitioner's contract if such action was for reasons that might be grounds for disciplinary action by the particular licensing board. As a querying agent for the National Practitioner Data Bank, CareFirst complies with the notification requirements.

Quality of Care Termination

Appeal requests relative to quality of care terminations are reviewed through a hearing panel. The hearing panel is comprised of clinical members of the corporate Quality Improvement Committee who were not previously involved in the review or decision of the case, and at least three practitioners with no adverse economic interests connected to the appealing practitioner and similar experience in the appealing practitioner's expertise (if appropriate). The appealing practitioner is notified in writing of the hearing process. Following the hearing, the panel will make a final decision to affirm, amend or reverse the sanction or network termination. The Medical Director, in consultation with CareFirst legal representative(s), will notify the

practitioner of the decision in writing, provides a statement for the basis of the decision and informs the practitioner the decision is final and not subject to further consideration by CareFirst.

All Other Sanctions or Terminations

The Medical Director or credentialing manager will reconsider appeals for all other sanctions or terminations based on new information provided by the practitioner. The Medical Director may seek recommendations from the CAC prior to making a final decision. The practitioner is notified of the final decision in writing and not subject to further consideration with CareFirst.

Member to be Held Harmless

CareFirst will make payments to the provider only for covered services which are rendered to eligible members and are determined by CareFirst to be medically necessary. Any services determined by CareFirst to have not been medically necessary, and ineligible for benefits, will not be charged to the member, except as otherwise provided in the relevant Participation Agreement. The provider may look to the member for payment of deductibles, copayments, and coinsurance or for services covered under the member's health benefit plan. Payment may not be sought from the member for any balances remaining after CareFirst's payment for covered services or for services denied due to the provider's lack of contracted compliance (i.e., lack of authorization), unless it is to satisfy the deductible, copayment or coinsurance requirements of the member's health benefit plan. The provider should not specifically charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against members or persons other than CareFirst or a third-party payer for covered services provided according to the Participation Agreement.

Note: If a referral is required for a service, and the member does not present one to the provider of care, the member is not liable for any charges not paid due to the missing referral.

Health Insurance Portability and Accountability Act (HIPAA) Compliant Codes

To comply with the requirements of HIPAA, CareFirst will add the HIPAA compliant codes and plan allowances to your base fee schedule when they are released from the American Medical Association (AMA) or the Centers for Medicare and Medicaid Services (CMS). These updates are made as needed during the calendar year. Fee schedules for these changes can be released at the provider's request.

Reimbursement

Participating providers agree to accept a plan allowance (also called allowed benefit or allowed amount) as payment in full for their services. Participating providers may not bill the member for amounts that exceed the allowed amount for covered services. Members may be liable for non-covered services, deductibles, copayments and coinsurance.

CareFirst's fee schedule is a list of plan allowances that are reviewed regularly. When adjustments to the fee schedule are made, providers will be notified if they will be impacted. They will receive a list of the impacted codes and fees. If the number of adjustments is too great, then a list of the most commonly billed codes (according to specialty) will be sent. Fee schedules for additional codes can also be obtained via CareFirst Direct.

Payment Policy Reference Manual

The online Payment Policy Reference Manual contains approved payment policies for all Commercial products offered by CareFirst. Payment policies are based on the most current research available at the time of policy development.

The policies in this Payment Policy Reference Manual are for informational use only. These policies are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract. Member/subscriber coverage will vary from contract to contract and by line of business. Benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts.

Refer to the table below for information about payment policy topics previously found in the manual or references to payment policy topics currently in the manual.

Payment Policy References		
ID Number	**Policy Name**	**Manual Topic**
PP CO 010.01	Place of Service Codes for Evaluation & Management Services - Professional	Evaluation and Management (E/M) Services
PP CO 013.01	Anesthesia	Anesthesia by Operating Surgeon
PP CO 014.01	Evaluation and Management Services	Transitional Care Management Services
PP CO 015.01	Visual Acuity Screening	Visual Acuity Testing
PP CO 016.01	Critical Care	Critical Care Services
PP CO 020.01	Limited License Providers	Limited Licensed Providers, Physician Assistants, Anesthesia Assistants, Assistant Behavior Analysts and Registered Behavior Technicians; Ambulatory Surgery Centers
PP CO 050.01	Bilateral Services	Bilateral Procedures; Policy Guidelines for Reporting Bilateral Procedures
PP CO 070.01	Co-Surgeon/Team Surgery	Co-surgeon and Team Surgery
PP CO 070.02	Surgical Assistants	Assistant Surgeon; Assistant-at-Surgery

Payment Policy References		
PP CO 070.03	Global Surgical Period	Global Period; Same Day Visit; Global Surgical, Anesthesia and Maternity Reimbursement Guidelines; E/M Services During the Global Period; Emergency Medicine
PP CO 080.01	Global Obstetrical Policy	Obstetrics and Gynecology; Obstetrics Package; Maternity Services
PP CO 090.01	NCCI Editing – Professional, DME Supplier and Facility	Add-on Codes Without Base; Add-on Procedures
PP CO 100.01	List of Eligible Services – DME Supplier	Durable Medical Equipment; Guidelines for Ancillary Claims Filing
PP CO 100.02	DME Percent of Change (POC)	Guidelines for Ancillary Claims Filing
PP CO 100.03	DME Owned in History/Rent to Own	Guidelines for Ancillary Claims Filing
PP CO 100.04	Supplies and Equipment	Supplies and Equipment
PP CO 200.01	After Hours Office Visits – Professional	After Hours Care
PP CO 200.02	Telehealth Services	Telemedicine; Online/Internet and Telephone Services
PP CO 400.01	Multiple Procedure Payment Reduction (MPPR) – Pay Percent – Therapy Services – Professional	Pay Percent Professional Therapy
PP CO 400.02	MPPR – Pay Percent – Diagnostic Imaging Services – Professional	Pay Percent Multiple Radiology
PP CO 400.03	MPPR – Pay Percent – Cardiovascular Services – Professional	Pay Percent Multiple Cardiology
PP CO 400.04	MPPR – Pay Percent – Ophthalmology Services - Professional	Pay Percent Multiple Ophthalmology

Payment Policy References		
PP CO 600.04	Professional, Technical and Global Services	Modifier Reimbursement Guidelines; Supervision, Interpretation and/or Guidance for Diagnostic Tests
PP CO 600.05	Modifier Policy	Payment/Non-Payment Modifiers; Modifier Reimbursement Guidelines; Global Surgical, Anesthesia and Maternity Reimbursement Guidelines; CPT Modifer-25; CPT Modifier-57
PP CO 800.01	Dialysis - Facility	Dialysis Facilities
PP CO 900.01	Home Health Agency - Facility	Home Health
PP CO 900.02	Hospice - Facility	Hospice
PP CO 900.03	Skilled Nursing Facility	Skilled Nursing Facility
PP CO 900.04	Ambulatory Surgery Centers (ASC)	Free-Standing Ambulatory Surgery Center Payment Methodology; Air Ambulance

Fee Schedule - Place of Service Code Assignments

Place of Service Code Assignments are used by CareFirst providers when submitting claims for payment. These codes are also located in the reference guides tab at carefirst.com/providerguides.

The Health Services Cost Review Commission

Maryland is the only all-payer state in the nation with respect to hospital services. This means that Medicare has provided Maryland an exemption from reimbursement under their Inpatient Prospective Payment and Outpatient Prospective Payment System methodologies and instead pays Maryland hospitals in accordance with state mandated rates set by the Health Services Cost Review Commission (HSCRC). Hospital rates set by HSCRC apply to all payers.

The HSCRC was established by Maryland state law in 1972 and received Medicare exemption in 1977. Since that time, all-payers pay approximately the same rate for hospital services in Maryland. Historically, Medicare and Medicaid received a 6% discount while commercial payers could receive up to 2.25% discount by providing advanced funding to hospitals to cover accounts receivable.

Effective July 1, 2019, Medicare and Medicaid's discount increased to 7.7% to recognize changes in commercial policies on current bad debts as a result of increases to members' copay and deductible provisions. Note that this rate was temporarily increased to 8.7% effective April 1, 2023, but will return to 7.7% effective July 1, 2024.

The waiver model has transformed over time from a focus on unit cost rates to total cost and quality measures. Hospitals are held at risk for financial and quality performance while the HSCRC provides rates that are equitable for effective and efficient hospitals to strive. CareFirst is a major supporter of the waiver and continues to be an active participant in policy setting and rate review.

Note: Maryland regulated general acute and private psychiatric hospitals are reimbursed according to rate structures set by the HSCRC.

Diagnosis Related Group Inpatient Payment Methodology

In general, participating hospitals, which are not located in Maryland, are reimbursed for approved inpatient services using a methodology similar to Medicare's DRG payment method. This method uses the principal and secondary diagnoses and the principal and secondary procedures, in addition to the member's age, gender and discharge status to assign a DRG. The diagnoses and procedure codes submitted by the hospital must be valid ICD-10 designated codes. Each DRG is assigned a relative weight.

Reimbursement should be calculated using:

- The DRG weight, standard average length of stay and other factors (for the grouper version in use by CareFirst at the time services were rendered).
- The methodologies defined in Appendix B to the Hospital Participation Agreement.

Note: A reimbursement description (available on the remittance schedule or through CareFirst Direct) allows you to check individual payment calculations.

Diagnosis Related Group Reimbursement Cases

Under no circumstances may a hospital deny a continued inpatient stay that is not medically necessary, due to placement delays or problems in securing alternative financial support needed to move a patient to a lower level of care. The facility may only issue a denial notification for a CareFirst member if:

- The facility, the attending provider, and CareFirst agree and document that it is not medically necessary for the member to remain in the facility.
- An appropriate discharge plan has been developed.
- The member or family member refuses discharge.

However, the hospital is strongly encouraged to discuss the case with the attending provider, the member, and/or a family member to ensure the patient and/or family member understands their financial responsibility before the written denial is issued.

A copy of the issued denial letter must be forwarded to CareFirst.

Methods of Reimbursement for Facilities

CareFirst provides several other methods of hospital reimbursement:

- All-inclusive per diem or case rate payments
- Predetermined per visit fees
- Percentage of charges (discounted)
- Predetermined flat fees
- Percentage of Medicare Resource Based Relative Value Scale fee schedule amounts
- Percentage of CareFirst standard Base Fee Schedule amounts

To determine the method(s) of payment for your facility and for the services in question, refer to the payment information contained in the Appendices to the Hospital Participation Agreement.

Office-Based Drug Reimbursement Methodology

Medications administered in the provider's office are covered under the member's medical benefit, not their prescription drug benefit. Prescription drug benefits cover injectable medications only when they are self-administered.

Note: Self-administered drugs will be denied with any of the following place of service codes, even if they are incident to a physician services: 01, 03, 04, 09, 11, 12, 13, 14, 15, 16, 20, 25, 32, 33, 49, 50, 54, 55, 57, 58, 71, 72, or 81. Codes J0129 or J2354 are an exception only when reported with modifier JA.

Note: Depo-Provera® (when used for contraception) is the only non-self-administered injectable covered under the prescription drug benefit.

Providers will need to obtain office administered injectable medications and bill CareFirst directly. Members may not fill a prescription and then deliver it to the provider. These medications are not covered by the member's prescription drug benefit.

For commercial members, providers may obtain injectable medications from a source of their choice. CareFirst has a contract with CVS Caremark®. CVS Caremark can ship single doses of most injectable medications, on an individual patient (prescription) basis, directly to the provider office for administering. This option is available for most office injectables, eliminating the upfront cost of stocking expensive specialty injectables. CVS Caremark will obtain eligibility and benefits, then bill CareFirst directly. Your practice should continue to bill CareFirst for the administration by following current procedural terminology (CPT®) guidelines and using the appropriate CPT codes.

Orders for non-refrigerated, refrigerated and frozen medications and vaccines are packed in temperature-controlled containers and shipped directly to your office, typically within 48 hours. Priority overnight delivery is also available. This is an optional service we make available and is not a guarantee of availability or supply by CareFirst. Not all drugs or individual prescriptions are available using this option.

Note: The arrangement with CVS Caremark does not apply to members whose primary coverage is Medicare.

Reimbursement methodology

If you obtain office injectable drugs, the following reimbursement methodology applies. Injectable drugs are reimbursed at 6% above the average sales price (ASP). Injectable drugs without an ASP may be reimbursed at 20% off the lowest average wholesale price (AWP). The ASP is calculated by the Centers for

Medicare and Medicaid Services (CMS) and is available at CMS.gov. The AWP is sourced from a third party and is reflective of data comprised from multiple nationally recognized pricing services, including pharmaceutical manufacturers.

Reimbursement for all in-office injectable drugs is updated quarterly on the first of February, May, August and November. These updates reflect the industry changes to ASP or AWP. If there are delays in industry changes for certain seasonal injectable drugs (e.g., flu), then reimbursements may be updated on the first day of the next month. The specific reimbursement arrangements for participants in the CareFirst oncology program are not impacted by the above changes.

Exemptions to pricing methodology include:

- Pediatric vaccines are reimbursed at 100% of AWP.
- Select vaccines are reimbursed at AWP-15%.

Medical Injectables

Certain high-cost medical injectables therapy drugs require prior authorization when administered in an outpatient hospital and home or office settings.

Intravenous immune globulin (IVIG) and select infusions can be administered in the outpatient hospital setting only if medical necessity criteria are met at the time of prior authorization. Information on all medications that require prior authorization and are part of the Site of Care program, including these therapy drugs is available at carefirst.com/preauth>*Medications*.

Note: CareFirst is aligning with CMS policy regarding code J1642. When heparin is used only for the irrigation of a catheter, the heparin itself is not separately billable. Medications given for a purpose other than the treatment of a particular condition, illness or injury are not covered unless otherwise specified.

Prior authorizations should be submitted online at carefirst.com/provider. Click on the Pre-Auth/Notifications tab to begin your request. Failure to obtain a prior authorization for these medications may result in a denial of the claim payment.

For questions related to a prior authorization that was submitted for these medications, please call CVS Caremark at 888-877-0518.

Outpatient Hospital Methodology

Outpatient hospital services billed on the UB-04 claim form are typically paid according to a fee schedule and are priced using the current procedural terminology (CPT®) or healthcare common procedure coding system (HCPCS) code that is filed in conjunction with the following services: laboratory, radiology, other therapy, and diagnostics, physical, occupational and speech therapies and drugs.

Claims for outpatient surgery are paid using a methodology in which each surgical CPT-4 or HCPCS codes is categorized into one of multiple payment categories. The rates for those payment group categories, as well as other payment rules including multiple procedure discounts, are defined in the applicable Appendix B of the hospital's agreement.

Emergency services are paid at an all-inclusive case rate based on the assigned level of emergency services.

To determine the method(s) of payment for your facility and for each outpatient service in question, refer to the payment information contained in the Appendices to the Hospital Participation Agreement.

Please remember that this information is based on the date the services were incurred.

Free-Standing Ambulatory Surgery Center Payment Methodology

Refer to Payment Policy PP CO 900.04 in our Payment Policy Database for more information.

Concierge Services Policy

CareFirst has expectations and requirements of participating providers, including those who choose the concierge practice model. We recognize that it is the member's choice to receive services from a concierge practice. At the same time, CareFirst has a responsibility to confirm services covered by the member's contract, if provided, are appropriately billed, in accordance with the applicable participation agreement(s).

To verify member benefits, use CareFirst Direct.

Please be advised that for the benefit of our members, we will identify concierge providers in our provider directories.

If you are considering a transition to a concierge practice model, along with the requirements noted above, CareFirst requires:

- 90-day written notification detailing your intent to transition to a concierge practice

To notify us of your transition, please leave a detailed voice message for provider relations at 410-872-3512 or 833-939-4107.

For providers enrolled in the PCMH program, please visit carefirst.com/pcmhinfo to learn more about requirements related to the concierge practice model.

Note: Concierge is defined as any private fee-based program, as well as any type of retainer, charge, and/or payment to receive additional "value-added" services from the provider.

Confidentiality

CareFirst is defined as a "covered entity' under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA requires CareFirst to ensure the confidentiality, integrity, and availability of all electronic protected health information that it creates, receives, maintains or transmits. This means that CareFirst must:

- Protect its customer data against any reasonably anticipated threats or hazards to the security or integrity of the data
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under HIPAA
- Ensure its workforce members comply with the HIPAA

In 2009, the American Recovery and Reinvestment Act (ARRA) included the Health Information Technology for Economic and Clinical Health Act (HITECH), which further modified HIPAA.

In 2013, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights issued a final rule that implemented a number of provisions of the HITECH Act to strengthen the privacy and security

protections for health information established under HIPAA. HIPAA requires CareFirst to develop procedures to protect the confidentiality, integrity, and availability of electronically protected health information. CareFirst has implemented all HIPAA-required security controls, including the ARRA-added requirements that became final with the publication of the HIPAA final rule, and has remained in compliance with these regulation since their original effective date.

CareFirst has implemented policies and procedures to protect the confidentiality of member information.

General Policy

- All records and other member communications that have confidential medical and insurance information must be handled and discarded in a way that ensures the privacy and security of the records.
- All medical information that identifies a member is confidential and protected by law from unauthorized disclosure and access.
- The release or re-release of confidential information to unauthorized persons is strictly prohibited.
- CareFirst limits access to a member's personal information to persons who need to know, such as our claims and medical management staff.
- The disposal of member information must be done in a way that protects the information from unauthorized disclosure.
- CareFirst releases minimum necessary protected health information in accordance with the Privacy Rule as outlined in HIPAA and our notice of privacy practices (NPP).

Member Access to Medical Records

It is the responsibility of the provider to give member access to their personal medical record. The member must follow the provider's procedures for accessing medical information from the provider, so long as such procedures are compliant with applicable law. Members may access their medical records by contacting the Primary Care Provider's (PCPs) office or the provider of care (such as a hospital). If the member contacts CareFirst for a copy of their personal medical record, we will refer the member back to the provider.

Provider Service HIPAA Validation

When calling into Provider Service, all providers will need to validate patient information. Please provide your name and then verify the following:

- Provider's name and Tax ID or NPI
- Patient/member name
- Member identification number
- Patient/member's birth date

Treatment Setting

Practitioners and providers are expected to implement confidentiality policies that address the disclosure of medical information, patient access to medical information and the storage/protection of medical information.

Information Security Policy

CareFirst requires all providers to implement safeguards to protect the confidentiality, integrity and availability of CareFirst information and information assets, where applicable. These safeguards, as defined by the HIPAA Security Rule, require the establishment of policies, procedures and processes in order to comply with HIPAA standards.

CareFirst's confidential and protected health information (PHI), throughout its lifecycle, will be protected in a manner consistent with its sensitivity and criticality to CareFirst. This protection includes an appropriate level of physical and electronic security for the networks, facilities, equipment and software used to process, store, access and/or transmit information. Information used in conducting CareFirst business must have adequate controls to protect the information from accidental or deliberate unauthorized disclosure, damage, misuse or loss. Only those with a "need to know" may view PHI. PHI must be carefully handled and appropriately secured at all times.

Quality Improvement Measurement

Data for quality improvement measures is collected from administrative sources, such as claims and pharmacy data, and/or from member medical records.

CareFirst protects member information by requiring that medical records are reviewed in non-public areas and do not include member-identifiable information.

Notice of Privacy Practices

CareFirst is committed to keeping the confidential information of members private. Under HIPAA, we are required to send our NPPs to fully insured members. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information. Providers must develop and provide their own NPPs to members.

Administrative Services Policy

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against members for covered services. This includes administrative services which are **inherent** in the delivery of covered services. Examples of such charges for administrative services include annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses and malpractice coverage increases. Additional examples of such services may also include but not be limited to:

- Writing new/refill prescriptions with or without an office visit
- Telephone consultations
- Copying and faxing
- Completing referral forms or providing pertinent paperwork related to referrals to other physicians
- Completion of physical forms, medication forms, preop forms and/or CareFirst requested forms
- Other expenses related to the overall management of patients and compliance with government laws and regulations required of healthcare providers

The provider may seek reimbursement from the member for providing specific healthcare services that are not covered under the member's health plan as well as fees for some administrative tasks and services which are **not inherent** in the delivery of covered services. Examples of such fees may include but not be limited to:

- Fees for completion of certain forms including school, work, camp and jury duty
- Disability forms not connected with the providing of covered services
- Missed appointment fees
- Charges for copies of medical records when the records are being processed for the member directly

Fees or charges for administrative tasks and services, such as those listed above may not be assessed against all members in the form of a blanket annual administrative fee, but rather to only those members who utilize the administrative service.

Treatment of Family Members or Self

Treatment of family members or self is not a covered benefit. Providers should not bill CareFirst for services rendered to family members or themselves. Further, providers should review the American Medical Association Code of Ethics which indicates that physicians "generally, should not treat themselves or members of their immediate families." Family members include spouses, parents, children, and siblings of a provider, and may also include other family members, in accordance with the applicable benefit contract.

Member Complaints

The CareFirst Quality of Care (QOC) department investigates member complaints related to quality of care and service of providers in our network, and takes action, when appropriate. This department also evaluates complaints annually to identify and address opportunities for improvement across all networks. Providers play an important role in resolving member complaints and help improve member satisfaction.

Should CareFirst receive a complaint from a member, the QOC department will contact the provider in question for additional information, as needed. At the conclusion of our investigation, the QOC will advise the provider and member of the findings and resolution. We are committed to resolving member complaints within 60 days, and timely responses help us meet that goal.

Providers may also register a complaint on behalf of a member regarding the quality of care or service provided to the member by another provider. You may submit the complaint in one of three ways:

- Send an e-mail to quality.care.complaints@carefirst.com
- Fax a written complaint to 301-470-5866
- Mail a written complaint to:
  CareFirst BlueCross BlueShield and
  CareFirst BlueChoice, Inc.
  Quality of Care Department
  P.O. Box 17636
  Baltimore, MD 21298-9375

Please include the following information when submitting a complaint:

- Your telephone number and name
- Your provider number
- The member's name and ID number
- Date(s) of service
- As much detail about the event as possible

Requests for Charts

Affordable Care Act Risk Adjustment

Risk Adjustment (RA) is a program within the commercial insurance market implemented under the Affordable Care Act (ACA).

Background

The RA Program relies on complete and accurate annual documentation and coding of all conditions to determine members' health status in order to assign a health plan risk score. Medical record documentation plays a critical role in determining member health status.

The purpose is twofold: to help stabilize premiums by mitigating the impact of adverse selection in the ACA marketplace and to ensure that CareFirst accurately and completely collects and submits medical diagnosis information to the U.S. Department of HHS.

Outreach to encourage patient visits or request medical records may occur at various times during the benefit year if gaps in care or coding are suspected. Gaps in care can occur for several reasons. A few common reasons are described below:

- Members with chronic conditions who do not visit the doctor during a benefit year.
- Medical diagnoses documented in the medical record were not submitted on the claim.
- The medical record does not reflect the patient's medical condition.

Clinical outreach

Patients with chronic conditions that may not have been evaluated or received recommended care during the benefit year may be identified. A patient list will be provided.

If you receive this list, we are asking that you review your patient list and encourage these patients to schedule a visit. During their visit, you should document all existing conditions in the medical record and confirm that all applicable diagnoses are included on the submitted claim.

Both you and your patients will benefit from this additional outreach and follow up care. Full documentation of a patient's conditions will lead to more timely and accurate payments for your practice. Patients will benefit from the additional evaluation, management and/or treatment of their conditions.

Medical record retrieval

Immediately following the close of the benefit year, CareFirst may identify gaps in coding and will request medical records to supplement the claims data to be submitted to CMS for the RA Program.

One or more of your patients' medical records may be identified for further review. If this is the case, CareFirst's contracted third-party retrieval vendor will work with you to retrieve the necessary medical records.

If your patients are identified, staff from the CareFirst designated third-party vendor will contact your office to determine a method of retrieval (e.g., mail, fax, electronic transmission or on-site collection).

Best practices in medical record documentation

The following are best practices you should follow when documenting medical records:

- Diagnoses need to be clearly documented in the medical record.
- Chronic conditions need to be evaluated and reported on a regular basis (at least annually).
- Medical records need to be legible, signed, credentialed and dated by the physician.
- Patient's name and date of service need to appear on all pages of the record.
- Treatment and reason for level of care needs to be documented; chronic conditions that potentially affect treatment choices considered should be documented.
- CareFirst requests that all providers comply with CMS guidelines on implementing ICD-10.

Common errors to watch for when documenting a patient's visit

Make sure to avoid these common errors:

- Incomplete medical record documentation
  - Lack of condition specificity where required
  - Key condition statuses (e.g., transplant, amputation)
- Missing provider signature and/or credentials
  - Missing provider signature on medical records
  - Missing provider credentials on medical records
- Short-hand documentation of medical record
  - Use of symbols or other medical terminology that cannot be translated into diagnosis codes
  - Lack of condition specificity where possible
- Other common errors
  - Name on medical record does not match other documents.
  - Pages from the medical record are missing.

These types of errors may increase the likelihood of a medical record review and other types of follow-up from CareFirst.

HHS Risk Adjustment Data Validation

CMS requires CareFirst to annually validate the accuracy of an ACA member status each benefit year.

Background

The member status is validated specifically for risk adjustment plans in the individual and small group markets through the validation of medical records. This process is known as the HHS Risk Adjustment Data Validation program

The purpose of this audit is to provide CMS with a better understanding of the data that they receive regarding disease prevalence, coding interpretation and variances across the country. This audit is not

specific to you or your practice and is not designed to monitor your practice, or your billing or coding patterns.

Provider outreach

One or more of your patients' medical records may be identified for further review. If this is the case, CareFirst's contracted third-party vendor will work with you to receive the necessary medical records.

If your patients are identified, staff from the CareFirst designated third-party vendor will contact your office to determine a method of retrieval (e.g., mail, fax, electronic transmission or on-site collection).

Evio Patient Outcome Program

Beginning in 2024, CareFirst is implementing a new outcomes-based drug efficacy tracking program, called Gene+ Outcomes. CareFirst has partnered with a clinical data collection vendor, Evio, and will utilize their Engage platform to administer all outcomes-based patient monitoring.

The Evio Engage platform includes a provider portal which enables clinicians to submit attestations (intentions to participate in the program) and clinical claims data needed for patient tracking of health outcomes and drug efficacy.

If your patient is receiving one of the drugs eligible for this program, you may be contacted by Evio to submit clinical data and patient-specific attestations. Here are some highlights of the Evio Engage provider portal:

- Evio will outreach to you when your patients meet the criteria for monitoring.
- Providers will be requested to submit patient-specific attestations, as well as provide clinical data and/or upload medical documentation to support tracking the drug efficacy.
- Evio will use this data to track efficacy of certain drugs.

HEDIS

CareFirst participates in several programs, such as HEDIS, required to evaluate and monitor the health status of identified members using different tools.

"The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public, policy makers and payers have the information they need to compare performance."[2]

HEDIS data is collected mostly via claims (e.g., visit, lab, pharmacy), but also from medical records. In the process of retrieving the medical records, we reach out to providers each year to collect their preferred methods of medical record collection.

Results from the HEDIS data collection serve as a measurement of the quality of healthcare received by our members and provide benchmarking that can be compared to other plans. The results are used to identify gaps in care and, opportunities for improvement of care, and to develop necessary provider and member education initiatives and effective preventive care programs.

Medical record retrieval process

CareFirst is contracted with a medical record retrieval (MRR) and review vendor, to help coordinate the medical record retrieval process for the HEDIS and RA Programs for the 2020 reporting year. This medical record retrieval process is time sensitive and lasts only for three months (from the first week of February

2 HEDIS® 2020 Volume 1, The National Committee for Quality Assurance, Washington, DC, 2019

until the first week of May). Requested medical records need to be provided to our vendor within 5 business days of the received request.

You may use any of the data collection methods listed below when submitting your records.

- Vendor remote electronic medical record (EMR) access
  - Your data is sent directly from the provider EMR system to our MRR vendor. After setting up remote access with help from your IT staff, our vendor will access the EMR from another location and extract the information needed.
- Secure Webportal Medical Record Upload
  - For this method, providers upload requested medical records to a secure web portal, and the vendor will collect the information needed.
- Onsite chart collections
  - CareFirst MRR vendor will come onsite to your office and scan the medical records we need into their system while at your office. This option will require our vendor to have access to a computer and some space to work in the office. Your office will be contacted to schedule a time when our vendor representative can come to your office for chart retrieval.
- Fax
  - You can send records directly to our vendor by fax.
- Mail
  - You can mail your records directly to our vendor, who will also provide prepaid postage labels.

Medical record email or fax requests will include a member list from the vendor identifying their assigned measure(s) and the minimum necessary information relevant to the measure(s).

There is no specific cost to you for this process; however, the retrieval process may require time from some of your office staff, and you will be responsible for any associated costs that accompany the copying and/or mailing of medical records.

CareFirst is not responsible for any associated costs related to the medical record retrieval process.

All participating provider offices are contractually obligated to provide copies of member medical records at no charge to CareFirst and/or CareFirst's MRR vendor.

If you are using a third-party chart copying service/vendor, you are still responsible and obligated to obtain the records from the vendor or cause the vendor to send the requested medical records at no charge to CareFirst or CareFirst's MRR vendor. Failure to comply with this request will be considered a breach of contract.

As a CareFirst provider, you have full responsibility for the cost of invoices issued to CareFirst from your copy service or medical records management vendor or partner.

CareFirst will not pay for copies of medical records or postage.

CareFirst is firmly committed to securing and protecting the privacy of our members. Our vendor has signed a Business Associate Agreement with CareFirst to make sure that the privacy of our members is protected and in compliance with all HIPAA regulations and requirements.

Documentation standards

Documentation standards help us quickly collect and review medical records as part of the medical record retrieval process. Please use the Medical Record Documentation Standards on all your medical documentation.

Claim filing tips

All claims should include the appropriate CPTII codes with the date of service. Please include additional claim lines on the standard claim with global codes to reflect the specific care provided on a specific date of service.

The tables below provide CPT II codes and their definitions for several of our billing areas. We recommend billing these CPT II codes, when appropriate, to increase the specificity of your claims so we can collect the information for HEDIS purposes from our claims systems and therefore reduce the number of charts we will request from your office for the HEDIS review.

Maternity Care	
Code Number	**Code Definition**
0500F	Initial prenatal care visit (refer to AMA CPT standard for details)
0501F	Prenatal flow sheet documented in medical record by first prenatal visit. Documentation includes: ■ Date of Service ■ Week of Pregnancy ■ Gestational age ■ Blood Pressure ■ Weight ■ Urine Protein ■ Uterine Size ■ Fetal heart tones ■ Estimated Due Date
0502F	Subsequent Prenatal Visit (refer to AMA CPT standard for details)
0503F	Postpartum Care Visit

PCP, Nephrology, Ophthalmology and Endocrinology	
Code Number	**Code Definition**
3044F	Most recent HbA1c level less than 7%
3045F	Most recent HbA1c level 7-9%
3046F	Most recent HbA1c level greater than 9%
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
3066F	Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, renal insufficiency, any visit to a nephrologist)
3060F	Positive microalbuminuria test result documented and reviewed
3074F	Most recent systolic blood pressure less than 130 mm of Hg
3075F	Most recent systolic blood pressure 130-139 mm of Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm of Hg
3078F	Most recent diastolic blood pressure less than 80mm of Hg
3079F	Most recent diastolic blood pressure 80-89 mm of Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm of Hg

High Blood Pressure	
Code Number	**Code Definition**
3074F	Most recent systolic blood pressure less than 130 mm of Hg

High Blood Pressure	
3075F	Most recent systolic blood pressure 130-139 mm of Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm of Hg
3078F	Most recent diastolic blood pressure less than 80mm of Hg
3079F	Most recent diastolic blood pressure 80-89 mm of Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm of Hg

FIGmd

In 2019, CareFirst launched a clinical data integration initiative with our partner, FIGmd. FIGmd is a cloud-based, interoperable, clinical data and quality management platform. FIGmd's core competency is to securely extract and store medical records.

Why did CareFirst partner with FIGmd?

As the state of healthcare transforms, there has been a shift to electronic medical records. This shift presents an incredible opportunity to improve the quality and efficiency of healthcare delivery. Interoperability among various electronic health record systems available on the market has not yet been achieved. Achieving interoperability would represent a quantum leap in improving healthcare delivery and outcomes.

CareFirst set out to solve this problem by partnering with FIGmd, a company able to extract data from 160 different electronic health record systems (and growing) and conform all structured and unstructured data into a common, curated format. They are also the operators of a collection of medical society registries established to measure clinical quality and performance of providers for multiple specialties.

Advance Directives

Advance directives are a patient's written instructions regarding medical care choices if they become incapacitated and are unable to communicate. PCPs should be informed of their patient's decisions.

PCP offices may be asked to do the following:

- Documenting the existence of an advance directive in a PT medical record;
- Maintaining a copy of the advance directive;
- Encouraging patients to establish an advance directive;
- Providing members who are Maryland residents a copy of the Maryland Attorney General's "A Guide to Maryland Law On Healthcare Decisions (Forms Included)" upon request.

Note: When a patient completes an advance directive, please document it in the patient's medical record.

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Chapter 4: Guidelines by Specialty/Service

Ancillary Providers

Information on the following ancillary providers is contained in this section:

- Air Ambulance
- Ambulatory Surgical Centers (ASC)
- Dialysis Facilities
- Durable Medical Equipment (DME)
- Home Health
- Home Infusion Therapy (HIT)
- Hospice
- Skilled Nursing Facilities

Contract Information

To be in-network for most of the CareFirst BlueCross BlueShield and CareFirst BlueChoice (CareFirst) memberships both locally and nationally, providers should hold two types of provider contracts:

- Regional Participating Preferred Network (RPN)
- BlueChoice Network

Claims and Billing Information

Use the CareFirst self-service tools, CareFirst Direct and CareFirst on Call, to verify a member's eligibility, benefits, authorization requirements and claim status. As a reminder, Third-Party Administrators (TPA) maintain all information on their members' and should be contacted directly for eligibility, benefits, claims status and payments.

All claims should be submitted electronically. If a paper claim needs to be submitted, use the current version of the form for your provider type. All required fields must be completed, or the claim will be rejected or returned:

- Current version of the CMS-1500 form (version 02/12) on original red-ink-on-white-paper. To order a supply of forms, please use your normal process.
- Current version of the UB-04 form. Visit the National Uniform Billing Committee™ website to find details for using and ordering the new form.

Providers are required to submit claims using standard code sets (e.g., CPT, HCPCS, ICD-10, revenue codes, etc.). Please refer to the section below for your specific provider type for more detailed information and to your provider contract when submitting a claim. Where needed, please use modifiers appropriately.

When needed, for more specific information, please refer to the CareFirst Medical Policies online.

Please keep medical records current in the event additional documentation is requested to adjudicate the claim. You will be contacted if this documentation is needed.

Submit claims timely. Timely filing is 365 days from the date of service unless a member's contract or health plan specifies differently.

Air Ambulance

Refer to Payment Policy PP CO 700.01 in our Payment Policy Database for more information.

Ambulatory Surgery Centers

Refer to Payment Policy PP CO 020.01 in our Payment Policy Database for more information.

Prior authorizations and referrals for ASCs

Prior authorization is not required for in-network freestanding ASCs for CareFirst members. Services are still subject to benefit exclusions under the patient's policy.

Prior authorization may be required for:

- BlueCard members
- TPA members
- Self-insured accounts

For these types of plans, check the member's benefits to determine if an authorization is required.

Claims and billing information

All extraordinary supplies, implants and high-cost devices are required to be billed by the ASC, not the Durable Medical Equipment (DME) supplier.

Expense of high-cost devices, extraordinary supplies, implants and prosthetics are inclusive in the facility fee unless otherwise noted in Attachment A-2.

Extraordinary supplies used or implanted should be billed on individual lines with the appropriate HCPCS and/or CPT codes.

Include the invoice for a corneal tissue implant.

Refer to Chapter 3 for reimbursement information.

Refer to Payment Policy PP CO 900.04 for additional information.

Must bill revenue code:
490 for each procedure
270, 274, 276, 278 for supplies

When Medicare is the primary payer, secondary claims must be submitted to CareFirst on a CMS-1500 claim form.

Dialysis Facilities

Refer to Payment Policy PP CO 800.01 in our Payment Policy Database for more information.

No authorization or referral is required if a CareFirst or FEP member uses an in-network dialysis facility.

For those members who are out of state/BlueCard, providers should contact the member's home plan and ask if an authorization is required. Please call 800-676-BLUE.

TPA Members should contact the TPA directly using the phone number on the back of the member's identification card.

Home Infusion Therapy

Claims and billing requirements

Please refer to Attachment A and Schedule A & B for specific code requirements. Please keep the following reminders in mind when submitting your claims:

- CareFirst has one HIT policy and processing guidelines for all lines of business.
- Submit claims electronically using HIPAA 837P.
    - If you do not have electronic capabilities, paper claims must be submitted using the current version of CMS-1500 or they will be rejected.
- Claims must be submitted with the provider's NPI.
- Do not submit attachments with claims.
- Please bill claims by year. The same claim cannot span multiple years.
- Medicare Explanation of Medical Benefits (EOMB) is waived for 99601 and 99602.

Home infusion therapy claims

- Home infusion therapy claims are billed with:
    - Per Diem code (S codes)
    - In-home nursing code (99601 & 99602)
    - Drug codes (J, S, P, Q, and B codes)
    - Modifiers for multiple therapies (SH - second concurrent therapy and SJ – third or more concurrent therapy)

In-home nursing for FEP

- Limit of 2 hours per day, up to 25 visits per calendar year (99601)
- Additional nursing (99602) will not be allowed or reimbursed. Please see the member's benefit booklet for more information.
- Please confirm that copays/coinsurance are applicable.

Drug volume

- CareFirst does not reimburse for the amount of drugs used for priming or residual use.
- Overfill/overflow is not covered.
- Reimbursement is based on the dosage prescribed, not the concentration ordered.

Renal failure/dialysis

- When a patient is receiving dialysis, the HIT provider is unable to bill for infusion of drugs (e.g., EPOGEN®) or other related ancillary services.

Stock supplies

In the event of discontinuation of therapy, cancellation of orders, change in medication, readmission to a facility or in the event of death, CareFirst will reimburse for 72 hours of drugs or Total Parenteral Nutrition stock supply.

- Clear documentation should be kept in the patient's service record.

Utilization of drug code J3490

- This code can be utilized when no other HCPCS are available for a specific drug.
- The corresponding National Drug Code number must be included.

Documentation required in the patient's file

- Signed and dated Plan of Treatment/Certificate of Medical Necessity or physicians' orders must be current
- Nursing assessment
- Nursing notes, documentation on additional nursing services beyond the contract limitations

Note: All treatment plans, certificates of medical necessity or physicians' orders must be updated yearly

Items not covered

- Oral medications
- Subcutaneous injections
  - Please bill through the patient's pharmacy benefit.
- Growth Hormone
- Synagis®
- Hormonal Therapy
- **Note:** CareFirst is aligning with CMS policy regarding code J1642. When heparin is used only for the irrigation of a catheter, the heparin itself is not separately billable. Medications given for a purpose other than the treatment of a particular condition, illness or injury are not covered unless otherwise specified.

Written requests

Written requests for any new or non-listed therapies should be submitted to Pharmacy Management:

Attn: Manager Home Infusion Therapy
CareFirst BlueCross BlueShield
1501 S. Clinton St.
Mail Stop Canton
Baltimore, MD 21224

Hospice

Refer to Payment Policy PP CO 900.02 in our Payment Policy Database for more information.

Authorization process

Prior Authorizations may be required for both inpatient and outpatient services for:

- CareFirst members
- BlueCard members
- TPA members
- Self-insured accounts

Be sure to check the member's benefits to determine if an authorization is required.

For inpatient authorizations contact the appropriate area for assistance:

Authorization Contacts	
Member type	**Phone number**
CareFirst member	Inpatient hospice 866-PRE-AUTH, option 1 (866-773-2884)
FEP member	800-360-7654, Care Management
BlueCard member	Contact home plan 800-676-BLUE (800-676-2583)
Self-Insured member	877-228-7268
TPA member	Contact the member's TPA at the phone number on the back of the member identifications card for instructions or refer to the number on the TPA prefix listing.

Skilled Nursing Facilities

Check a member's benefits to determine if a prior authorization is required. Please contact the appropriate authorization area using the phone numbers below.

Authorization Contacts	
Member type	**Phone number**
CareFirst member—admitted from inpatient setting	866-PRE-AUTH, option 1 (866-773-2884)
CareFirst member—admitted from home or community	1-866-Pre-Auth, Option 1 1-866-773-2884
Case Management	1-800-443-5434, Option 5
FEP member	800-360-7654, Care Management
BlueCard member	Contact home plan 800-676-BLUE (800-676-2583)

Authorization Contacts	
Self-Insured member	877-228-7268
TPA member	Contact the member's TPA at the phone number on the back of the member ID card for instructions or refer to the number on the TPA prefix listing.

When there is a need for a member to be admitted into a Post-Acute Facility (SNF, Acute Rehab, Long-Term Acute Care, Hospice) from an inpatient facility, the facility discharge planner works with the member/member's family and the CareFirst Inpatient Clinical Navigator (ICN) to determine the appropriate level of care for the member. The facility discharge planner must complete and fax the Utilization Management Request for Authorization form to the Post-Acute Care Team at 410-505-2588. CareFirst's ICN's are available to assist with the member's care coordination. The ICN will provide an admission decision within 24 hours of the request for transfer. The authorization is given to the facility within 24 hours of verification of the admission.

When there is a need for a member that is out of CareFirst's service area (outside of Maryland, D.C., or Northern Virginia) to transfer into a Post-Acute Facility, the facility must complete and fax the Utilization Management Request for Authorization form to Post-Acute Care Team at 410-505-2588.

CareFirst will verify the member's benefits, and the ICN will provide an admission decision and authorization within 24 hours of the request for transfer. The ICN assigned to the Post-Acute Facility will also be responsible for continued stay review and decision.

Refer to Payment Policy PP CO 900.03 in our Payment Policy Database for more information.

Professional Services, Tips and Reminders

Primary Care

The Patient-Centered Medical Home (PCMH) Program is designed to provide primary care providers (PCPs) with a more complete view of their patients' needs. PCMH guides members to establish a relationship with their PCP to receive consistent quality care. Using PCPs as a first contact or "home base" for most medical and behavioral needs ensures members get the care they need, when they need it, leading to improved health, increased communication and better outcomes.

To aid in this communication and relationship, providers are given exclusive access to resources like electronic medical records and a large network of specialized clinicians. Behavioral health clinicians and Registered Nurses help providers better coordinate their member's overall health and assist in navigating the complex healthcare landscape.

The PCMH Program requires greater provider engagement and CareFirst meaningfully compensates providers for that engagement. PCMH is structured around PCPs organized into teams called Panels—groups of five to 15 physicians—for purposes of coordinating the care of CareFirst members to improve healthcare outcomes and reduce the global cost of care. As care-giving teams, Panels have the opportunity to earn robust financial incentives—a 12% participation fee increase and a reimbursement for Care Coordination. In addition, Panels can earn Outcome Incentive Awards that are paid as increases to their fee schedules based on both the level of quality and degree of savings they achieve against projected costs each year.

For more information on how to join and be successful in the PCMH Program, view our Adult and Pediatric program description and guidelines or visit carefirst.com/pcmhinfo.

Helpful Information for Specialists

Specialty type	Medical society resources	Key medical policies	Healthcare Effectiveness Data and Information Set (HEDIS)® focus
Gastroenterology	American College of Gastroenterology Society of American Gastrointestinal and Endoscopy American Gastroenterological Association	Screening for colorectal cancer – 2.03.011A Surgery – 7.01 Obesity – 7.01.036 Transplants 7.03	■ Colorectal cancer screening ■ Optimal diabetes care ■ Hypertension ■ All cause readmission ■ Emergency department utilization
General Surgery	American College of Surgeons	Surgery – 7.01 Surgical Assistants – 10.01.008A	■ Smoking Cessation ■ Optimal Diabetes Care ■ Hypertension ■ All cause readmission ■ Emergency department utilization
Obstetrics/Gynecology	American Gynecological & Obstetrical Society American College of Obstetricians and Gynecologists	Global Maternity Care – 4.01.006A Preventive services – 10.01.003A Global surgical care rules – 10.01.009A	■ Breast cancer screening ■ Cervix cancer screening ■ Early elective delivers ■ Prenatal and postpartum

Specialty type	Medical society resources	Key medical policies	Healthcare Effectiveness Data and Information Set (HEDIS)® focus
		Multifetal pregnancy reduction – 4.02.003A Preimplantation genetic testing – 4.02.007 Lactation consultations – 4.01.010	■ Optimal diabetes care ■ Hypertension ■ All cause readmission
Orthopedic Surgeons	Academy of Orthopedic Surgeons American Orthopedic Society for Sports Medicine	Durable medical equipment – 1.0 Medical Equipment – 1.01 Medical supplies – 1.02 Orthotic devices and orthopedic appliances – 1.03 Prosthetics – 1.04 Surgery – 7.01 Rehabilitation therapy – 8.00 Physical/occupational /speech therapy – 8.01	■ Use of imaging for lower back pain ■ Optimal diabetes care ■ Hypertension ■ All cause readmission ■ Emergency department utilization

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Chapter 5: Claims, Billing and Payments

Introduction to Claims Submission

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) supports electronic claims submission and automatic posting of remittance advice and electronic funds transfer. We strongly encourage providers to complete the "electronic round trip." Electronic transactions help facilitate streamlined claims submission, reconciliation and direct deposit of funds to your bank accounts. This section of the manual explains our claims submission requirements, how to follow up on claims and how to appeal claims when necessary.

Provider Self Service

CareFirst encourages the use of self-service channels for routine matters, such as eligibility, benefit or claims information. This helps free up resources to telephonically address matters requiring special handling.

Today, most of all telephone inquiries to customer service are for routine matters. We are moving our support for these simple, direct and factual queries to electronic channels and discouraging calls for these purposes.

When calling our service lines, you will be directed to a self-service channel to more quickly address your inquiry. Queries about the most common causes of calls will be answered in seconds through self-service technology. If you use one of our call centers for these simple inquiries, expect a longer wait than you have in the past, since we are redirecting our service staff toward more complex issues and away from simpler inquiries.

CareFirst Direct

CareFirst Direct is a convenient tool available at carefirst.com/providers that gives you fast access to the information you need. With CareFirst Direct, you can:

- Make inquiries on your own time
- Avoid time consuming phone calls
- Verify eligibility and benefits
- Check claim status

It is important to designate one person to manage all users for the entire practice. This person is responsible for maintaining access for all others in the office. They must also remember to revoke access to users who no longer have access. This person is also responsible for granting access to your billing service or agent.

You can set up a CareFirst Direct account for each tax identification number (TIN) used in your practice. When obtaining eligibility and benefits or claim status information, have the patient's date of birth and member ID number available. For claim inquiries, log in using the same TIN the claim was submitted under. You can find user guides for CareFirst Direct by going to carefirst.com/learning and selecting CareFirst Direct under Courses by Topic section.

For access to on-demand training and interactive guides, visit carefirst.com/learning.

CareFirst on Call

CareFirst on Call is an Interactive Voice Response (IVR) system that allows providers to retrieve CareFirst member eligibility, benefits, deductibles, maximums, claim status and authorization status. Callers may use the telephone keypad input to interact with CareFirst on Call. The system has the capability to provide this information via fax for those who prefer printed documentation.

The system is available 24 hours a day, seven days a week (with periodic outages for system maintenance). CareFirst maintains a record of each IVR interaction to enable the retrieval of historic inquiries in case of questions regarding information received.

You can find more information about CareFirst on Call by going to carefirst.com/provider and selecting Manuals & Guides under the Resources tab.

Basic Claim Submission Requirements

Reporting Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes

CareFirst does not usually receive claims with procedure codes specific to Medicare and Medicaid, or temporary national codes (non-Medicare). Therefore, unless otherwise directed through BlueLink or other communication means, providers should report services for our members using the standard CPT codes instead of comparable Level II HCPCS codes. This includes but is not limited to Medicare temporary G-codes and Q-codes; Hand T-codes which are specific to Medicaid; and non-Medicare S-codes.

This policy does not apply to:

- Crossover claims which are reimbursed by CareFirst as secondary to Medicare
- Claims for durable medical equipment (DME) supplies, orthotics/prosthetics or drugs for which there is no comparable CPT code
- Select services as outlined in the federal employee health benefit plan (FEHBP) manual

Reporting ICD-10 Diagnosis codes

When submitting claims, follow coding guidelines outlined in the most current ICD-10 coding book for reporting diagnosis codes. Guidelines of importance include:

- Code to the highest level of specificity, as appropriate.
- List the primary or most important diagnoses for the service or procedure first.
- Code chronic complaints only if the patient has received treatment for the condition.
- When referring patients for laboratory or radiology services, code as specifically as possible and list the diagnosis that reflects the reason for requesting these services.

Claims that are not coded properly may be returned to the reporting provider, which will delay adjudication.

CPT Category II Codes

Purpose

CPT Category II codes are supplemental tracking codes used to measure performance. The purpose of CPT II codes is to share valuable information about the care of your patient that is not obtainable through

CPT codes. They help us fill gaps in care information by documenting clinical outcomes. Submission of these codes decreases the need for medical record requests and chart reviews. Additionally, they assist the provider in minimizing the administrative burden for a number of quality-based initiatives such as the Healthcare Effectiveness Data and Information Set (HEDIS).

CPT Category II codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures (HEDIS) and that have an evidence base as contributing to quality patient care.

Why use CPT Category II codes?

CPT Category II codes can relay important information related to health outcome measures such as:

- BMI
- Cholesterol management
- Controlling blood pressure
- Comprehensive diabetes care
- Tobacco cessation
- Clinical depression

CPT Category II codes also assist us with the development of a provider's profile score.

For PCMH providers, CareFirst aligned the Quality Measures with those promoted by the Center for Medicare and Medicaid Services (CMS) and the health insurance industry as the core measures. As part of the Core 10 Measures, PCMH providers should submit CPT Category II codes related to the measures as outlined in the Adult and Pediatric Program Description and Guidelines.

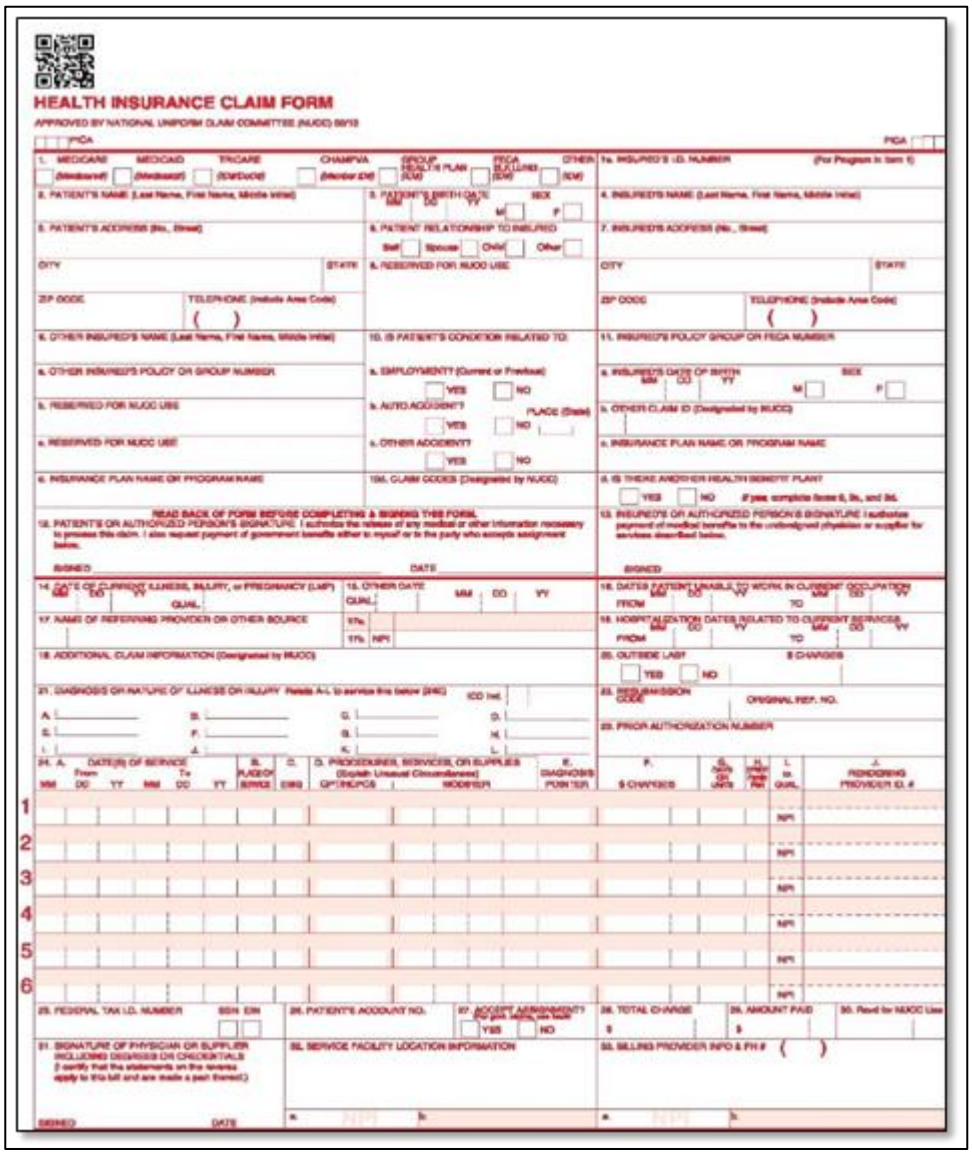
Where to locate CPT Category II codes

CPT Category II codes are released annually as part of the full CPT code set and are updated semi-annually in January and July by the American Medical Association (AMA). CPT Category II codes are arranged according to the following categories and are comprised of four digits followed by the letter "F."

CPT Category II Codes	
Composite Measures: 0001F-0015F	Therapeutic, Preventive or Other Interventions: 4000F-4306F
Patient Management: 0500F-0575F	Follow-Up or Other Outcomes: 5005F-5100F
Patient History: 1000F-1220F	Patient Safety: 6005F-6045F
Physical Examination: 2000F-2050F	Structural Measures: 7010F-7025F
Diagnostic/Screening Processes/Results: 3006F-3573F	

How to enter CPT Category II codes on the CMS-1500 Claim Form

For claims submitted on the CMS-1500 Form, procedure codes are reported in field 24D. Whether submitting electronic or paper claims, complete all necessary data elements (or fields) on the billing line item.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

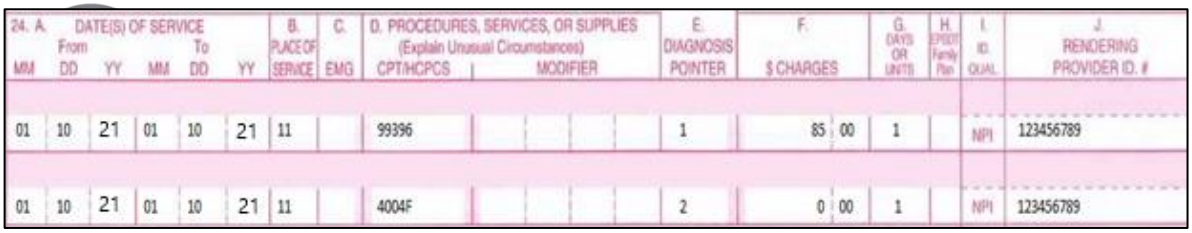
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

How to enter CPT Category II codes on the CMS-1500 Claim Form Field 24D

CPT Category II codes are billed in the procedure code field, just as CPT Category I codes are billed. CPT Category II codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative value. Therefore, CPT Category II codes are billed with a $0.00 billable charge amount.



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	10	21	01	10	21	11		99396		1	85 00	1		NPI	123456789
01	10	21	01	10	21	11		4004F		2	0 00	1		NPI	123456789

Guidelines for Ancillary Claims Filing

For a full list of claims filing guidelines for Laboratory, Durable Medical Equipment (DME) and Specialty Pharmacy, visit carefirst.com/ancillaryclaims.

Please refer to the Payment Policy database for additional information found under PP CO 100.01 DME Eligible Codes, PP CO 100.02 DME Percent of Change (POC) and PP CO 100.03 DME Owned in History/Rent to Own.

Special Claims Submission Information for Facility Billing

Observation Services Guidelines

Observation services defined

Observation services are necessary to evaluate a patient's condition or to determine the need for admission as an inpatient. These services are provided on a hospital's premises and include bed use and periodic monitoring by hospital nurses or other staff. These services are covered only when provided under the order of a provider or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

Observation guidelines

In Maryland, observation services should be billed based on one unit of service per each clock hour (with partial hours rounded up or down to the nearest full hour) in accordance with Health Services Cost Review Commission guidelines. D.C. and Virginia Diagnosis Related Grouper (DRG) hospitals are typically paid an hourly rate or a daily rate (for each date of observation service) for medically necessary observation care, unless these services are considered to be packaged into a payment under another payment methodology (i.e., inpatient DRGs, outpatient Ambulatory Surgery Center (ASC) Groups or Emergency Room (ER) case rates), in accordance with the terms and conditions of the hospital's contract.

Professional provider services should be billed separately and will be paid in addition to the payment for the hospital's facility services. All observation services require a facility authorization for CareFirst BlueChoice members; no other CareFirst insurance plans require an authorization for observation services.

Mother and Baby Claims Billing

CareFirst requires the submission of the mother's delivery and the baby's routine newborn charges as a single request for payment. The routine newborn charges will be processed under the mother's name. Should the baby require special care, a separate request for payment will be required for these charges and will be processed under the baby's name. A separate authorization for the baby's stay will be required if the baby stays longer than the mother. Include an itemization to differentiate routine versus non-routine charges. For an itemized chart of routine versus non-routine charges, see Mother and Baby Claims-Billing Guide.

Mother and Baby Diagnosis Related Grouper Payment

Routine delivery payment:

- Calculated using standard DRG payment methodology (i.e., DRG weight x base rate for type of coverage).
- The baby's payment for routine delivery is a per diem payment based on DRG 795 (NORMAL NEWBORN). Follow the formula listed in your facility's Data Sheet for a per diem substituting the number of nursery days paid on the claim for revenue code 170-179 for APPROVED DAYS in the calculation. Add the mother's DRG payment to the total of the per diem payment for the child to determine the total payment dur for the delivery.
- For the hospital to receive a separate payment for the baby based on a sick DRG:
  - The baby must have a separate, approved authorization.
  - The hospital must file a separate claim for the baby.
  - The primary diagnosis for the claim for a sick baby cannot be ICD-10 codes Z38.00-Z38.8 (live born infant must be the sick diagnosis resulting in the extended stay).

Medicare Supplemental Products Billing

CareFirst offers a variety of Medicare supplemental policies to complement Medicare benefits through group contracts as well as directly to individual subscribers.

- **The Tax Equity and Fiscal Responsibility Act (TEFRA)**: TEFRA is legislation enacted by the federal government that states an active employee age 65 and over, or the spouse age 65 and over of an active employee, may enroll in the same group coverage offered to younger employees and their spouses (the Deficit Reduction Act is an amendment to TEFRA which stipulates that spouses fall under TEFRA). For members who have elected group coverage pursuant to TEFRA, CareFirst is the primary carrier and Medicare is the secondary carrier. After CareFirst has processed the claim, you must forward the claim to Medicare.
- **Requirements for itemization (CareFirst BlueChoice only):** CareFirst BlueChoice requires itemization when billing the following to determine if services are covered under the member's plan:
  - Supplies (Revenue Code 270)
  - Implants (Revenue Code 278)
  - Pharmacy charges if related to blood services (Revenue Code 250)
  - DME
  - Blood processing and storage charges (Revenue Code 390 and 391)

- ☐ Private room charges
- ☐ Educational training
- ☐ Non-covered inpatient days

Note: This itemization is not required if the charges are paid at a DRG or per diem rate inclusive of all services provided.

Federal Employee Program coordination of benefits

In order to comply with FEP requirements, ask your FEP patients to go to the FEP member portal to complete the Coordination of Benefits Form and follow instructions for submission.

Denial Notices Issued by Hospital

When CareFirst denies the certification of an admission or continued stay certification and the facility or provider disagrees, the facility or provider may appeal the adverse decision.

Non-DRG reimbursement cases (MD only)

A facility may only issue a denial notification to a CareFirst member if:

- The facility, the attending provider and CareFirst agree and document that it is not medically necessary for the member to remain in the facility.
- An appropriate discharge plan has been developed.
- The member or family member refuses discharge. However, the hospital is strongly encouraged to discuss the case with the attending provider and the member and/or a family member, to ensure that the patient and/or family member understands their financial responsibility before the written denial is issued. It is recommended that the hospital have the member sign a document indicating their understanding that they remainder of the stay could be member liability.

Timely Filing of Claims

Note: To be considered for payment, claims must be submitted within 365 days from the date of service.

Institutional claims must be submitted within 365 days after:

- The services are rendered for ER, observation or other outpatient care and services
- The date of discharge for inpatient care

A member cannot be billed by a provider for failure to submit a claim to CareFirst within the guidelines listed above.

Reconsideration

Claims submitted beyond the timely filing limits are generally rejected for not meeting these guidelines. If your claim is rejected but you have proof that the claim was submitted to CareFirst within the guidelines, you may request processing reconsideration.

Timely filing reconsideration requests must be received within six months of the provider receiving the original rejection notification Notice of Payment (NOP) or Electronic Remittance Advice (ERA). Requests received after six months will not be accepted and the charges may not be billed to the member.

Documentation is necessary to prove the claim was submitted within the timely filing guidelines.

- **For electronic claims**: A confirmation is needed from the vendor/clearinghouse that CareFirst successfully accepted the claim. Error records are not acceptable documentation.
- **For paper claims**: A screenshot from the provider's software indicating the original bill creation date along with a duplicate of the clean claim or a duplicate of the originally submitted clean claim with the signature date in field 12, indicating the original bill creation date.

Electronic Capabilities

CareFirst encourages all providers to take advantage of the benefits of utilizing electronic capabilities to improve claims submission, expedite adjudication, receive remittance advices and payments faster and more. CareFirst offers the following Electronic Data Interchange (EDI) Services through our trading partners:

- 837P - Professional Claims
- 837I - Institutional Claims
- 835 - Electronic Remittance Advice
- 277CA - Payer Acceptance Report
- 270 - Eligibility Inquiry
- 276 - Claim Status

For more details, contact your trading partner or one of CareFirst's preferred trading partners for information on the electronic capabilities listed below.

Electronic Claims (837P and 837I)

Electronic submission will help your practice save time, money and eliminate incomplete submissions, resulting in faster claims adjudication.

We urge you to submit claims electronically whenever possible, including for the following types of claims:

- Initial
- Corrected
- Late Charge (Institutional only)
- Interim (Institutional only)
- Medicare Secondary claims that do not automatically crossover from CMS
- Coordination of Benefits claims where a commercial payer is paid as primary and CareFirst is secondary

Your billing and rendering National Provider Identifier (NPI) are required on all claim submissions.

Electronic Remittance Advice (ERA – 835)

Payment vouchers can be delivered by your trading partner through an ERA - 835. The ERA - 835 includes the payment details, Health Insurance Portability and Accountability Act (HIPAA) adjustment reason codes and HIPAA remark codes necessary for you to reconcile your patient accounts. Receiving payment information electronically allows you to realize claim resolution faster and save money.

For more information and to set-up ERA, please contact your trading partner.

Electronic Fund Transfer

If you are receiving an ERA - 835, you can also take advantage of Electronic Fund Transfer (EFT). By enrolling to receive payments through EFT, you reduce paperwork and get paid faster with secure direct deposits from CareFirst. These are the preferred trading partners who offer EFT services.

Payer Acceptance Report (277CA)

The Payer Acceptance Report (277CA) is returned by CareFirst the same day claims are received from the trading partner. This report will confirm which claims were accepted for adjudication and which claims were rejected. Claims that have been rejected with errors should be corrected and resubmitted. This report can be used with the CareFirst document control number as documentation for timely filing, if needed.

Eligibility Inquiry (270)

The Eligibility Inquiry (270) can be used to obtain eligibility and benefits information for patients. The provider billing NPI should be used when submitting these inquiries. Contact your trading partner for more information on setting up this capability.

Claim Status (276)

The Claim Status (276) can be used to request claim status information through your trading partner. Please wait at least 48 hours after submitting a claim to request the status.

Questions?

For more information on all of the electronic capabilities, claims submission, companion guides, frequently asked questions and more, visit carefirst.com/electronicclaims.

Paper Claims Submission Process

Paper claims should be submitted as an exception. CareFirst encourages all providers to take advantage of the benefits of utilizing electronic claim submission. When paper claims are received, they are scanned, and a digitized version of the claim is produced and stored electronically. Successful imaging of the claim depends on print darkness. To help ensure your claim is accurately processed, please make sure the print is dark and legible.

Incomplete claims create unnecessary processing and payment delays. The fields listed below must be completed on all UB-04 and CMS-1500 claims submitted to CareFirst. Claims missing information in any of the fields below will be returned.

Claim Fields		
Field name	**CMS-1500 box**	**UB-04 locator**
Insured ID Number	1a	FL60
Patient Name	2	FL08b
Patient Date of Birth	3	FL10

Claim Fields		
ICD-10 Diagnosis	21	FL67
Dates of Service	24a	FL06
Place of Service, Facility Code	24b	FL04
Procedure Code/Revenue Code	24d	FL42
Charge	24f	FL47
Days of Units	24g	FL46
Rendering National Provider Identifier	24j	N/A
Federal Tax ID	25	FL05
Signature of provider	31	N/A
Billing NPI	33a	FL56

Note: The three-digit prefix must be included if present on the member's ID card. FEP member numbers do not have a three-digit prefix but begin with an R and have eight numeric digits.

Claims must be submitted on an original UB-04 claim form for institutional providers and a CMS-1500 form (version 02/12) for professional/ancillary providers. All information must fit properly in the blocks provided.

Medicare Crossover Claims Submission

Check CareFirst Direct or CareFirst on Call to verify if the claim has been received by CareFirst. You may check any time after the receipt of a Medicare Remittance Notice. You do not need to wait 30 days from Medicare's processing date to check CareFirst Direct or CareFirst on Call. However, the following rules govern the submission of Medicare secondary claims:

- Wait 30 days from the Medicare Explanation of Benefits (EOB) date before submitting your secondary claim.
- If you are submitting a secondary claim electronically, you must include the Medicare EOB or remittance advice date.
- Out-of-area member claims for covered services will be rejected by the member's home plan. When you receive a rejection notification, you must resubmit these claims to CareFirst for processing through BlueCard.

- Medicare claims billed using a ”GY” modifier can be submitted directly to CareFirst without prior submission to Medicare. These claims are not impacted by the 30-day requirement and do not require the inclusion of a Medicare EOB.

For these requirements and directions on how to submit Medicare Secondary claims, visit carefirst.com/electronicclaims > Medicare secondary page.

How to Submit Claims with Denied Charges

Complete the following field locators when submitting electronic or paper claims for admissions with denied days. If you submit claims electronically, contact your vendor to determine the correct format for this data.

- **Statement Covers Period Covered Days** (UB-04 Paper Form Locator 39, 40 or 41 and value code 80) days of care authorized for coverage. Do not include non-covered days.
- **Non-Covered Days** (UB-04 Paper Form Locator 39, 40 or 41 and value code 81) days of care denied for coverage.
- **Total Charges** (UB-04 Paper Form Locator 47) Total charges pertaining to the related revenue code for the current billing periods as entered in the Statement Covers Period.
- **Non-Covered Charges** (UB-04 Paper Form Locator 48) To reflect non-covered charges for the primary payer pertaining to the related revenue code.

Any claims with denied days that are not submitted in this format will be rejected and the claim should be resubmitted.

Note: This does not apply to FEP. Please do not use this process when submitting denied claims for FEP members. Please refer to Chapter 2 of this manual for guidelines on FEP inpatient admissions. Follow the appeals process outlined later in this Chapter if necessary.

Notice of Payment

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. A NOP or ERA is available for each voucher and enables providers to identify members and the claims processed for services rendered to those members. A check may not be issued if there is no payment.

Claims Overpayments

If an overpayment from CareFirst is discovered, the provider should not return the check. This causes a delay in the payment and the initial check must be voided. In such a situation, the provider should complete the provider refund submission form. The claims will be processed, and a new check will be issued.

Collection of Retroactively Denied Claims

A provider reimbursement may be offset against a retroactively denied claim by an affiliated company of CareFirst. The processing of claim adjustments for overpaid claims do not require a signed agreement from the medical provider.

Effective Follow-Up on Claims

To follow-up on claims submitted more than 30 days ago, you can check CareFirst Direct or CareFirst on Call to determine the claim status.

Do **not** resubmit claims without checking CareFirst Direct or CareFirst on Call first. Submitting a duplicate claim already in process will generate a rejection and cause a backlog of unnecessary claims to be processed.

Step-by-Step Instructions for Effective Follow-Up

Claim status

The most effective way to accomplish follow-up on submitted claims is to access CareFirst Direct or CareFirst on Call. If there is no record of the claim, the claim must be resubmitted.

If the claim has been pending in the system for less than 30 days, wait until 30 days have elapsed from the processing date given on CareFirst Direct or CareFirst on Call. If processing has not been completed after 30 days, the preferred method for submitting an inquiry is electronically through CareFirst Direct's inquiry analysis and control system (IASH) function.

When you cannot use CareFirst Direct's IASH function, please use the provider inquiry resolution form (PIRF) to submit your Inquiry.

Large volume of unpaid claims

- Please be sure that all NOPs or ERAs have been posted.
- Use CareFirst Direct or CareFirst on Call to verify receipt and status of claims.
- If you still have questions, please contact the appropriate customer service unit for assistance.

Corrected Claims, Inquiries and Appeals

What is a Corrected Claim?

A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). A corrected claim is not an inquiry or appeal.

How do I Submit a Corrected Claim?

Corrected claims should be submitted electronically to save time, money and help expedite claims processing—here's how:

- Professional providers should submit corrected claims in the HIPAA transaction 837P.
- Institutional providers should submit corrected claims in the HIPAA transaction 837I.

Professional and Institutional Provider claims should include:

- A value of "7" in Loop 2300, Segment CLM05-3.
- The original claim number in Loop 2300, Ref*F8.

We urge you to submit all claims electronically. However, if you do not have electronic claim submission capabilities, you can submit them on paper. Do not submit a PIRF with a corrected claim.

If submitting a paper CMS-1500 or UB-04, "Corrected Claim" must be written at the top of the claim form. For a claim submitted on paper UB-04, include a "Type of Bill" code ending with "7" (i.e.,: XX7) in Field Locator 4.

Paper claims should be mailed to the appropriate claim address for the member. This address is located on the back of the membership ID card. Do not mail these claims to the correspondence address. For more detailed information on how to submit "correct" claims, refer to carefirst.com/providers > Resources tab > Corrected Claims.

For electronic and paper claims submission, please allow 30 days for reprocessing prior to checking your claim status on CareFirst Direct or the CareFirst On Call.

What is an Inquiry?

An inquiry is an informal request to review or explain why a claim was processed or paid a certain way. It could pertain to authorizations, correct frequency, ICD-10, medical records, procedure/code and referrals. Before sending an inquiry, consider submitting a corrected claim.

The preferred method for submitting an inquiry is electronically through CareFirst Direct using the IASH function. When you cannot use CareFirst Direct, please use the PIRF to submit an inquiry.

For questions about claims that are denied because of enrollment, copay/deductible, lack of prior authorization and claims payment, contact Provider Services at 800-842-5975 or 202-479-6560.

An inquiry must be submitted to the appropriate addresses below within 180 days or six months from the date of the EOB. Please allow 30 days for a response.

Correspondence address:

For MD, National Capital Area, BlueChoice, local BlueCard and NASCO:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512

For FEP providers in Montgomery & Prince George's counties, D.C. and Northern Virginia:

Mail Administrator
P.O. Box 14112
Lexington, KY 40512

For all other MD FEP inquiries:

Mail Administrator
P.O. Box 14111
Lexington, KY 40512

Helpful tips when completing a PIRF

- Use a separate form for each patient.
- Include the entire subscriber identification number, including the prefix.
- Attach a copy of the claim with any additional information that might assist in the review process.
- The form can be downloaded at carefirst.com/providerforms.

What is an Appeal?

Providers may appeal an adverse benefit determination based on medical necessity, appropriateness, healthcare setting, level of care or a decision to deny experimental/investigational or cosmetic procedures. Appeals must be submitted in a letter on the provider's office letterhead within 180 days or six months from the date of the EOB or adverse decision notice. The appeal letter must describe the reason(s) for the appeal and the clinical justification/rationale for the request. Do not use a PIRF for an appeal.

Please include the following information on the letter:

- Patient's first and last name
- Identification number
- Claim number
- Admission and discharge dates (if applicable) or date(s) of service
- A copy of the original claim or EOB denial information and/or denial letter/notice
- Supporting clinical notes or medical records including lab reports, X-rays, treatment plans, progress notes, etc.

Professional Providers	Institutional Providers
Mail Administrator P.O. Box 14114 Lexington, KY 40512-4114	Clinical Appeals and Analysis Unit (CAU) Mail Administrator CareFirst BlueCross BlueShield P.O. Box 17636 Baltimore, MD 21298-9375

All appeal decisions are answered in writing. Please allow 30 days for a response to an appeal.

Expedited or emergency appeals process

An expedited request for medical care or services can be filed if the standard appeal process for routine or non-threatening care determinations could seriously jeopardize the life, health or safety of the members or others. This can be determined by:

- The member's psychological state; or
- If a practitioner with knowledge of the member's medical or behavioral condition believes the normal appeals process would subject the member to adverse health consequences without the care or treatment.

Note:

- Retrospective or post service denials are not eligible for expedited review.
- We will answer an expedited review or emergency appeal within 24 hours from the date the appeal is received.
- Expedited appeals can be faxed to 410-528-7053 and will be responded to within 24 hours.

Appeal resolution

Once the internal appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the appeal decision.
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based.
- A statement regarding the availability of all documents, records or other information relevant to the appeal decision is available free of charge, including copies of the benefit provision, guideline, protocol or other documents on which the decision was based.

- Notification that the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning will be provided free of charge upon request.
- Contact information regarding a state consumer assistance program.
- Information regarding the next level of appeal as appropriate.

Visit carefirst.com/inquiriesandappeals for more information.

Clinical Appeals and Analysis Unit

Peer-to-peer conversation

The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss a pre-service adverse benefit determination denial with a CareFirst Medical Director. This process is available only when a pre-authorization request has been denied because the service has been determined to not be medically necessary. The ordering or treating provider can initiate the peer-to-peer discussion by calling the Care Management Department at 410-528-7041. If the request is made after five days of the adverse benefit determination denial, the provider should file an appeal.

Overview

CareFirst provides and appeal process as a mechanism for providers to dispute an adverse benefit determination. An appeal is a formal written request to CareFirst for reconsideration of a medical or contractual adverse benefit determination. The CAU is responsible for review, preparation, reconciliation, communication, reporting and analysis of all clinical appeals for CareFirst.

A provider has 180 days from the date of the initial denial of coverage in which to file an appeal. Providers may appeal an adverse benefit determination based on medical necessity, appropriateness, healthcare setting, level of care or a decision to deny experimental/investigation or cosmetic procedures. At the time of a denial determination, the provider is informed of the right to appeal and the process for initiating an appeal.

Written appeals should be mailed to either of the following addresses:

Professional Providers
Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

Institutional Providers
CAU
CareFirst BlueCross BlueShield
P.O. Box 17636
Baltimore, MD 21298-9375

Applicable Products

The provider appeal process described in this manual applies to all CareFirst members regardless of where the member resides. Below are the phone numbers for providers to call for questions regarding provider appeals:

- Maryland: 800-854-5256
- D.C.: 800-842-5975
- Virginia: 800-552-6989

Instructions for submitting an appeal

- The appeal type is determined by the urgency of the situation, as well as the provider's assessment of the situation. There are two types of appeals available to providers following a medical necessity denial: an expedited appeal or a standard appeal.

Expedited appeals process

You may request an expedited appeal if the member is receiving an ongoing service or is scheduled to receive a service and the service has been denied, but the provider believes a delay in receiving the service could adversely impact the member's health or the safety of the member or others. This process can be used when any of the following circumstances exists:

- A delay in decision making which might impact the member's psychological state, jeopardize the member's life, health or ability to regain maximum functions based on a prudent layperson's judgement and confirmed by the treating provider.
- If a provider with knowledge of the member's medical or behavioral condition believes the normal appeals process would subject the member to severe pain or adverse health consequences without the care or treatment.

Note: Retrospective or post-service denials are not eligible for expedited appeal. An expedited appeal is not available when the service has already been performed.

We will answer an expedited appeal within 24-72 hours from the date the appeal is received. Expedited appeals can be faxed to 410-528-7053.

Standard appeals

A standard appeal is used under all other circumstances. An appeal must be submitted in writing and describes the reason for the appeal and the clinical justification or rationale. Please be sure to include the following information:

- A letter of medical necessity written on the provider's professional letterhead, which explains the clinical justification or rationale for the denied service
- Member name and ID number
- Provider number or TIN
- Admission and discharge date, if applicable or the date(s) of service
- Claim number
- A copy of the original claim or denial information
- The treating provider's name
- Supporting clinical notes or medical records which may include pertinent lab reports, X-rays, treatment plans and progress notes

If the appeal concerns a denial of inpatient or skilled nursing facility (SNF) days, please include the complete inpatient medical record. Please follow these additional guidelines for inpatient or SNF days appeals:

- If the appeal includes a request for review of ancillary services, the letter of medical necessity should specifically state why the ancillary services were medically necessary on the denied inpatient day.
- A licensed professional who is a member of the hospital's staff or a nurse working in conjunction with the provider should write the letter of medical necessity. A licensed professional who is a member of the hospital staff can include the attending or treating provider.
- If a nurse writes the letter of medical necessity, it should indicate the provider's involvement in
- the appeal.

Appeal resolution

CareFirst offers one level of internal appeal. The appeal of a medical necessity decision will be reviewed, as appropriate, by a provider of the same or similar specialty as the treatment under review. The appeal review will be performed by a provider who was not part of the original denial. All appeal decisions are answered in writing. Please allow 30 days for a response to an appeal. Once the internal appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the appeal decision
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based
- A statement regarding the availability of all documents, records or other information relevant to the appeal decision, free of charge, including copies of the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Notification that the diagnosis code and the treatment code and their corresponding meanings will be provided, free of charge, upon request
- Contact information regarding a state consumer assistance program and instructions on how to contact the Corporate Office of Civil Rights
- Information regarding the next level of appeal, as appropriate

Coordination with Other Payers/Other Party Liability

Subrogation

Subrogation refers to the right of CareFirst to recover payments made on behalf of a member whose illness, condition or injury was caused by the negligence or wrongdoing of another party. Such action will not affect the submission or processing of claims, and all provisions of the participating provider agreement will apply.

Personal Injury Protection – No Fault Automobile Insurance

Personal Injury Protection (PIP) is an automobile insurance provision that covers medical expenses and lost wages experienced by the insured or passengers as a result of an automobile accident. PIP may be required by automobile insurance laws to provide benefits for accident related expenses without determination of fault. PIP is a law in Maryland and does not include D.C. or Virginia. While Maryland law requires this coverage for passengers and family members under the age of 16, many insured members choose to continue to carry other passengers under this provision in their automobile insurance contracts.

CareFirst benefit contracts may contain a provision that requires coordination with PIP and may only provide benefits for covered medical expenses not reimbursed by the automobile insurer. A copy of the record of payment from the automobile insurer must be attached to the claim form submitted to CareFirst for any additional payment due.

Workers' Compensation

Health benefit programs administered by CareFirst exclude benefits for services or supplies for injuries/illnesses arising out of or in the course of employment to the extent that the member obtained or could have obtained benefits under a Workers' Compensation Act, or similar law. If CareFirst benefits are inadvertently or mistakenly paid despite this exclusion, CareFirst will exercise its right to recover its payments.

Workers' compensation replaces health insurance. A participating provider cannot balance bill CareFirst or the member for any amount not covered under workers' compensation unless it is determined that the charges are non-compensable under workers' compensation. If workers' compensation determines that the charges are non-compensable, attach a copy of the denial from the workers' compensation carrier to the claim.

Under the Maryland Workers' Compensation Act, certain businesses may elect to waive coverage. Verification from the subscriber of this waiver may be required by CareFirst in order to process claims.

Coordination of Benefits

Coordination of Benefits (COB) is a cost-containment provision included in most group and member contracts and is designed to avoid duplicate payment for covered services. COB is applied whenever a member covered under a CareFirst contract is also eligible for health insurance benefits through another insurance company or Medicare.

If CareFirst is the primary carrier, benefits are provided as stipulated in the member's contract.

Note: The member may be billed for any deductible, coinsurance, non-covered services or services for which benefits have been exhausted. These charges may then be submitted to the secondary carrier for consideration. Group contracts may stipulate different methods of benefits coordination, but generally, CareFirst's standard method of providing secondary benefits for covered services is the lesser of:

- The balance remaining up to the provider's full charge; or
- The amount CareFirst would have paid as primary, minus the other carrier's payment (i.e., the combined primary and secondary payments will not exceed CareFirst allowance for the service.)

For many plan types, when coordinating benefits with Medicare, the amount paid by CareFirst, when added to the amount paid by Medicare, will not exceed the Medicare allowable amount. Claims for secondary benefits must be accompanied by the explanation of benefits from the primary carrier.

CareFirst
Family of health care plans

Chapter 6: Fraud, Waste and Abuse

Special Investigations Unit

The Special Investigations Unit (SIU) of CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) and its affiliates and subsidiaries, is the in-house, dedicated unit responsible for coordinating the detection, investigation, referral and prevention of suspected fraud, waste and abuse (FWA). The resolution of these issues is consistent with CareFirst's mission: to provide affordable and accessible healthcare to its members.

The SIU strives to protect CareFirst, members, providers, vendors, and assets from FWA-caused harm. To accomplish its goals, the SIU may pursue a wide array of strategies, which may range from educational activities to financial recovery of improperly paid Company funds to termination of network providers. In certain instances, the SIU may engage, work with, and support local or federal law enforcement.

The SIU's anti-fraud activities are both proactive and reactive. Cases are derived from a variety of internal and external sources, such as tips, calls to the anonymous anti-fraud hotline, referrals from internal departments or external agencies, and leads generated from profile analysis of data stored in internal operating and claims processing systems. Case resolution results in education opportunities, changes in internal policies, processes, practices or procedures, recovered savings, referrals to law enforcement for criminal investigations and/or civil recovery of assets, termination of providers from CareFirst networks, and/or administrative referrals to applicable professional boards.

Fraud, Waste and Abuse

Our members and providers play an important role in helping us identify and combat fraud, waste and abuse. CareFirst's definitions of fraud, waste and abuse include:

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

Waste

The expenditure, consumption, mismanagement, use of resources, practice of inefficient or ineffective procedures, systems and/or controls to the detriment or potential detriment of entities. Waste is generally not considered to be caused by deliberate misconduct but rather by the misuse of resources.

Abuse

Actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary, without knowingly and/or intentionally misrepresenting facts to obtain payment. Deliberate ignorance or reckless disregard of rules and procedures may be considered fraud.

If you suspect fraud, waste and/or abuse, call our hotline at 800-336-4522. You may also email us at SIU@carefirst.com.

Claims Reviews

CareFirst's SIU is comprised of experienced healthcare professionals with expertise in clinical, financial, revenue cycle, health information management and coding specializations and the unit works with various other functions within CareFirst to coordinate a comprehensive approach to the claims review process.

- **Flagged claims review:** CareFirst may review claims flagged as at risk for fraud, waste and abuse prior to payment. We look for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package.
- **Pre-payment review:** As a result of a post-payment audit or investigation, a provider may be required to submit all or selected claims with supporting medical records for review before claims are paid. This review is to determine appropriateness of services billed and/or the medical necessity of the services reported.
- **Post-payment review:** The SIU may perform a review after claims are paid to determine appropriateness of claim coding, services billed and medical necessity.

During the review process, CareFirst examines medical records to ensure they appropriately support the services billed on the claim. Documentation and services must meet contractual and individual provider licensing requirements, as well as be medically necessary, appropriate and covered by the member's benefit plan. This includes, but is not limited to, compliance with the Medical Record Documentation Standards Policy and compliance with national coding and billing standards (CPT®, HCPCS, ICD-10). Records that contain cloned documentation, conflicting information or other such irregularities may be disallowed for reimbursement.

Post-Payment Investigations and Audits

When a potential fraud, waste and abuse problem is identified or reported, CareFirst's SIU performs an investigation which may include obtaining medical records or performing an onsite visit at the provider's office, a facility or other locations where medical records are stored. Once complete, CareFirst notifies the provider of the findings. The provider may then be asked to perform a self-audit of clinical records and claims not previously subject to review. Additionally, CareFirst's SIU educates the provider on proper coding and billing practices and expects the provider to adhere to such practices on any future billings. CareFirst may also require the provider to comply with pre-payment claims review until appropriate billing practices are demonstrated.

If potential fraud is detected, CareFirst's SIU refers the issue to the appropriate law enforcement and/or regulatory agency. If necessary, the SIU will work with CareFirst's Provider Contracting department to terminate providers from the CareFirst networks.

Retroactive Denials and Overpayment Recovery

CareFirst's SIU will, to the extent allowed by law and the provider contract, deny claims and collect overpayments through a future offset of payments when appropriate. Situations giving rise to such denials, recoveries and/or offsets may include a provider's failure to supply requested records, identification of improperly coded or billed claims or other identified fraud, waste and abuse. Providers will be notified in advance of the SIU's intent to conduct such recovery and will be provided an opportunity to provide supplemental information regarding the underlying claims related to the SIU's decision.

Payment Integrity Program

CareFirst has multiple prepayment and post payment activities that occur to identify billing errors. CareFirst partners with several third-party strategic vendors to help support our payment integrity activities.

CareFirst's Payment Integrity program is comprised of experienced healthcare professionals with expertise in clinical, financial, revenue cycle, health information management and coding specializations, and the unit works with various other functions within CareFirst to coordinate a comprehensive approach to the claims review process.

- **Claims Editing:** Medical claims will go through first and second pass claims editing to ensure any billing errors are identified in an automated process to ensure accurate payments. These edits may be national coding requirements, billing regulations and/or CareFirst published medical and payment policies. We look for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package. See Clinical Editing Applications in Chapter 9 for additional information.
- **Pre-payment Review:** Enhanced Automated and Manual claim code editing applies approved medical and reimbursement policies to submitted claims using nurses/clinicians for manual review of the members history.
- **High Dollar Forensic Review:** Based on billed amount on medical claims, a team of certified coding nurses will use itemized bills or other medical documentation to review the high dollar claim to identify potential billing errors.
- **Post-payment Audits:** CareFirst uses multiple vendors to conduct data mining, hospital bill audits, chart reviews and credit balance audits to identify overpayments.
- **Third Party Liabilities:** CareFirst utilizes vendor work with members and their legal counterparts to manage subrogation, mass tort, class action lawsuits and workers compensation cases.
- **Post-Payment Review:** The SIU may perform a review after claims are paid to determine appropriateness of claim coding, services billed and medical necessity.

CareFirst reserves the right to request a vendor be onsite at the provider's office to conduct these reviews when appropriate.

CareFirst will send a letter of representation on behalf of each participating vendor. As the vendors identify overpayments, a notification letter will be sent to inform the provider of the overpayment and to provide guidance on the next steps.

Providers will have the option to sign the letter in agreement with the overpayment, initiating an offset toward future remittances. Providers will also have the option to send a check for the amount of the overpayment, or to submit a request for reconsideration along with supplemental documentation. Please refer to the overpayment letter for additional information on timeframes and where to send responses for the overpayment in question.

The processing of claim adjustments for overpaid claims does not require a signed agreement from the medical provider. Overpaid charges will be offset if no response is received. In the case of a level of care audit or a hospital bill audit, previously unbilled charges will not be processed without an accurate and updated bill. If a corrected claim is requested and not received, CareFirst will recoup the claim in full.

CareFirst
Family of health care plans

Chapter 7: Care Management

Quality Improvement Program

This section describes the Quality Improvement (QI) Program, which serves as a framework to improve the quality, safety and efficiency of clinical care, to enhance patient satisfaction, and to improve the health of CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients and the communities we serve. This section also explains what is expected from participating providers, including access and availability to care for our members.

QI Program

The QI program offers continuous assessment of all aspects of healthcare and services delivered to CareFirst members. We partner with you, our providers, to ensure that members receive the highest level of service and member experience. CareFirst recognizes you as a critical resource and team player in care offered to members. Assessment of member care and services involves quantitative/qualitative assessment of relevant data, by which the plan seeks to identify barriers or causes for less-than-optimal performance, identify opportunities for improvement and implement interventions to effect positive change. This continuous process improvement cycle is the foundation to ensure CareFirst delivers the highest quality and safest clinical care and services, including behavioral healthcare, to all members, at all levels and in all settings.

In performance review, and to establish and maintain appropriate care, various data sources are collected and analyzed, including but not limited to:

- Medical/treatment records
- Claims
- Pharmacy data
- Health risk appraisals
- Healthcare Effectiveness Data and Information Set (HEDIS®) results
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results
- Health Outcome Survey results
- Utilization Management (UM) statistics
- Member/provider surveys
- Current literature

As our partner in care, we look to you for feedback about how we can ensure your satisfaction with the level of service offered to you and your patients. To help assess your overall experience, you will periodically receive surveys asking specific questions about the services we deliver. Your responses and overall results help identify opportunities to improve plan systems and support services, ultimately driving quality for you and our members. Full participation and honest feedback offer the greatest opportunity to understand your needs and identify and prioritize services and areas of importance to you and your patients. In addition, on an ongoing basis, we invite you to submit provider feedback via our website.

CareFirst strives to provide access to healthcare that meets the National Academy of Medicine's aim of improving health for all by advancing science, accelerating health equity, and providing independent, authoritative and trusted advice nationally and globally.

Goals and objectives

- Improve experience of care as well as member health by anticipating and evaluating needs and proactively aligning those needs with appropriate programs and services to reduce and/or control risk and cost.
- Address the needs of patients along the entire healthcare continuum, including those with complex health needs and/or behavioral health illness.
- Support and promote population health initiatives through all aspects of the CareFirst member centered programs to ensure optimal quality of care (QOC), safety, access, efficiency, coordination and service.
- Maintain a high-quality network of providers to meet the needs and preferences of our members by maintaining a systematic monitoring and evaluation process.
- Implement methods to track, monitor and oversee processes for all clinical programs, and measure their value and impact for appropriate patients with complex healthcare needs.
- Establish collaborative partnerships to proactively engage providers, hospitals and other community organizations to implement interventions that address the identified (medical and behavioral) health and services needs of our membership through the entire continuum of care focusing on those most likely to result in improved health outcomes.
- Deliver data and support to clinicians to promote evidence-based clinical practices and informed referral choices and encourage members to use their benefits to their fullest.
- Maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety and efficiency of clinical care (medical and behavioral health) and quality of service. Utilize advanced analytics and proven quality improvement strategies and tools to measure and improve outcomes of care and services and achieve meaningful and sustainable improvement.
- Monitor and oversee the performance of delegated functions.
- Develop and maintain a high-quality network of healthcare providers who meet the needs and preferences of members, by maintaining a systematic monitoring and evaluation process.
- Operate a QI program that is compliant with and responsive to federal, state and local public health goals and requirements of plan sponsors, regulators and accrediting bodies.
- Provide insight based on SearchLight data to increase the knowledge base of the medical panels in the evaluation of their outcome measures.
- Support quality improvement principles throughout the organization, acting as a resource in process improvement activities.

Note: CareFirst recognizes that large racial and ethnic health disparities exist, and communities are becoming more diverse. Racial, ethnic and cultural backgrounds influence a member's view of healthcare and its results. This information is assessed annually in a Cultural, Ethnic, Religious, and Language (CERL) report which is published on the CareFirst website. CareFirst may use member race, ethnic and language data to find where disparities exist, and may use that information in quality improvement efforts.

QI Committees

CareFirst's multi-disciplinary committees and teams work closely with community physicians to develop and implement the QI program.

Clinical providers, including designated behavioral healthcare providers, provide input and feedback on QI program activities through participation in the following committees:

QI program committees	
Committee	**Purpose**
Quality Improvement Advisory Committee (QIAC)	A multi-specialty committee of providers who advise the insurer about standards of medical and behavioral healthcare
Quality Improvement Council (QIC)	Evaluates the quality and safety of clinical and behavioral healthcare and the quality of services provided to members
Credentialing Advisory Committee	Reviews the credentials of providers and potential providers applying for initial or continued participation in the plan
Care Management Committee	Monitors and analyzes the care management program and promotes efficient use of healthcare resources by members and providers
Delegation Oversight Committee	Monitors and analyzes the activities of delegates performing functions on behalf of CareFirst

Clinical Guidelines

CareFirst's Clinical Practice and Preventive Service Guidelines are available online to guide the assessment and management of members with specific diseases. The Clinical Practice Guidelines, which serve as a valuable resource in the care of your patients, include:

- Attention Deficit Hyperactivity Disorder
- Asthma
- Autism Spectrum Disorder
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease
- Colorectal Cancer Screening
- Coronary Artery Disease
- Depression
- Diabetes
- Diabetes Testing During Pregnancy
- Heart Failure
- Hypertension
- Low Back Pain
- Major Depressive Disorder
- Obesity
- Osteoarthritis
- Prescribing Opioids for Chronic Pain
- Substance Use Disorder

PrEP Medication and Related Ancillary Services

Preventive care at $0 cost-share

Following updated guidelines from the U.S. Preventive Task Force (USPSTF), members who are at high risk of HIV infection may benefit from using pre-exposure prophylaxis (PrEP) medication with anti-retroviral therapy.

CareFirst encourages the use of PrEP when appropriate and has no prior authorization requirements. CareFirst recommends monitoring of patients on PrEP consistent with the USPSTF guidelines, evidence-based medicine, and prescription labeling. All this care is preventive and, accordingly, CareFirst will waive all cost sharing if the member's contract is not grandfathered. Here's what's included:

- **HIV Testing:** Screened before starting PrEP and every three months while taking PrEP. Services should be submitted as a preventive screening.
- **Hepatitis B:** Screened at baseline for initiation of PrEP. Services should be submitted as a preventive screening.
- **Hepatitis C:** Screened at baseline and periodically consistent with CDC guidelines for all individuals with ongoing risk of contracting Hepatitis C. Services should be submitted as a preventive screening.
- **Creatinine Testing and calculated estimated creatine clearance (eCRCl) or glomerular filtration rate (eGFR):** eCrCl or eGFR must be measured and calculated at beginning of treatment. Creatine and eCrCl or eGFR should checked periodically. Submit lab tests with preventive diagnostic code (Z113 or Z114).
- **Pregnancy Testing:** Before starting PrEP and periodically during treatment. Services should be submitted as preventive screening.
- **Sexually transmitted infection screening and counseling and medication adherence follow-up visits:** Use procedure codes 99401-99404 for counseling or follow-up visits, or preventive medicine codes 99381-99387 or 99391-99397 for comprehensive preventive visit.

See USPSTF guidelines for more information on evidence-based care guidelines for members who are at-risk for HIV infection.

Population Assessments

CareFirst continuously analyzes the cultural, ethnic, racial and linguistic characteristics of its members and, in April 2019, produced its first Cultural, Ethnic, Racial and Linguistic (CERL) report. The assessment is performed annually and includes specific characteristics of the geographic populations we serve correlated to CareFirst membership. Various data sources are used in producing this report and analysis.

CareFirst is committed to a strong cultural diversity program, recognizing the diverse and specific cultural needs of its consumers and addressing the needs in an effective and respectful manner. The CERL information presented was collected through a variety of sources that include:

- The U.S. Census Bureau American Community Survey (ACS)
- Association of American Colleges (AAMC) Race and Ethnicity Study

- CAHPS member satisfaction questions regarding age, sex, education, ethnicity and cultural and language needs
- CareFirst membership data
- Network provider characteristics including age, sex and languages spoken
- Member complaint data
- Pew Research Center Religious Landscape Study
- Use of language assistance/translator services, via the language line

Maintaining the Access, Availability and Quality of Our Network Providers and Hospitals

In support of the maintenance of the networks with which providers have contracted, providers are required to keep CareFirst informed of the following:

Network Maintenance		
Provider responsibility	**Rationale**	**Associated CareFirst activity**
Tender notification of termination to CareFirst	■ Facilitate continuity and coordination of care across the delivery system ■ Support ease of continuity of care	CareFirst notifies members affected by the termination of a provider or practice group and helps them select a new provider, or as warranted, arranges continued care based on the specifics of the point in treatment.
Maintain and update current information	■ Maintain the accuracy of the provider directories ■ Provide the ability to locate providers that meet members' needs or preferences ■ Decrease the unnecessary selection of out-of-network providers	CareFirst provides information to members and prospective members that is useful in selecting a physician and hospital through its paper and web-based physician and hospital directories. The information includes, but is not limited to the provider's name, gender, specialty, hospital affiliation, medical group affiliations, board certification, whether the provider is accepting new patients, languages spoken by the clinician or clinical staff and office locations and phone numbers. CareFirst uses the information to monitor, identify

Network Maintenance		
		and act on opportunities for improvement of availability of providers and hospitals in its networks.
Maintain and update office hours	■ Maintain information on accessibility of services for members ■ Monitor network adequacy (provider type, ratio and geography)	CareFirst assists members with the ability to find a provider when they need them, and it uses the information in its database to not only identify who is accepting patients but the days and times they are able to see patients to meet the members needs and preferences. Whether a member contacts CareFirst via the phone or uses web-based services, this is a key feature and service CareFirst provides its members. CareFirst uses the information to monitor, identify and act on opportunities for improvement of access to providers and hospitals in its networks.
Alert CareFirst to potential adverse events and complaints	■ CareFirst reports adverse events to the appropriate licensing boards and to the National Provider Data Bank.	CareFirst identifies, and when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing and recredentialing activities. Such activity includes monitoring of provider sanctions, complaints and quality issues.

Population Health Management: The Patient-Centered Medical Home and Clinical Program Model

On an annual basis, CareFirst assesses and evaluates its programs designed to positively impact the member's health. These programs support members in all stages of health, from those with few identified health risks to patients with severe illness and multiple co-morbidities. The Patient-Centered Medical Home (PCMH) Program has become the model for coordinated care delivery, bringing the right interventions to bear for the right member, at the right time, with the best possible outcomes and at the lowest cost.

The PCMH Program is based on several beliefs, assumptions and theories about what must be done to transform the healthcare system in the CareFirst region—and, by extension, the American healthcare system. The PCMH Program works with providers and members in their communities, and is supported by a clinical program model, offering programs designed to meet specific member needs such as transition from the acute care setting to skilled nursing facilities or home-based care services. At its core, the goal is to help members achieve the highest level of recovery and stabilization possible and to support PCP panels to achieve their goals of improving quality and restraining the rise in healthcare spending.

The PCMH program has a significant upside for the provider, for the patient, and for CareFirst as a steward of its members' healthcare dollars. For more specific program information, including eligibility and how to get started, visit carefirst.com/pcmhinfo.

National Committee of Quality Assurance

All of CareFirst's health maintenance organization (HMO) and preferred provider organization products are accredited through the National Committee for Quality Assurance (NCQA). Accreditation is awarded to plans that meet NCQA's rigorous requirements for consumer protection and quality improvement.

NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. NCQA's Accreditation standards are publicly reported in five categories:

- **Access and service** – do health plan members have access to the care and services they need?
- **Qualified providers** – does the health plan assess each doctor's qualifications and monitor members' provider reviews?
- **Staying healthy** – does the health plan help members maintain good health and detect illness early?
- **Getting better** – how well does the health plan care for members when they become sick?
- **Living with illness** – how well does the health plan care for members when they have chronic conditions?

Complaint Process

CareFirst has a defined process for handling both QOC and service complaints received from members. The purpose of the Customer Complaint Process is to provide a thorough, appropriate, consistent and timely review and resolution of customer complaints and appeals for all CareFirst products. A systematic approach to recording customer dissatisfaction allows the plan to monitor trends, identify opportunities for improvement and initiate corrective action plans as needed.

A "complaint" is defined as a written communication from a member, or the provider on behalf of the member, which primarily expresses a grievance. A complaint may pertain to the availability, delivery or quality of healthcare services including the following:

- Claims payments
- The handling or reimbursement for such services
- Plan operations
- Any other matter pertaining to the covered person's contractual relationship with the plan.

CareFirst has a policy to initiate office site visits for practitioners who receive three or more QOC complaints related to any combination of the following within a three-month period:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and exam room space
- Adequacy of medical/treatment record keeping

In addition to the above, an office site visit may be performed at the request of the medical director, QOC Nurse, or a regulatory board. The timeframe for completion of the site visit will be accomplished within 60 calendar days of the identification need for the site visit, or sooner if determined necessary.

Complaints received by CareFirst are tallied and reported to the QIC. If the QIC determines that research is needed for additional evidence, the provider may be asked to assist in the investigation and respond appropriately to the member, if warranted. Complaints are reviewed annually, or more frequently as determined by CareFirst, to determine if further action is needed.

Language Assistance

To meet potential linguistic needs of CareFirst's member population, CareFirst makes its written member material available in English and Spanish. CareFirst's website includes plug-ins for translation of website pages in multiple languages to assist members with self-service features. Members have access to an interpreter line and TTY services when needed.

CareFirst complies with applicable federal civil rights laws and does not discriminate based on race, age, sex, religion, creed, color, national origin, ancestry, physical handicap, health status, military veteran status, marital status, sexual orientation or gender identity. CareFirst does not exclude people or treat them differently because of race, age, sex, religion, creed, color, national origin, ancestry, physical handicap, health status, military veteran status, marital status, sexual orientation or gender identity.

CareFirst provides free aid and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages.

Your patients in need of these services may contact CareFirst at 855-258-6518.

Language Line Services

CareFirst believes that communication between healthcare providers and their patients is key. We make available to your office no-cost interpreter services. To take advantage of this service, simply contact Provider Services and let the Customer Service Advocate know that you would like to request an interpreter.

Disease Management Programs

CareFirst offers disease management programs designed to educate members about their conditions and reinforce the physician's care plan. All programs are voluntary and confidential, conducted by licensed registered nurses who are specially trained in the member's conditions.

CareFirst uses claims data to identify members with the following chronic conditions who are eligible for disease management:

- Asthma
- Diabetes
- Coronary Artery Disease (CAD)
- COPD
- Heart Failure
- Chronic Low Back Pain
- Osteoarthritis
- Atrial Fibrillation
- Irritable Bowel Syndrome
- Fibromyalgia

Members enrolled in the disease management program:

- Participate in coaching sessions to better understand their doctor's recommendations, medications and treatments
- Are assigned a care manager if their condition is severe
- Receive educational materials, including condition-specific workbooks, action plans and newsletters
- Learn how to better manage their condition and set goals to reach their best health

Call 877-260-3253 to obtain more information or to enroll patients into one of these programs administered by Sharecare, Inc., an independent company that provides health improvement management services to CareFirst members.

Note: These programs are not currently available to all members. Please verify the member's benefits.

For resources on any of the chronic conditions mentioned above, review the clinical practice guidelines.

Clinical Programs

CareFirst offers a variety of care programs for our members to assist them whenever a healthcare need arises. The table below outlines the different programs we offer along with which members are eligible. Program descriptions can be found below the table.

Note: Please verify your patient's eligibility and benefits for these programs before referring your patients.

Clinical Programs Chart			
Program Name	**Commercial**	**MA - Individual**	**MA - Group**
Expert Consult	X		
24/7 Virtual Care Options	X		
Genetic Testing Prior Authorization	X		
Diabetes Virtual Care	X	X	X
Physiological Remote Monitoring	X		
Behavioral Health Digital Resource	X		
MAPD Palliative Care		X	X
24 Hour Nurse Advice Line	X	X	X
Medication Reconciliation Post-Discharge		X	X

Expert Consult

About the Program

The Expert Consult[3] program delivers a comprehensive virtual consult for the diagnosis and treatment of complex/orthopedic cases. This is useful when patient symptoms are not improving, have no diagnosis, are wanting a confirmation of diagnosis or whose treatment path may not be clear.

Fast Facts

- 75% of participating members rated the program as excellent[4]; and
- Reduces care costs by helping patients make informed treatment decisions

Who is Eligible?

CareFirst members enrolled in commercial and Federal Employee Program (FEP) PPO plans.

Who is Not Eligible?

CareFirst members enrolled in Medicare Advantage, Medicaid, or CareFirst Administrator plans.

How Patients Can Engage

The CareFirst team assists treating physicians by identifying members who may benefit from a virtual Expert Consult.

- A CareFirst care manager receives consent from the member and treating physician and conducts an intake interview with the member;
- A top expert medical specialist reviews relevant medical records, pathology and more then provides a treatment recommendation; and
- The treating physician and the member receive a thorough report based on the member's condition, preferences and latest treatment research.

24/7 Virtual Care Options

CareFirst is committed to providing 24/7 virtual care to our members who continuously ask for these options. When regular providers are not available, CareFirst members can use CloseKnit® or find other telehealth options offered by select value-based care provider partners. These options can be found on our website at carefirst.com/virtualcare. To be featured on this page, provider partners must meet the following criteria:

- 24/7 access and availability
- Appointment availability
- HIPAA compliant telehealth platform
- Active provider practice license in the CareFirst Service Area

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[3] This program is offered by Best Doctors by Teladoc, an independent company that provides virtual consult services to CareFirst members. Best Doctors does not sell Blue Cross Blue Shield products or services. Expert Consult and Best Doctors are service marks or registered service marks of Teladoc Health, Inc.

[4] Based on clinical quality and addressing their concerns. CareFirst BOB 2023 Member Satisfaction response.

- In-network provider for our largest CareFirst networks
- Primary care listed as the primary specialty
- Participation in a value-based care agreement
- Accepting new patients
- Maintains active status and usage of CareFirst's Provider Portal
- Commits to sharing notes back with the member's PCP

We encourage you to discuss the telehealth options your practice offers with your patients. If you don't offer telehealth, these partners are great options for CareFirst members when you aren't available.

Note: FEP members must use Teledoc®.

Genetic Testing Prior Authorization

About this Program

This program provides clinical appropriateness review services for genetic testing through Carelon Medical Benefits Management[5] using evidence-based clinical guidelines and real-time decision support.

Fast Facts

- Cost savings of $ 0.71[6] per member per month;
- More than 26,000[7] annual authorizations completed;
- 93%[8] provider satisfaction rate; and
- 91%[9] program intake rate.

Who is Eligible?

Available to CareFirst commercial and Federal Employee Health Benefit Program members.

Who is Not Eligible?

Not currently available to members enrolled in Medicare Advantage, Medicaid, DSNP, Federal Employee Program (FEP) PPO plans, or CareFirst Administrator plans.

How Patients Can Engage

To access this program:

- Only ordering providers and their staff may submit requests for prior authorization through CareFirst's provider portal at **carefirst.com/providerlogin** and navigate to the Pre-Auth/Notifications tab to begin your request; or
- By calling Carelon directly at 844-377-1277, Monday- Friday, 8 a.m. – 5 p.m. EST.

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5 Carelon Medical Benefits Management is an independent company that provides clinical solutions for CareFirst BlueCross BlueShield members. Carelon does not provide Blue Cross and Blue Shield products or services.

[6] Based on avoidance of unnecessary testing for calendar year 2022.

[7] Based on volume for calendar year 2022.

[8] Based on vendor conducted provider survey for calendar year 2022.

9 Based on percent of reviewed tests requested on their web utilization for calendar year 2022.

Diabetes Virtual Care

Program Overview

The Diabetes Virtual Care program provides support for members who need help stabilizing their type 2 diabetes. In collaboration with Onduo[10], a leading virtual care management company, this program offers personalized support, easy-to-use tools and access to certified diabetes educators through a mobile app. The program provides members with the care and support they may need in between their doctor visits, such as testing supplies and connected devices, virtual coaching, insights about their glucose levels, A1c trends and more.

Fast Facts

- Personalized support access to diabetes educators and easy-to-use tools through a mobile app
- Since 2020, more than 6,300 CareFirst members with type 2 diabetes have enrolled and stayed active[11]
- Enrolled members with A1C of 8% or greater, showed an overall average A1C decrease of 1.2%[12]

Who is Eligible?

Available to CareFirst commercial members. To access the program, members are identified and referred by their provider or a member of the CareFirst clinical team. Not available for CareFirst Administrators/Federal Employee Program PPO/Medicare Supplement/Fund Account members. Eligible members will be contacted about joining the program. Some elevated clinical risk exclusions apply.

Who is Not Eligible?

Members with the following conditions are not eligible to participate at this time:

- Pregnancy
- History of or diagnosed with cirrhosis or liver failure
- History of or diagnosed with severe end-stage kidney disease
- Organ transplant or bone marrow transplant
- Cystic fibrosis
- Any other condition or situation that, in Onduo's discretion, is deemed not the best fit

How Do Members Enroll?

Members are referred into the program by a CareFirst case manager, CareFirst care coordinator or by self-enrolling after receiving a personalized communication (phone call, letter, email) from CareFirst and

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10 This program is offered through Onduo by Verily. Onduo offers certain care management and coordinated clinical care programs for eligible individuals, as further described in these materials and at onduo.com. Onduo LLC and a network of affiliated professional entities (collectively, "Onduo") collaborate to offer the services. Onduo services are meant to be used in conjunction with regular in-person clinical services and not intended to replace routine primary care. Onduo is an independent company and does not provide Blue Cross and Blue Shield products or services.

11 Data based on Onduo member enrollment statistics for CareFirst as of Q3 2023.

12Results are based on members who are engaging with their care lead and program materials and have provided an initial and at least one follow-up A1c value since program inception. Individual results may vary.

Onduo. Members must be 18 years of age or older, been diagnosed with type 2 diabetes, own a smartphone, and have medical benefits through CareFirst.

Members can register for the program at onduo.com/carefirst, or call 833-HiOnduo (833-446-6386) with questions.

Physiological Remote Monitoring

Remote Patient Monitoring (RPM) enables patients to better manage their chronic health conditions and actively participate in coordinating healthcare decisions with their designated provider. RPM facilitates the capture and transmission of patient generated physiological data from electronic devices that measure blood pressure, heartrate, pulse oximetry, body temperature and weight in a timely and accurate manner.

RPM requires a prescription from either the discharging inpatient/emergency department provider or patient's personal primary care or specialty care provider. CareFirst covers remote monitoring for the following diagnoses for members who have had an ED visit or inpatient discharge in the previous 60 days.

Remote Patient Monitoring	
Condition	**Activity Monitored**
Congestive Heart Failure (CHF)	Weight, Blood Pressure, Pulse OX, Daily Heart Rate
Chronic Obstructive Pulmonary Disease (COPD)	Weight, Blood Pressure, Pulse OX, Daily Heart Rate
Chronic Kidney Disease (CKD)	Weight, Blood Pressure, Pulse OX, Daily Heart Rate
High Blood Pressure – Hypertension (HBP)	Blood Pressure
Coronavirus Disease (COVID-19)	COVID-19 Symptom Monitoring

Coverage for remote monitoring may continue for 120 days from the date of ED service or inpatient discharge. Devices must be Bluetooth enabled and should be supplied by the provider. Personal devices such as an Apple Watch® or Fitbit® are not approved for RPM. Eligible remote monitoring devices must:

- Meet the FDA definition of a "medical device," and
- Be able to transmit the patient's physiological data through a secure connection established by the prescribing provider.

CPT code 99453 may be used for the device setup and patient education. Monitoring and interactive communications may be billed every 30 days for codes 99454, 99457, and 99458.

Behavioral Health Digital Resource

CareFirst, along with 7 Cups of Tea (7 Cups), a global behavioral health company, offers an innovative approach to helping patients across the entire mental health/mental illness spectrum—from those who want to maintain their mental well-being to those needing help getting through a difficult time.

The **Behavioral Health Digital Resource** is available to CareFirst patients 13 years and older, with medical benefits—anonymously, confidentially and at no cost. At this time, it's not available to patients enrolled in Medicare Advantage, Medicaid or CareFirst Administrator plans.

7 Cups uses a robust technology platform to provide access to a variety of options through a smartphone, computer or tablet:

- **Talk with someone who understands:** 7 Cups maintains a network of more than 430,000 trained active listeners who provide real-time one-on-one emotional support in more than 140 languages. All listeners go through the Active Listener Training Course. This course consists of content, videos, and interactive exercises, including chatbot simulations. After completing the courses, listeners are enrolled in a continuing education program, engaging in additional trainings and gaining more experience assisting people in need.
- **Learn new coping skills:** Aimed at helping patients better understand conditions, treatment and self-management options. Includes 35 treatment plans consisting of educational and therapeutic exercises.
- **Support forums:** Online discussion boards, moderated chat rooms and scheduled topic-specific group chats allow for real-time support, available in multiple languages.
- **Connect with a licensed therapist:** Patients can connect with a CareFirst behavioral healthcare manager who can help them make an appointment with a provider. Standard medical benefits apply.

Patient's accessing 7 Cups can connect with behavioral health providers in the CareFirst provider network.

You patient's may start by visiting carefirst.com/myaccount and selecting the Behavioral Health tile, or by downloading the 7 Cups app from the iOS or Android stores.

MAPD Palliative Care Program

About This Program

The CareFirst BlueCross BlueShield Palliative Care Program[1] provides support services for advanced and end-stage disease for Medicare Advantage members with illnesses such as cancer (stage IV and certain stage III cancers) , advanced heart failure (Class III-IV), advanced chronic obstructive pulmonary disease (COPD, Stage III-IV), advanced end-stage renal disease (ESRD), end-stage liver disease, advanced neurologic disease, and advanced dementia.

The service begins with an initial visit in the home or virtually. In this first meeting, the provider will learn about the member's illness, their goals, symptoms and challenges, and the level of support available from family, friends, and other caregivers. Based on this information, the vendor works with the member and you to develop a care plan that is focused on the member's needs and goals.

Fast Facts

- 42 patients served;
- 194 in-home visits completed;
- 68% reduction in hospital readmissions for program participants[13]

Who is Eligible?

Medicare Advantage members who have been identified as having advanced illness, either through an identification process or provider referral.

How Patients Can Engage

Members are contacted by our vendor, based on clinical need, to enroll in the program.

24-Hour Nurse Advice Line

About this Program

When members have questions about their health, they may not be sure where to go. Instead of waiting and worrying, they can call the Nurse Advice Line staffed by registered nurses 24 hours a day, seven days a week, 365 days a year. The nurse will ask a few questions and give information to help members decide what to do next. The Nurse Advice Line provides support and guidance for any non-emergency situations, such as fever, cuts, burns, sore throat, coughing, sinus pain, or any health-related issues. The service is personal, confidential and available at no cost.

Fast Facts

The Nurse Advice Line service is personal, confidential and available at no cost and can help members:

- Decide when to visit their doctor or go to a convenience clinic, urgent care center or the emergency room;
- Understand their medications;
- Find network doctors and prepare for an appointment;
- Learn about preventive care.

For foreign language calls, Nurse Advice Line utilizes a global telephone interpretation service that has linguists available 24/7 to assist with more than 200 languages and dialects.

Who is Eligible?

The Nurse Advice Line is available to all CareFirst members with medical benefits under commercial, Medicare Advantage, DSNP and Medicaid.

How Patients Can Engage

To access this program, members can dial the toll-free number on the back of their CareFirst medical insurance card reach a nurse for general questions about health issues or where to go to for care.

- Commercial members call 800-535-9700
- Medicare Advantage members call 833-968-1773

[13] Data provided by Aspire Health based on CareFirst BOB since program inception in January 2021. Results may vary.

- DSNP members call 800-229-8201
- Medicaid members call 800-231-0211

Medication Reconciliation Post-Discharge

Medication reconciliation is a critical part of post-discharge care coordination for all members. As such, CareFirst will support this initiative by reaching out to certain members who have been recently discharged from the hospital and review their medications. We may send you documents detailing our discussions with members and may ask for certain changes to the medication regimen we discuss.

Clinical Resources

Clinical resources are developed under our QI program and support our providers in treating chronic disease and conditions and providing preventive care. These resources include the clinical practice guidelines and the preventive service guidelines.

Outpatient Pre-Treatment Authorization Plan

The Outpatient Pre-Treatment Authorization Plan is a pre-treatment program that applies to outpatient physical, speech and occupational therapy. Providers should use CareFirst Direct to determine member benefits and if an authorization is required. If so, then use CareFirst Direct to submit the authorization.

Coordinated Home Care and Home Hospice Care

The Coordinated Home Care and Home Hospice Care programs allow recovering and terminally ill patients to stay at home and receive care in the most comfortable and cost-effective setting. To qualify for program benefits, the patient's physician, hospital or home care coordinator must submit a treatment plan to CareFirst. Authorization requests should be submitted via CareFirst Direct. A licensed home health agency or approved hospice facility must render eligible services. Once approved, the home health agency or hospice is responsible for coordinating all services.

Inpatient Management

The Inpatient Management nurses are responsible for managing timely and smooth transitions from inpatient to home or other levels of care for members admitted to a facility across the nation.

The nurse uses experience and skills in utilization management, including proficiency leveraging Milliman Care Guidelines, to determine medical necessity and appropriate level of care. They also use their case management experience and interventions to engage members/enrollees, their families and other support systems in discharge planning. Whether onsite or telephonic, the Inpatient Management nurse collaborates with hospital care team including case managers, social workers and discharge planners to ensure CareFirst members/enrollees for all lines of business receive the appropriate level of care and partner to address any potential barriers to discharge. The RNs will refer to appropriate wrap around services and/or Case Management to meet the member's ongoing care coordination needs.

Comprehensive Medication Review Program

The Comprehensive Medication Review program seeks to review and mitigate the potential for medication-related issues in high-risk and high-cost members. The program engages a specialized pharmacist to review a member's medication profile and identify medication recommendations. The pharmacist will evaluate for drug compatibility and interactions to ensure each drug is as effective as possible. Any medication recommendations and the reasons for the changes are communicated to the prescribing physicians.

Behavioral Health and Substance Use Disorder Program

CareFirst's Behavioral Health and Substance Use Disorder (BSD) program is designed with a patient-advocacy focus. Our licensed behavioral health professionals provide behavioral health and substance use disorder care coordination to members in need. Services under this program include:

- BSD care coordination
- Transition of care services
- Needs assessment
- Assistance with locating providers and setting initial appointments

For more information visit carefirst.com/pcmhguidelines.

Gender Services

CareFirst is committed to supporting LGBTQ+ individuals, their families and their employers, and we understand that lesbian, gay, bisexual, transgender and gender diverse people face unique health disparities. Our dedicated Gender Services specialist can help members:

- Understand what treatment choices are available;
- Navigate benefits and what an individual's plan covers; and
- Provide support and guidance.

Additionally, our Gender Services Specialists provide educational support and guidance to providers.

For more information, send an email to gender.services@carefirst.com.

Inpatient Hospitalization Services

Pre-Authorization Process for Elective Admissions

- All elective inpatient hospital admissions must be authorized. The participating hospital must request authorization through CareFirst Direct. For CareFirst BlueChoice

members, all services must be approved by the PCP, who must concur that the proposed treatment plan is clinically appropriate

- You can request prior authorization:
  - Online: Log in at carefirst.com/provider and click the Prior Authorization/Notifications tab to begin your request
    Note: Pre-Authorizations should be requested prior to the date of service. Effective May 15, 2024, requests received more than three calendar days after the date of services will be administratively denied. Requests for pre-authorization can be entered 31 days before the outpatient date of service. Submit the authorization request to the Pre-Authorization department at least 15 business days prior to all elective admissions, except when it is not medically feasible due to the member's medical condition. Request review timelines vary, and are based on applicable NCQA, state and federal requirements. Necessary clinical information must be submitted to conduct a review of the request. For on-demand training and resources, visit carefirst.com/learning.
  - By fax: Visit carefirst.com/providerforms to download the appropriate prior authorization form.
  - By phone: Call 866-PRE-AUTH (773-2884).
- Unauthorized hospital stays will result in a retrospective review of the admission.
- Written authorization denials are issued within one business day of making the decision. Expedited or standard appeal information is included with the denial information.
- If the admission dates for an elective admission change, notify the care management department as soon as possible, and no later than one business day prior to the admission.

Emergency admission certification process

- All emergency inpatient hospital admissions must be authorized within 48 hours of the admission or next business day. The hospital must request authorization.
- Unauthorized hospital stays result in a retrospective review of the admission.

Prospective and Concurrent review process

- Prospective review is performed when the inpatient authorization is requested prior to admission or within 48 hours of the admission to the inpatient facility.
- The hospital's utilization review (UR) department must provide clinical information to the assigned CareFirst Clinical Review Nurse (CRN) (for prospective reviews), Concurrent Clinical Review (CCR) nurse, or call the number listed next to pre-auth/pre-cert on the Provider Quick Reference Guide).
- CareFirst's CCR nurse will contact the attending provider or follow agreed hospital protocol if further clarification of the member's status is necessary.
- CRN and CCR nurses use approved medical criteria to determine medical necessity for acute hospital care.
- If the clinical information meets CareFirst's medical criteria, the days/services will be approved.
- If the clinical information does not meet the approved medical criteria, the case will be referred to our medical director.

- The CRN or CCR nurse will notify the attending provider and the facility of our Medical Director's decision.
- The attending provider may request an appeal of an adverse decision.

Retrospective review process

The UR nurse will notify the appropriate hospital department and request medical records when a retrospective review of the clinical record is necessary.

Discharge Planning Process

The hospital or attending provider must initiate a discharge plan as a component of the member's treatment plan. The hospital, under the direction of the attending provider, should coordinate and discuss an effective and safe discharge plan with both CareFirst and the patient immediately following admission. Discharge needs should be assessed, and a discharge plan developed prior to admission, when possible. Referrals to hospital social workers, long-term care planners, discharge planners or hospital case managers should be made promptly after admission and coordinated with CareFirst.

An appropriate discharge plan should include:

- Full assessment of the member's clinical condition and psychosocial status
- Level, frequency and type of skilled service care needs
- Verification of member's contractual healthcare benefits
- Referral to a CareFirst BlueChoice participating provider, if needed
- Alternative financial or support arrangements, if benefits are not available

Outpatient Hospital Services

CareFirst BlueChoice requires authorization for all outpatient services, including laboratory and radiology, performed in a hospital setting.

- The hospital is responsible for initiating all requests for authorization for outpatient services through CareFirst Direct.
- If authorization criteria are met, authorization will be issued. In addition, the caller will be instructed whether the member is accessing an in- or out-of-network benefit. There will be instances in which the member will be directed to a more appropriate network provider for certain services (i.e., laboratory, radiological services).
- If the admission date for an outpatient elective procedure changes, care management must be notified by the hospital as soon as possible, but no later than one business day prior to the procedure. Lack of notification may result in a denial of the claim.

Note: All pre-operative services must be performed by or arranged by the member's PCP/specialist.

Utilization Management

Decisions are based on the following criteria:

- Milliman Care Guidelines
- MCG Health Behavioral Health Care Guidelines

- American Society of Addiction Medicine (ASAM) is for all substance use disorders medical decisions. ASAM criteria is an evidence-based template to determine the appropriate level of substance use disorder intervention for an individual.
- CareFirst Medical Policy Reference Manual
- CareFirst's Dental Clinical Criteria have been developed, revised, and updated periodically. They are reviewed and approved by the CareFirst Dental Advisory Committee (DAC) and/or the Oral and Maxillofacial Surgery Advisory Committee (OMSFAC). The criteria are derived from reviews of the current dental literature, subject textbooks, other insurance companies, and
  - Practice Parameters, American Association of Periodontology
  - Parameters of Care, American Association of Oral and Maxillofacial Surgery
  - Oral Health Policies and Clinical Guidelines, American Academy of Pediatric Dentistry
  - Position Statements, American Association of Dental Consultants
  - Dental Practice Parameters, American Dental Association

CareFirst makes physician reviewers available to discuss UM decisions. Providers may call 410-528-7041 or 800-367-3387, ext. 7041 to speak with a physician reviewer or to obtain a copy of any of the above-mentioned criteria. All cases are reviewed on an individual basis.

Important note: CareFirst affirms that all UM decision-making is based only on appropriateness of care and service. Practitioners and/or other individuals are not rewarded for conducting UR for denials of coverage or service. Additionally, financial incentives for UM decision makers do not encourage underutilization of coverage or service.

Prior Authorizations and Notifications

Prior Authorizations and notifications should be requested according to the timeframes below. Many of our member contracts include provisions for penalties, if prior authorizations/notifications are not obtained in the timeframes set forth below.

Prior Authorizations and Notifications Timeframes

Type of admission/service	Submission requirement	Response timeframe	Notes
Inpatient (routine)	15 days in advance of admission	Within 15 days of request for non-risk accounts. Within two days of request for risk accounts.	Notification is late if request is not received prior to the date of admission. Penalties may apply.
Emergency admissions	Within seven days of the emergency admission	Auto approvals via the authorization system for emergency admissions	Notification is late if not submitted within seven days after the emergency admission. Penalties may apply.

Prior Authorizations and Notifications Timeframes			
Outpatient hospital	15 days in advance of the procedure	Within 15 days of request for non-risk accounts. Within two days of request for risk accounts.	
PT/OT/ST	15 days in advance of the treatment	With 15 days of request for non-risk accounts. Within two days of request for risk accounts.	Notification is late if request is not received prior to the beginning of care. Penalties may apply.

Complex Case Management

CareFirst has designed a program to help its members with acute, multiple or complex conditions to obtain access to care, services and resources. A team of registered nurse case managers work closely with the member and their family. The case managers will take an interdisciplinary approach to provide short term or comprehensive interventions as needed. Additionally, case managers create a plan of care specific to the member's needs that produces positive clinical results and promotes independence in managing their healthcare. Interventions and services may include, but are not limited to:

- A physical and psychosocial assessment
- Social determinants of health
- Care coordination
- Referrals to community resources
- Referrals to other clinical programs with both internal and external partners

Case managers provide specialized care for:

- High-risk pregnancy
- Acute and complex medical needs
- Trauma
- Special needs pediatrics
- Adult and pediatric oncology
- Hospice, palliative and end-of-life care

Case Management Referral Process

Healthcare providers, patients, family members, employers or anyone familiar with the case may refer candidates for CCM by calling 888-264-8648 or 866-773-2884.

CareFirst
Family of health care plans

Chapter 8: BlueChoice

Health Maintenance Organization

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 (4.01.06A).

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 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® 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 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.
Infertility Testing	Yes, if performed in a hospital setting.	Must verify the member's benefits.

Services	Care Management Authorization Required?	Comments
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.

CareFirst
Family of health care plans

Chapter 9: Policies and Procedures

Medical Policy and Technology Assessment

Medical Policies and Medical Policy Operating Procedures

The CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) evidence-based medical policies and medical policy operating procedures can be found in the Medical Policy Reference Manual. This manual is an informational database, which, along with other documentation, is used to assist CareFirst in reaching decisions on matters of medical policy and related member coverage. These policies and procedures are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract.

Member coverage will vary by contract and line of business. Benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts.

Medical policies and medical policy operating procedures are not intended to replace or substitute for the independent medical judgment of a practitioner or other health professional for the treatment of an individual. Medical technology is constantly changing, and CareFirst reserves the right to review and update its medical policy periodically and as necessary.

For specific reporting codes and instructions, refer to the appropriate and current coding manual, such as:

- The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS Level II codes)
- The International Classification of Diseases (ICD)
- The American Medical Association's Current Procedural Terminology (CPT®) (HCPCS Level I codes).

The Medical Policy Reference Manual is organized according to specialty, and in some cases, subspecialty, as follows:

- 00 Introduction
- 01 Durable Medical Equipment
- 02 Medicine
- 03 Mental Health
- 04 OB/GYN/Reproduction
- 05 Prescription Drug
- 06 Radiology/Imaging
- 07 Surgery
- 08 Rehabilitation/Therapy
- 09 Anesthesia
- 10 Administrative
- 11 Laboratory/Pathology
- 99 Archived Policies and Procedures

The introduction to the Medical Policy Reference Manual should be referenced prior to reviewing the medical policies and procedures. This section describes the medical policy process, format of documents, and definitions and interpretive guidelines of key terms such as medical necessity, cosmetic and experimental/investigational.

The medical policies and procedures located in the Medical Policy Reference Manual provide guidelines for most local lines of business. Many national accounts, processed through the National Account Service Company (NASCO) system, and members with federal employee program benefits, may defer to policies developed by the Blue Cross and Blue Shield Association. For these accounts, when there is no policy on a specific service, CareFirst's Medical Policy Reference Manual will apply.

Therefore, there may be differences in medical policy and technology assessment determinations depending on the member contract. Benefits and coverage determinations should be verified prior to providing services.

Technology Assessments

A technology assessment is a process in which current or new/emerging technologies are thoroughly researched, evaluated and formulated, as appropriate, into evidence-based CareFirst medical policy. Technologies include drugs, devices, procedures and techniques. CareFirst has adopted the criteria of the BlueCross and BlueShield Association Technology Evaluation Center (TEC) for use in determining a technology's appropriateness for coverage. These criteria, along with an explanation of how they are applied, can be found in the introduction of the Medical Policy Reference Manual under Definitions and Interpretive Guidelines.

Technology assessments are presented with supportive data to the CareFirst technology assessment committee (TAC) on a regular basis. TAC is comprised of members of the healthcare policy department, CareFirst medical directors and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether the technology is experimental/investigational) are made by consensus of the TAC. TAC determinations are effective on the first day of the month following the meeting.

Claims Adjudication Edits

Overview

Claim adjudication policies and associated edits are based on thorough reviews of a variety of sources including, but not limited to:

- CareFirst medical policy
- American Medical Association (AMA) guidelines
- CMS policies
- Professional specialty organizations (e.g., American College of Surgeons (ACS), American Academy of Orthopedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Member benefit contracts
- Provider contracts
- Current healthcare trends
- Medical and technological advances
- Specialty expert consultants

Clinical Editing Applications

Our policies and clinical rules are developed through a compilation of information from a variety of sources. The clinical rules we use are designed to verify the coding accuracy on professional and Facility claims. CareFirst utilizes several clinical editing applications as part of the overall editing process for claims. These applications ~~is~~ are updated on a monthly and quarterly basis and provides a means for our claims systems to recognize new and/or revised CPT and HCPCS codes, including any reclassifications of existing CPT codes. Providers are notified of key changes through BlueLink or newsflash updates at

carefirst.com/providernews. We recommend that providers regularly access and review these policy statements to keep current with changes and updates.

Use of CPT, HCPCS or ICD-10 codes represent nationally recognized and published clinical coding systems of definitions and clinical rationales. These codes are used in claims processing to fully communicate and accurately identify the services being rendered by the healthcare provider. Each is a Health Insurance Portability and Accountability Act compliant code set.

Claims are filed utilizing these reporting codes and are reviewed to determine eligibility for reimbursement. If services are determined by CareFirst to be incidental, mutually exclusive, integral to or included in other services rendered or part of a global allowance, they are not eligible for separate reimbursement. Participating providers may not balance bill members for these services.

Claims are adjudicated first based on member benefits and subsequently based on claim editing policies. Claims may also be manually reviewed throughout the adjudication process. If needed, our clinical staff will review all medical documentation from you and determine if further review from a medical director is necessary.

Examples of edits applied during claims processing:

General Edit	Description	Professional	Facility
Global period—PP CO 070.03 Global Surgical Period	Payments for services associated with a surgical procedure are included in a single payment for services that fall within the specified date range (global surgical package).	X	X
Payment/non-payment modifiers—PP CO 600.05 Modifier Policy	Identifies claim lines with invalid modifier to procedure code combination.	X	X
Age edit	The service reported was inappropriate for patient's age.	X	X
Age code replacement	Edits claims where the procedure code is not appropriate for the patient's age and is replaced with a more appropriate procedure code.	X	
Gender conflict	The service reported was inappropriate for patient's gender.	X	X
Gender code replacement	Edits claims where the procedure code is not appropriate for the	X	X

General Edit	Description	Professional	Facility
	patient's gender and is replaced with a more appropriate code.		
Frequency Validation	Edits claims when a procedure code contains terminology that does not warrant multiple submissions of that procedure code for a single date of service.	X	
Duplicate procedures/similar service	Edits based on the maximum times a procedure code can be performed per date of service. Represents the total number of times it is clinically possible or clinically reasonable to perform the procedure code.	X	X
Multi code re-bundling	Occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service performed.	X	
Incidental procedures	An incidental procedure is carried out at the same time as a more complex primary procedure and/or clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.	X	X
Integral/included in procedures	Procedures that are considered integral or included in occur in a variety of circumstances including, but not limited to, services that are part of an overall episode of care, or multiple surgery situations, when one or more procedures are	X	X

General Edit	Description	Professional	Facility
	considered to be an integral part of the major procedure or service.		
Mutually exclusive procedures	Mutually exclusive procedures include those that may differ in technique or approach but lead to the same outcome. Procedures that represent overlapping services are considered mutually exclusive. In addition, reporting an initial and subsequent service on the same day is considered mutually exclusive. Procedures reported together on the same anatomic site with terms such as open/closed, partial/total, unilateral/bilateral, simple/complex, single/multiple, limited/complete and superficial/deep usually result in mutually exclusive edits. In these instances, if both procedures accomplish the same result, the procedure with the higher relative value unit (RVU) will usually be eligible for reimbursement. The higher valued procedure is likely to be the more clinically intense procedure, but the RVU will determine which procedure/service is reimbursed.	X	X
Assistant surgeon—PP CO 070.02 Assistant Surgeons	Is a physician who actively assists the operating surgeon. An assistant may be necessary because of the complex nature of the procedure(s) or the patient's condition. The assistant surgeon is usually trained in the same specialty.	X	X

Assistant-at-surgery—PP CO 070.02 Assistant Surgeons	May be a physician assistant or nurse practitioner acting under the direct supervision of a physician, where the physician acts as the surgeon and the assistant-at-surgery as an assistant.	X	X
Co-surgeon—PP CO 070.01 Co-Surgeon and Term Surgery	Occurs when two surgeons, usually of different specialties, work together as a primary surgeon performing distinct part(s) of a procedure.	X	
Team Surgery—PP CO 070.01 Co-Surgeon and Team Surgery	Occurs when several (more than two) surgeons with different specialties are involved in highly complex procedures that require different skillsets.	X	
Cosmetic procedures	Operative procedures performed with the primary intent to improve appearance. Service or supply provided with the intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma or previous therapeutic intervention.	X	X
Experimental/investigational procedures	Services or supplies that are in the development stage and are in the process of human or animal testing. Services or supplies that do not meet all five of the criteria listed below adopted by the BlueCross BlueShield Association Technology Evaluation Center (TEC) are deemed to be experimental/investigational: ■ The technology* must have final approval from the appropriate government regulatory bodies; and ■ The scientific evidence must permit conclusions	X	X

	concerning the effect of the technology on health outcome; and ■ The technology must improve the net health outcomes; and ■ The technology must be beneficial as any established alternatives; and ■ The improvement must be attainable outside the investigational settings. *Technology includes drugs, devices, processes, systems or techniques. Refer to Medical Policy Reference Manual for more detail.		
Unlisted procedures	Services or procedures performed by physicians or other qualified healthcare professionals that are not found in CPT/HCPCS. Both CPT and HCPCS have specific numbers designated for unlisted procedures.	X	
Same day visit	Evaluation and Management (E/M) services which are rendered on the same date of service as a procedure that has a global period.	X	
Add-on codes without base—PP CO 090.01 NCCI Editing – Professional, DME Supplier and Facility	Procedures designated as add-on (or listed separately in addition to the codes for the primary procedure for CPT) are only reported in addition to the specific code for the primary (or parent) procedure.	X	X
Obstetrics package—Payment Policy PP CO 080.01 Global Obstetrical Care Services	Includes antepartum care, delivery services and postpartum care. Claim lines are evaluated to determine if the antepartum care, delivery services and postpartum	X	

	care are reported during the average length of time of a typical pregnancy, which is between 280-322 days.		
Female/male only diagnosis(es)	Identifies diagnoses that are inconsistent with the patient's gender.	X	X
Frequency x-walk	Evaluates procedure codes with "single" or "unilateral" in the description that have been submitted more than once per date of service and recommends replacement for all occurrences of single/unilateral with appropriate multiple or bilateral code.	X	
Diagnosis age valid	Identifies diagnoses that are inconsistent with the member's age.	X	X
New patient	A new patient is one who has not received services from the same physician or group in the same specialty in the past three years. An established patient E/M visit must be reported if the patient is seen, for any reason, by the same physician or member of the group, within a three-year timeframe. This also applies to physicians who are on-call for or covering for another physician. In this case, the patient's E/M service is classified as it would be for the physician who is not available. The covering physician should report the appropriate level E/M service according to the three-year timeframe as described above. If a new patient E/M is reported more than once by the same provider/group within the three-year timeframe, the code will	X	

	automatically be replaced with the appropriate established E/M code.		
Lifetime event	This rule identifies claim lines that contain a procedure code that has been submitted more than once or twice across dates of service because it has been identified as a procedure that can only be performed once or twice in a lifetime, for the same member. Once audited for the maximum number of times the procedure can be performed, any additional submissions of the procedure are then not recommended for reimbursement.	X	
Medically unlikely edits – PP CO 090.01 NCCI Editing – Professional, DME Supplier and Facility	A medically unlikely edit is defined as the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.	X	X
Pay percent multiple radiology – PP CO 400.02	Recommends an adjustment in the pay percent when multiple diagnostic imaging services within the same radiology family are submitted on the same date for certain radiology procedures. In addition, it also identifies claim lines with certain procedures that are subject to payment reduction when computed tomography (CT) equipment does not meet the National Electrical Manufacturers Association Standard XR-29-2013 and are required to be submitted with modifier CT. The CT reduction would then be applied on top of any other reduction over and above other reductions.	X	

Pay percent multiple cardiology – PP CO 400.03 / 400.10	Recommends an adjustment in the pay percent when multiple cardiology procedures are submitted on the same date for certain procedures. These procedures are defined on CMS Medicare Physician Fee Schedule Database (MPFSDB), with a value of 6.	X	X
Pay percent multiple ophthalmology – PP CO 400.04 / 400.09	Recommends an adjustment in the pay percent when multiple ophthalmology procedures are submitted on the same date or service for certain procedures. These procedures are defined on CMS MPFSDB, with a value of 7.	X	X
Pay percent professional therapy – PP CO 400.01	Recommends an adjustment in the pay percent when multiple therapy procedures are submitted on the same date of service for certain procedures. When multiple therapy procedures are rendered in an office or non-institutional setting, these procedures are defined on CMS MPFSDB, with a value of 5.	X	

Requests for Clinical Information

In order to accurately adjudicate claims and administer member benefits, it is sometimes necessary to request medical records. The following is a list of some of the claims categories from which CareFirst may routinely require submission of clinical information, either before a service has been rendered, or before or after adjudication of a claim. Some of these specific modifiers are discussed in more detail throughout this manual. These categories include:

- Procedures or services that require prior authorization.
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies.
- Procedures or services that are or may be considered experimental/investigational.
- Claims involving review of medical records.
- Claims involving pre-existing condition issues.
- Procedures or services related to case management or coordination of care.

- Procedures or services reported with unlisted, not otherwise classified or miscellaneous codes.
- Procedures or services reported with CPT Modifiers 22, 62, 66 and 78.
- Quality of care and/or quality improvement activities (e.g., data collection as required by accrediting agencies, such as National Committee of Quality Assurance/Healthcare Effectiveness Data and Information Set®/Quality Rating System).
- Claims involving coordination of benefits.
- Claims being appealed.
- Claims being investigated for fraud and abuse or potential inappropriate billing practices.
- Claims that are being investigated for fraud or potential misinformation provided by a member during the application process.

This list is not intended to limit the ability of CareFirst to request clinical records. There may be additional individual circumstances when these records may be requested. By contract, these records are to be provided without charge.

Place of Service Code Assignments

Information about Place of Service Code Assignments can be found by going to carefirst.com/providerguides. Select "See More" on the medical accordion. Click the Place of Service Code Assignments PDF.

Basic Claim Adjudication Policy Concepts

The following represent key coding methodologies, claims adjudication policies and reimbursement guidelines.

Note: These claim adjudication and associated reimbursement policies are applicable to local CareFirst lines of business. Adjudication edits/policies may differ for claims processed on the national processing system (NASCO) depending on the account's home plan and FEP.

Unbundled Procedures

Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service provided. Unbundled services are not separately reimbursed. If the more comprehensive code is not included on the claim, the unbundled services will be re-bundled into the comprehensive code; if it is a covered benefit, the more comprehensive service will be eligible for reimbursement. Always report the most comprehensive code(s) available to describe the services provided.

Incidental Procedures

An incidental procedure is carried out at the same time as a more complex primary procedure and/or is clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.

Integral/Included in Procedures

Procedures that are considered integral or included in occur in a variety of circumstances including, but not limited to, services that are a part of an overall episode of care, or multiple surgery situations, when one or more procedures are considered to be an integral part of the major procedure or service. Separate procedures should not be reported when they are carried out as an integral component of a total service or procedure. Integral or included in procedures are not eligible for reimbursement.

Providers should refer to CPT guidelines for reporting separate procedures when they are not a component of a total service. CPT Modifier-59 should be appended to the separate procedure code to indicate that it is a distinct, independent procedure and not related to the primary procedure.

Mutually Exclusive Procedures

Mutually exclusive procedures include those that may differ in technique or approach but lead to the same outcome. In some circumstances, the combination of procedures may be anatomically impossible.

Procedures that represent overlapping services are considered mutually exclusive. In addition, reporting an initial and subsequent service on the same day is considered mutually exclusive. Procedures reported together on the same anatomic site with terms such as open/closed, partial/total, unilateral/bilateral, simple/complex, single/multiple, limited/complete and superficial/deep usually result in mutually exclusive edits. In these instances, if both procedures accomplish the same result, the procedure with the higher RVU will usually be eligible for reimbursement. The higher valued procedure is likely to be the more clinically intense procedure, but the RVU will determine which procedure/service is reimbursed.

Global Allowances

Reimbursement for certain services is based on a global allowance. Services considered to be directly included in a global allowance are considered integral to that allowance and are not eligible for separate reimbursement.

Duplicate Services and Multiple Reviews

Paying more than one provider for the same procedure or service represents duplicate procedure reimbursement. This includes, but is not limited to, multiple interpretations or reviews of diagnostic tests such as laboratory, radiology, and electrocardiographic tests reported with CPT Modifier-26 (professional component) or -59 (distinct procedural service).

CareFirst will reimburse only once for a service or procedure. Duplicate procedures, services and reviews, whether reported on the same or different claims, are not eligible for reimbursement.

The following criteria may be used to determine duplicate services across claims: Subscriber ID, Dependent ID, Date of Service, Procedure Code, Modifiers, Units, Claim Type, Provider ID, Tax ID, Specialty, Different Claim IDs, Revenue Codes, Charge Amount and/or Bill Type.

Unlisted Procedures

In the Federal Register, CMS establishes and publishes RVUs for most CPT and some HCPCS Level II codes. RVUs are a weighted score used to determine the fee scales for procedures and services performed by professional providers. These RVUs are used to determine allowances for reimbursement. CMS, however, does not assign RVUs to all procedure codes. Some codes are unlisted (no specific definition) and no RVU is assigned. Therefore, the unlisted code has no established allowance.

Unlisted CPT and HCPCS codes should only be reported when there is not an established code to describe the service or procedure provided.

Submissions of claims containing an unlisted code are reviewed by our Medical Review Department. A reimbursement allowance is established based on this review using a variety of factors including, but not

limited to, evaluating comparable procedures with an established RVU. To be considered for reimbursement, an unlisted CPT or HCPCS code must be submitted with a complete description of the service or procedure provided. Any applicable records or reports must be submitted with the claim.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with unlisted codes.

All modifiers will be considered invalid with unlisted codes. Do not report modifiers with any unlisted procedure codes.

Fragmented Billing

Reporting services provided on the same date of service on multiple CMS 1500 claim submissions is considered fragmented billing. This practice may lead to incorrect reimbursement of services, including delays in claims processing or retractions of overpaid claims. Historical claims auditing is performed to ensure that all services or procedures performed on the same date are edited together. Therefore, services or procedures performed by a provider on the same date must be reported together on the same claim whether submitted electronically or on a paper form.

Modifier Reimbursement Guidelines

Refer to Payment Policy PP CO 600.05 Modifier Policy and Payment Policy PP CO 600.04 Professional, Technical and Global Services.

Submissions of claims containing the following CPT modifiers are reviewed by our Medical Review Department and should be submitted with the pertinent medical records (i.e., complete operative record, office notes, etc.) in order to be appropriately and expeditiously adjudicated. Documentation should clearly support the intent of the modifier and demonstrate the reason for its submission.

- CPT Modifier-22: Not valid with E/M codes. Pertinent medical records that clearly demonstrate the reason that the procedure/service requires “substantial additional work” compared with that of the reported procedure must accompany the claim. This modifier should be reported only when the work performed is clearly out of the ordinary for the particular procedure. While not required, it is often helpful for the provider to attach a separate letter to the medical records that outlines why the procedure or service was particularly unusual.
- CPT Modifier-62: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed distinct and separate parts of a procedure must be available if requested. Each surgeon submits a separate claim for the operative session. CPT Modifier-62 should be appended only to procedures performed by the two surgeons. Do not use in lieu of CPT Modifier-66 or CPT Modifiers-80, -81, -82 or HCPCS Modifier-AS.
- CPT Modifier-66: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed components of a procedure in a team fashion must accompany the claim.
- CPT Modifier-78: Only valid with surgery procedure codes. Operative records that clearly demonstrate a related procedure had to be carried out during the post-operative period must accompany the claim.

Global Surgical, Anesthesia and Maternity Reimbursement Guidelines

Surgical procedures described in CPT (see CPT surgical package definition in the CPT manual) usually include, at a minimum, the following components, in addition to the surgery itself:

- Local infiltration, select blocks or topical anesthesia
- After the decision for surgery is made, one E/M visit on the day before or on the day of surgery (including history and physical exam)
- The surgical procedure/intraoperative care
- Immediate post-operative care
- Interacting with the patient's significant other and other care providers
- Writing post-operative orders
- Assessing the patient in the post-anesthesia care area
- Usual post-operative follow-up care

Separate benefits are provided for moderate (conscious) sedation whether rendered by the physician performing the diagnostic or therapeutic service the sedation supports or by another physician. Moderate sedation codes are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation or monitored anesthesia care. Refer to medical policy operating procedures 9.01.001A, 9.01.003A, 9.01.004A, 9.01.007A in our Medical Policy Reference Manual.

Combining the above services and reporting them under a single fee as a surgical package, is referred to as global billing. In the event that only a component of the surgical package is provided, follow CPT guidelines for reporting the following split care CPT Modifiers-54, -55 and -56.

Depending on the nature of the procedure, member or provider contract or specific policies, certain services may include additional components in the global allowance, such as for maternity or anesthesia services. Examples of services that are reimbursed with a global allowance can be found in the following references:

- Maternity services that are and are not included in the global allowance.
  - Refer to global maternity services, 4.01.006A in our Medical Policy Reference Manual.
- Surgical services and related global periods.
  - Refer to global surgical procedure rules, 10.01.009A in our Medical Policy Reference Manual.
  - Refer to Payment Policy PP CO 070.03 Global Surgical Period in our Payment Policy Database.
- Anesthesia services that are/are not included in the global anesthesia allowance.
  - Refer to anesthesia services, 9.01.001A in our Medical Policy Reference Manual.
- Procedures containing the term "one or more sessions" in the description.
  - When reporting services where the procedure code indicates "one or more sessions," the CPT code should be reported only one time for the entire defined treatment period, regardless of the number of sessions necessary to complete the treatment. While the defined treatment

period is determined by the physician and varies depending on the patient, diagnosis and often the location of treatment, these services may be reported only once during the global post-operative period assigned to the specific code.

- Refer to Payment Policy PP CO 600.05 Modifiers Policy for additional guidelines.

- Refer to Payment Policy PP CO 050.01 Bilateral Procedures for additional information on Bilateral Procedures Reimbursement and Policy Guidelines.

Multiple Surgical and Diagnostic Procedures Reimbursement Guidelines

General Guidelines

Multiple surgical and select diagnostic procedures (including endoscopic and colonoscopy procedures) are edited to ensure appropriate reimbursement for the benefit.

Covered procedures performed during the same operative session, through only one route of access and/or on the same body system and that are clinically integral to the primary procedure, are usually considered incidental, integral to/included in or mutually exclusive to the primary procedure. The primary procedure is reimbursed at 100% of the allowed benefit. Incidental, integral to/included in or mutually exclusive procedures are not eligible for reimbursement.

Covered procedures performed during the same operative session that are not clinically integral to the primary procedure (i.e., those performed at different sites or through separate incisions) are usually eligible for separate reimbursement. The most clinically intense procedure is reimbursed at 100% of the allowed benefit and the second and subsequent procedure(s) at 50% of the allowed benefit.

Multiple procedures not considered to be integral to the primary procedure should be reported with the CPT Modifer-51 appended to the second and subsequent procedure codes.

Some surgical, diagnostic or therapeutic procedures may appear to be integral to, included in, mutually exclusive or duplicates of other procedures performed during the same encounter or session by the same provider. In order to distinguish these procedures as distinctly different (i.e., different operative site or procedure, separate incision, etc.), CPT Modifier-59 should be appended to these select procedures. Follow CPT guidelines for reporting CPT Modifier-59.

As one factor in determining a fee schedule allowance, CareFirst typically uses the fully implemented non-facility total RVU (as published annually in the CMS national physician fee schedule) for all places of service. In addition to including the provider work and malpractice factor, this RVU also includes a robust PE component. The use of this RVU is particularly significant when multiple procedures are performed during the same session by the same provider, as its value determines the ranking of these procedures (i.e., what is considered the primary procedure, and how any subsequent/secondary procedures are ranked.)

CareFirst utilizes the transitioned non-facility total RVU (Column P in the link below) as published by CMS.

For additional information on this methodology, visit the CMS website to view the Physician Fee Schedule.

Note: Effective with claims processed on and after January 1, 2013, CareFirst will utilize the non-facility total RVU (Column L) now that the transition period has been completed.

Multiple Endoscopic Procedures Through the Same Scope

When an endoscopic procedure is considered to be a component of a more comprehensive endoscopic procedure, the more clinically comprehensive procedure is usually eligible for reimbursement.

Multiple Endoscopic and Open Surgical Procedures

Endoscopic and open surgical procedures performed in the same anatomic area are not usually eligible for separate reimbursement. If an open surgical procedure and an endoscopic procedure accomplish the same result, the more clinically intense procedure is usually reimbursed. The comparable procedure is considered mutually exclusive and is not eligible for reimbursement.

If a number of endoscopic-assisted, open surgical procedures are performed on the same anatomic area during the same operative session, these procedures are usually eligible for separate reimbursement based on the additional time, skill and physician resources required when two approaches are used for a surgical procedure.

Serial Surgery Reimbursement Guidelines

Separate or additional reimbursement is not made each time a procedure is performed in stages or for procedures identified as “one or more sessions” in the code definition. Global surgical rules apply.

General and Specialty Related Claim Adjudication Policies and Reimbursement Guidelines

Consultations

Consultation services should be reported using the appropriate consultation E/M codes (office/outpatient, inpatient) according to CPT reporting guidelines and as follows:

- Consultation services are reimbursed according to the terms of the member’s benefit contract and applicable claims adjudication policies. A consultation occurs when the attending physician or other appropriate source asks for the advice or opinion of another physician for the evaluation and/or management of the patient’s specific problem. The need for a consultation must meet medical necessity criteria and be documented in the referring physician’s medical record.
- A physician consultant may initiate diagnostic and/or therapeutic services as part of or during the consultation process. The request for a consultation from the attending physician or other appropriate source and the reason for the consultation must be documented in the patient’s medical record. The consultant’s opinion/recommendation and any services that were ordered or performed must also be documented in the medical record and communicated to the requesting provider.
- If the attending physician requests a second or follow-up office or outpatient consultation, an office/outpatient consultation E/M visit may be reported a second time, as there is no follow-up consultation code for this setting.
- A consultation initiated by the patient and/or family and not requested by a physician should not be reported using consultation codes. Report these services using the setting specific non-consultation E/M codes, as appropriate.

- Office or other outpatient consultation services billed in the office setting when any other evaluation and management service has been billed in any place of service in the previous year are not eligible for reimbursement.

A consultation code is not eligible for reimbursement when an attending physician requests that the second (consulting) physician take over care of the patient. If the attending physician decides to transfer care of the patient to the consultant after the consultation, the consultant may not continue to report a consultation visit. The consultant should report the appropriate non-consultation E/M codes. (See CPT E/M services guidelines.)

Concurrent Care

Reimbursement may be made for multiple providers caring for a patient during an episode of care, according to the terms of the member's benefit contract and applicable claims adjudication policies. This includes providers of multiple specialties caring for a patient in an inpatient setting on the same date of service. The need for multiple provider participation in the patient's care must meet medical necessity criteria and be documented in the medical record (see also consultations above and CPT E/M services guidelines regarding concurrent care and transfer of care).

Standby Services

Standby services are not eligible for reimbursement (see medical policy operating procedure, 10.01.004A, Standby Services), except for attendance at delivery when requested by the obstetrician (10.01.002A, Attendance at Delivery). Refer to the Medical Policy Reference Manual for both policies.

Evaluation and Management (E/M) services

Benefits are available for E/M services according to the terms of the member's benefit contract and applicable claims adjudication policies. Incidental, integral to/included in, mutually exclusive and global services editing policies apply to all E/M services.

E/M services are reported for the appropriate level of service in accordance with CPT guidelines and must be supported in the medical record according to the CareFirst Medical Record Documentation Standards, located in Operating Procedure 10.01.013A, in our Medical Policy Reference Manual. Additional information concerning E/M services can be found in PP CO 010.01 Place of Service Codes for Evaluation & Management Services - Professional and PP CO 014.01 Evaluation and Management Services.

New Patient Visit Frequency

According to CPT guidelines, a new patient is one who has not had services from the same physician or group in the same specialty in the past three years. An established patient E/M visit must be reported if the patient is seen, for any reason, by the same physician or member of the group, within the three-year timeframe. This also applies to physicians who are on-call for or covering for another physician. In this case, the patient's E/M service is classified as it would be for the physician who is not available. The covering physician should report the appropriate level E/M service according to the three-year timeframe as described above. Refer to CPT reporting guidelines for further instructions.

If a new patient E/M code is reported more than once by the same provider/group within the three-year timeframe, the code will automatically be replaced with a corresponding established E/M code.

Preventive Services

Preventive services, also known as health maintenance exams, include preventive physical examinations, related X-ray, laboratory or other diagnostic tests, and risk factor reduction counseling. Most CareFirst member contracts include a benefit for these preventive examinations, many of which are limited to once

per benefit year/annually. Preventive services (CPT 99381-99397) should only be reported when providing the complete health maintenance exam and related tests and immunizations. Routine, age-specific immunizations are reported separately (see Reimbursement for Injectables, Vaccines and Administration later on in this chapter). Providers must report the appropriate E/M codes (i.e., CPT 99201-99215) for other encounters such as preoperative or pre-diagnostic procedure evaluations.

For additional information, refer to the CareFirst Preventive Services Guidelines.

Preventive Services Under the ACA

As part of the ACA, certain preventive services for children and adults must be covered at no cost to the member when using in-network providers.

As a reminder, providers should use the proper diagnosis screening code and CPT code in order to be reimbursed.

Multiple E/M Services on the Same Date

Multiple E/M services reported by the same provider on the same date of service are usually considered mutually exclusive. The most clinically intense service is usually reimbursed.

There are times that a patient may be present for a health maintenance/preventive medicine service visit and a condition or symptom is identified that requires significant additional effort to address and treat. If the treatment of the condition or symptom requires the performance of the key components of a problem-oriented service, then the appropriate level E/M code may need to be reported in addition to the preventive care visit code. CPT Modifier-25 must be appended to the E/M code to indicate that a significant separately identifiable E/M service was provided in addition to the preventive service.

CareFirst considers significant additional effort as encompassing all of the following:

- Additional time is required to diagnose and treat the presenting problem; and
- The physician develops and initiates a treatment program for the identified condition by the end of the office visit.

If a physician monitors a chronic condition (e.g., hypertension, diabetes) at the time of the preventive medicine visit and the condition does not require a significant change in the plan of care, then CareFirst considers this monitoring to be part of the comprehensive system review and assessment. Likewise, if a patient requires problem-focused care (e.g., for a sore throat or viral illness) or needs to be referred to a specialist, this is considered to be included in preventive medicine evaluation and management and is not considered significant additional effort. In both these instances it would not be appropriate to report an E/M service in addition to the preventive visit.

Counseling Services

Follow CPT guidelines when reporting preventive counseling services (i.e., CPT codes 99401-99429). Since these guidelines indicate that these codes are used for persons without a specific illness, it is inappropriate to report these codes for services such as preoperative counseling.

Care Plan Oversight

CareFirst provides a benefit for care plan oversight services (CPT codes 99374-99380) for one physician who provides a supervisory role in the care of a member receiving complex case or disease management services. These services are reported in accordance with CPT guidelines and may be reported in addition to direct patient care E/M services as appropriate.

Advance Planning

CareFirst provides a benefit for advance care planning (CPT 99497, 99498). These codes are used to report the face-to-face service between a physician or other qualified healthcare professional and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. Refer to CPT guidelines for reporting CPT 99497 and 99498 separately if performed on the same day as another E/M service.

Chronic Care Coordination Services

CareFirst provides a benefit for complex chronic care coordination services (CPT 99487–99490). These services are reported in accordance with CPT guidelines (e.g., time spent per calendar month, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT code book. Attention should be given to the services that may not be separately reported during the month for which chronic care coordination services are reported, also as outlined in the CPT code book.

E/M Services in Conjunction with Immunizations

If immunization(s) and administration of the drug(s) are reported together, both are eligible for separate reimbursement. If a significant, separately identifiable E&M Service is rendered at the time of the immunization/injection, CPT Modifier-25 should be appended to the E&M code for reimbursement.

Prolonged Services

Prolonged physician service codes (CPT codes 99354-99359) may be reported when there is patient contact beyond the usual E/M service in either the inpatient or outpatient setting.

Several of these are add-on codes and must be reported in addition to other E/M codes. They are not valid when reported with any other procedure or service. See CPT guidelines when reporting CPT 99358-99359 as these may be reported on a different date from the E/M visit under certain circumstances.

Prolonged service codes are not eligible for reimbursement in combination with the following:

- Emergency services (CPT 99281-99288)
- Observation services (CPT 99217-99220)
- Observation or inpatient services (CPT 99234-99236)
- Critical care services (CPT 99291-99292)

Prolonged services are not eligible for reimbursement for time spent by a non-physician incidental to the physician's service (e.g., office staff discussing dietary concerns with a patient).

Follow CPT reporting guidelines when reporting prolonged services, including base codes with which they may be reported. Because these are time-based codes, documentation in the medical record must clearly reflect exact times spent on base and prolonged services in order to verify appropriate use of these codes.

Intensity of Service Auditing

CareFirst will not automatically reassign or reduce the code level of E/M codes for covered services, except in the case of replacing a new patient visit code with an established patient visit code, in accordance with CPT guidelines. We will evaluate and reduce or reassign code levels if it is determined through review of clinical information that the reported code(s) is not reflective of the service rendered.

Billing for Services Rendered to Patients

Except for very limited circumstances (e.g., physician assistants or registered nurses administering injections), providers may only report and submit claims for services rendered to patients that the practitioner individually and personally provides. CareFirst contracts with participating providers to perform services for an agreed upon fee. It is that provider, and only that provider, who can submit a claim and receive reimbursement.

As outlined in the CareFirst medical record documentation standards policy, 10.01.013A, in the Medical Policy Reference Manual, participating providers must accurately and completely document the medically necessary services they perform in the appropriate medical record and sign the document(s) attesting that they performed the service.

Attending physicians and other qualified healthcare professionals who supervise and teach residents or students are allowed to submit claims for those services the resident or student in training provides, only if the supervising provider also interacts with the patient/family, examines the patient (if applicable) and personally documents their patient encounter in the medical record. Services rendered by residents, associates, graduate students or others in training (in any discipline, specialty or occupation) are not eligible for reimbursement unless these requirements are met.

Reporting Medication Administration

In all instances, providers should only report the actual services provided to the patient, including medications administered in any setting. CareFirst will only reimburse providers for the amount of the medication administered. Providers should schedule patients to minimize any waste and utilize medications efficiently. If a specific dose of medication is drawn from a multi-dose vial, only the amount of medication administered to the patient is to be reported—not the total amount of the drug in the vial.

Reimbursement for Injectables, Vaccines and Administration

Covered vaccines and injectables are reimbursed and administered according to an established fee schedule. Newly recommended vaccines are eligible for reimbursement as of the effective date of a recommendation made by any of the following:

- The U.S. Preventive Services Task Force
- The American Academy of Pediatrics
- The Advisory Committee on Immunization Practices

Benefits for vaccinations and immunizations are contractually determined. Providers should ensure that benefits are available prior to rendering these services.

Additional information is available in the Medical Policy Reference Manual and the CareFirst Preventive Services Guidelines.

For information regarding procurement of office administered medications, refer to the Medication section of this manual.

The D.C. Minor Consent for Vaccinations Amendment Act of 2020

CareFirst has implemented the D.C. Minor Consent for Vaccinations Amendment Act of 2020 (the Act). This legislation allows minors, 11 years of age or older, to receive a vaccine, if the minor is capable of meeting the informed consent standard and the vaccination is recommended by the United States Advisory Committee on Immunization Practices (ACIP) and provided in accordance with the United States Advisory Committee on Immunization Practices' recommended vaccinations schedule.

The Act applies to all age-appropriate vaccines including COVID-19. Vaccine(s) given under the Act must be administered in Washington, D.C.

Providers are not required to administer vaccines to minors without parental consent. However, should the elect to do so, the Act requires that providers notify CareFirst as well as seek reimbursement directly from the insurer for vaccinations given without parental consent, pursuant to the Act.

To support the Act, CareFirst developed the following process so we can suppress the EOB statement normally sent to the parent/guardian.

To ensure proper reimbursement and suppression of the corresponding EOB for vaccines administered under this Act, providers must complete both the D.C. Minor Consent Notification Form and the appropriate paper claim form.

Note: Claims for vaccines administered under this Act should not be sent electronically and must be sent on one of the paper forms below:

- Professional claims – please use the current version of the CMS-1500 form (version 02/12) on original red-ink-on-white-paper.
- Institutional claims – please use the current version of the UB-04 form on original red-in-on-white-paper.

Providers must submit both the completed notification form and correct paper claim form by mail to the following address:

CareFirst BlueCross BlueShield
Privacy Office
P.O. Box 14858
Lexington, KY 40512

Please note: Providers must follow this process exactly as outlined or CareFirst will not be able to suppress the EOB.

Refer to the Frequently Asked Questions and instructions for the paper claim form process for more information.

Collecting Copayments/Coinsurance During Global Surgical Periods

- If an E/M service/visit is allowed, regardless if rendered before, during or after a global surgical period, a claim should be submitted, and the applicable copayment or coinsurance may be collected.
- If an E/M service/visit is disallowed and/or bundled into the global surgical allowance, a claim should not be submitted, and a copayment or coinsurance may not be collected

It is not appropriate to collect a copayment/coinsurance from a member and not submit a claim for a service/visit. See also medical policy operating procedure 10.01.009A, Global Surgical Care Rules, in the Medical Policy Reference Manual.

Special Services

Services rendered during off-hours, on weekends, on holidays, on an emergency basis and for hospital mandated on call (CPT 99026-99060) are considered incidental or mutually exclusive to other services. Incidental and mutually exclusive services are not eligible for reimbursement.

Exception

CPT 99050 and 99051 are eligible for separate reimbursement for after-hours service or service on holidays, when required by law. After-hours service is defined as medical office services rendered in the office after 6 p.m. and before 8 a.m. weekdays, weekends, and national holidays.

Do **NOT** use CPT code 99050 or 99051 if the patient has an appointment during business hours but is not seen until later because the office is behind. These codes must be reported in addition to an associated basic service(s) (e.g., Evaluation and Management, Psychotherapy) and are not reimbursable as stand-alone procedures.

Additionally, if the associated basic service(s) is denied, no additional reimbursement is made for the adjunct services. CPT 99050 and 99051 are not eligible for separate reimbursement for services rendered at an urgent care center or by a specialist.

Cerumen Removal

Removal impacted cerumen (ear wax) using irrigation/lavage unilateral, CPT code 69209 (effective January 1, 2016), has been established to report the removal of impacted cerumen by irrigation and/or lavage. Several exclusionary and instructional notes were added to the CPT guidelines to ensure appropriate reporting of CPT codes 69209 and 69210 are unilateral.

A new code was warranted to differentiate between direct and indirect approaches of removing impacted cerumen performed or supervised by physicians or other qualified healthcare professionals. Impacted cerumen is typically extremely hard and dry and accompanied by pain and itching and can lead to hearing loss. CPT 69210 only captures the direct method of earwax removal utilizing instrumentation such as curettes, hooks, forceps and suction.

Another less invasive method uses a continuous low pressure flow of liquid (i.e., saline water) to gently loosen impacted cerumen and flush it out with or without the use of a cerumen softening agent (i.e., cerumenolytic) that may be administered days prior to the procedure or at the time of the procedure. CPT 69209 enables the irrigation or lavage method of impacted cerumen removal to be separately reported and not mistakenly reported with CPT 69210.

CPT codes 69209 and 69210 should not be reported together when both services are provided on the same day on the same ear. Only one code (CPT 69209 or 69210) may be reported for the primary service (most intensive time or skilled procedure) provided on that day on the same ear. Two instructional parenthetical notes have been added following CPT 69209 and 69210 to exclude them from being reported together. If either one of the cerumen removal procedures is done on both ears, Modifier-50 should be appended as indicated in the new parenthetical note added following CPT codes 69209 and 69210. The E/M codes should be reported when non-impacted cerumen is removed according to the section category defined by the site of service (e.g., office or other outpatient, hospital care, nursing facility services) as instructed in the parenthetical notes following CPT 69209 and 69210.

Handling and Conveyance

Handling and conveyance (CPT 99000–99002) are considered integral to most procedures and services including, but not limited to E/M, surgery and surgical pathology. Integral services are not eligible for reimbursement.

Hot and Cold Packs

Hot and cold packs (CPT 97010) are considered incidental or mutually exclusive to most services, including but not limited to chiropractic manipulation, therapeutic exercise, therapeutic activity, manual therapy, massage and whirlpool therapy. Incidental or mutually exclusive services are not eligible for reimbursement.

Supervision, Interpretation and/or Guidance for Diagnostic Tests

Interpretation of diagnostic studies, including but not limited to, laboratory, radiology, and electrocardiographic tests are considered incidental or integral to all E/M services and other services that include evaluation components. Incidental or integral services are not eligible for reimbursement.

Specialty physicians (e.g., radiologists, cardiologists, pathologists) that perform the final interpretation and separate, distinctly identifiable, signed, written report (per CPT guidelines) of a diagnostic service may be eligible to receive reimbursement when the procedure is reported with CPT Modifier-26. Refer to Payment Policy PP CO 600.04 Professional, Technical and Global Services.

CPT codes reported for supervision and interpretation and radiologic guidance (e.g., fluoroscopic, ultrasound or mammographic) are eligible for reimbursement to the extent that the associated procedure code is recognized and eligible for reimbursement, and provided that the associated procedure code does not include supervision and interpretation or radiologic guidance services. For each procedure (e.g., review of x-ray or biopsy analysis or ultrasound guidance), only one qualified provider/healthcare professional shall be reimbursed.

Reimbursing more than one provider for the same service represents duplicate procedure payment. Duplicate services are not eligible for reimbursement. (See also “Duplicate services and multiple reviews” listed earlier in this chapter.)

Introduction of Intravenous Needles/Catheters

Introduction of a catheter/needle (CPT 36000) is considered incidental to all anesthesia services, select radiology procedures, critical care E/M services and all procedures that typically require the patient to have a peripheral IV line. Incidental procedures are not eligible for reimbursement.

Hydration, Infusions and Injections

Follow CPT guidelines when reporting hydration, injection and infusion services alone or in conjunction with other infusion/injection procedures and/or chemotherapy. Because a number of factors determine correct code assignment (e.g., reason for encounter, indications for additional procedures, sequencing of initial, subsequent and concurrent procedures, inclusive services and time) it is imperative the medical record documentation be accurate and clearly identify all of these pertinent issues to ensure reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of infusion/injection procedures. Incidental procedures are not eligible for separate reimbursement.

Routine injections (CPT 96372) are usually eligible for separate reimbursement when reported with office E/M services. If a physician is not present, they should report (exception CPT 99211. Follow CPT guidelines when reporting injection procedures. Injections are considered incidental when reported with services such as anesthesia, emergency and inpatient E/M, surgery, select radiology and select therapeutic and diagnostic procedures. Incidental procedures are not eligible for reimbursement.

Hydration, infusion and injection procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those facilities. It is not appropriate, therefore, for the professional provider to report those services unless that provider personally performs the service.

Pulse Oximetry

Non-invasive pulse oximetry determinations (CPT 94760–94762) are considered incidental when reported with E/M services, anesthesia and other procedures. Incidental procedures are not eligible for reimbursement. These codes are only eligible for reimbursement when they are reported as stand-alone procedures (i.e., when no other services are provided to the patient on the same date).

When appropriate, a distinct services modifier can be listed with the services to allow consideration for reimbursement.

Vital Capacity Measurements

This procedure (CPT 94150) is considered incidental to all other procedures. Incidental procedures are not eligible for reimbursement. This code is only eligible for reimbursement when it is reported as a stand-alone procedure (i.e., when no other services are provided to the patient on the same date).

Miscellaneous Services

The following are considered incidental to all services:

- Educational supplies (CPT 99071)
- Medical testimony (CPT 99075)
- Physician educational services (CPT 99078)
- Special reports (CPT 99080)
- Unusual travel (CPT 99082)
- Telephone calls (CPT 99441–99443)
- Collection/interpretation/analysis of data stored in computers (CPT 99090–99091)

CareFirst member contracts do not provide benefits for these services, and these services are not eligible for reimbursement.

Venipuncture

Venipuncture procedures (CPT 36400–36410) which require a physician's skill are eligible for separate reimbursement when reported with laboratory tests from the CPT 8xxxx series. Please note these procedures are not to be used for routine venipuncture. In addition, separate procedure rules apply.

Routine venipuncture procedures (CPT 36415) are considered incidental to all laboratory services. Incidental procedures are not eligible for reimbursement. If billed with an office visit, venipuncture procedures may be eligible for separate reimbursement.

If a routine venipuncture (as noted above) laboratory test from the CPT 8xxxx series and an E/M service are reported on the same claim, same date of service and from the same provider, the venipuncture will be considered incidental to the laboratory test.

Medical/Clinical Photography

Photographs taken for any purpose are considered the same as medical documentation for a patient. As with written or typed documentation, photography, regardless of the individual performing the photography, is considered to be an integral part of any service, procedure or episode of care. Integral services are not eligible for separate reimbursement.

Emergency Medicine

Emergency medicine E/M services (CPT 99281-99285) are provided in a hospital-based emergency department (see CPT reporting guidelines).

Many procedures are performed on patients during the emergency care encounter and are provided by personnel employed by the hospital (e.g., nurses, respiratory therapists, phlebotomists, technicians). Procedures performed by hospital personnel are included in the facility charge and should not be reported on the professional claim unless personally provided by the emergency physician or other qualified provider.

Services personally rendered by other physicians (consultants) are reported separately by those providers.

Procedures including, but not limited to the following, are considered incidental or mutually exclusive to emergency medicine E/M services:

- Inhalation treatment (CPT 94640)
- Ventilation management (CPT 94002–94004)
- Ear or pulse oximetry (CPT 94760–94762)
- Sedation (see operating procedure 9.01.003A in the Medical Policy Reference Manual)
- Physician direction of Emergency Medical Systems (EMS) (CPT 99288)
- Interpretation of diagnostic studies

Certain procedures when personally performed by the emergency physician are usually eligible for separate reimbursement and include:

- Wound repair (CPT 12001-14350)*
- Endotracheal intubation (CPT31500)
- Insertion of central venous catheter (CPT 36555-36571)*

*Global surgical rules apply. This means that E/M services are not eligible for separate reimbursement when provided with procedures for which the E/M is considered part of the surgical package. CPT Modifier-25 may be required if there is a significant, separately identifiable E/M service provided on the same date as certain procedures (see PP CO 070.03 Global Surgical Period). Emergency physicians who perform surgical procedures should report these with CPT Modifier-54, as appropriate, since they typically provide the surgical component, not the pre-or post-operative component of the surgical package.

Physician direction of EMS (CPT 99288) when reported alone is not eligible for reimbursement.

Hearing Aids

Hearing aid benefits are defined by the member's contract. When reporting these services to CareFirst, follow the guidelines below:

- The description of the CPT/HCPCS procedure code specifies Monaural/Binaural and is eligible for reimbursement only once on a single date of service.
- Because these codes indicate Monaural/Binaural in the description, it is not appropriate to report the code with CPT modifier 50 or with Category II modifiers RT/LT.
- The fee schedule allowance for Monaural is set to allow for one, and Binaural is set to allow for two.
- Claims for CPT codes 92590–92595 and HCPCS codes V5010–V5298 should only be submitted with a frequency of one.

Note: Any of the hearing aid codes should only be reported with a frequency of **one** in the unit's field.

Surgery/Orthopedics

Fracture Care, Strapping/Casting

Follow CPT guidelines when reporting fracture care and casting/strapping. Fracture care provided by multiple providers on various days, is subject to historical claims auditing.

Certain casting supplies (HCPCS A4580, A4590) are eligible for separate reimbursement when reported with fracture care and casting and strapping procedures.

Gender Affirmation Services/Gender Dysphoria

Gender Affirmation and Gender Dysphoria services are often defined by the member contract. For additional information on this topic, including authorization requirements, refer to medical policy 7.01.123 Gender Reassignment Services and 7.01.017 Cosmetic and Reconstructive Surgery with Attached Companion Table in the Medical Policy Reference Manual.

CareFirst has a dedicated Gender Services specialist on staff to assist members with questions about gender-related care. We can also assist providers with educational support to better care for the community. Please contact gender.services@carefirst.com for more information.

Lesion Removals and Biopsies

Covered, non-cosmetic lesion removals are eligible for separate reimbursement according to the terms of the member contract and applicable medical policies. Follow CPT guidelines for reporting excision, destruction and shaving of benign and malignant lesions. Multiple lesion removal procedures reported together with the same CPT code are usually considered duplicates or mutually exclusive to each other. CPT Modifier-59 should be appended to lesion removals subsequent to the primary procedure to indicate that they were distinct procedures (i.e., separate sites, separate lesions). Multiple procedure editing rules apply.

Lesion Excision and Wound Closures

Follow CPT guidelines for reporting single and multiple wound closures. When intermediate, complex or reconstructive closures are reported with lesion excisions, both procedures may be eligible for separate reimbursement. Simple wound repair procedures (CPT 12001) are considered incidental to excision of lesions in the same anatomic site. Incidental procedures are not eligible for separate reimbursement.

Surgical Trays

As discussed in the supplies and equipment section of this guide, a portion of the RVU is PE. This also includes trays necessary for surgical procedures performed in the office setting. Therefore, additional charges for trays (HCPCS code A4550) used for a surgical procedure or during an office visit are considered incidental to all services and procedures. Incidental procedures are not eligible for reimbursement.

Nasal Sinus Endoscopy/Debridement

Nasal sinus endoscopy (CPT 31237, separate procedure) is eligible for separate reimbursement when performed as postoperative care following functional endoscopic sinus surgical procedures that have a zero-day global period or after a ten-day global period. Endoscopic surgical sinus cavity debridement is not eligible for separate reimbursement when performed as a postoperative treatment related to major surgeries (septoplasty) within a 90-day global period. When the patient is being followed postoperatively for both a zero or 10-day global and a major (90-day global) procedure, append CPT Modifier-79 to CPT 31237 to indicate that the debridement is unrelated to the major procedure. In addition, ensure that medical record documentation and associated ICD-10 diagnosis codes accurately describe for which procedure(s) the endoscopic sinus debridement is being performed. It should be noted that many nasal surgery codes are considered unilateral. Append CPT Modifier-50 as appropriate when a procedure is performed bilaterally. As always, separate procedure rules apply, according to CPT guidelines.

Medicine/Oncology

Allergy Testing/Immunotherapy

Allergy services and procedures benefits are often defined by the member contract. For additional information on this topic, refer to medical policy 2.01.023, Allergy Testing, medical policy 2.01.017, Allergy Immunotherapy and other applicable policies in the Medical Policy Reference Manual.

Chemotherapy (Office, Inpatient and Outpatient Settings)

Chemotherapy procedures (CPT 96401–96549) are considered independent from E/M services. E/M services, when reported with chemotherapy, are not eligible for reimbursement unless CPT Modifier-25 is appended to the E/M code to indicate that a significant, separately identifiable E/M service was performed in addition to the chemotherapy.

Follow CPT guidelines when reporting chemotherapy services alone or in conjunction with other infusion and injection procedures. Because a number of factors determine correct code assignments (e.g., reason for encounter, indications for additional procedures, sequencing of initial, subsequent and concurrent procedures, inclusive services, time), the medical record documentation must be accurate and clearly identify all of these pertinent issues so reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of chemotherapy. Incidental procedures are not eligible for separate reimbursement.

Medically necessary, non-experimental/investigational chemotherapeutic agents and other drugs are usually eligible for separate reimbursement when reported with the appropriate HCPCS code. Chemotherapy procedures provided in inpatient and/or outpatient centers are typically provided by

personnel in those settings and reported on claims for those centers. The professional provider (physician) should not report those services unless that provider personally performs the service.

Nutrition Therapy and Counseling

Follow CPT guidelines for reporting nutritional therapy services. For instance, non-physicians should report these services using CPT codes 97802-97804. Providers are instructed to report these services with an appropriate E/M code.

Sleep Disorders

CareFirst provides benefits for the diagnosis and management of sleep disorders, including oral appliances. Most sleep disorder services can be provided in the home setting. Refer to medical policy 2.01.018, Sleep Disorders in the Medical Policy Reference Manual for details and authorization requirements.

Genito-Urinary

Erectile Dysfunction

Refer to medical policy 2.01.025, Erectile Dysfunction, in the Medical Policy Reference Manual.

Pediatrics/Neonatology

Normal Newborn

Benefits for newborn care are defined by the member contract. Follow CPT guidelines when reporting all aspects of newborn care. For further information, refer to medical policy 10.01.006, Care of the Normal Newborn in the Medical Policy Reference Manual.

Neonatal and Pediatric Intensive Care Services

Follow CPT guidelines for reporting pediatric critical care transport (CPT 99466–99467 and 99485–99486), inpatient neonatal and pediatric critical care (CPT 99468–99476) and initial and continuing intensive care services (CPT 99477– 99480).

Note: These represent 24-hour global services (except pediatric critical care transport) and may only be reported once per day, per patient. These guidelines also define procedures and services that are considered incidental to CPT 99468–99480.

Incidental services are not eligible for separate reimbursement.

Obstetrics and Gynecology

Lactation Consultations

Lactation consultation refers to the educational services provided to women who plan to breastfeed but encounter difficulties due to anatomic variations, complications and feeding problems with newborns. Refer to medical policy 4.01.010, Lactation Consultations in the Medical Policy Reference Manual.

Maternity Services

Maternity benefits are defined by the member contract. Follow CPT guidelines for reporting maternity services, including reporting non-global services (e.g., separate antepartum, delivery and/or postpartum care). Refer to Medical Policy 4.01.006A, Global Maternity Care in the Medical Policy Reference Manual, along with Payment Policy PP CO 080.01 Global Obstetrical Care Services.

Multiple births

Refer to medical policy operating procedure 4.01.006A, Global Maternity Care in the Medical Policy Reference Manual.

Contraceptive Devices

Family planning services are defined by the member contract. Established patient E/M services reported with insertions and removals of intra-uterine devices (CPT 58300-58301) are considered to be included in the surgical package for the procedure and are not eligible for separate reimbursement unless the E/M service is a significant, separately identifiable service. In that case, CPT Modifier-25 should be appended to the E/M service.

Diaphragm/cervical cap fitting (CPT 57170) is considered incidental to all established patient E/M services. Incidental procedures are not eligible for reimbursement.

Radiology/Imaging

Mammography

Mammography benefits are defined by the member contract. Depending on the member contract and related CareFirst Preventive Services Guidelines, both a screening and/or diagnostic mammogram may be eligible for reimbursement on the same date of service. In this case, the procedure with the higher RVU will be reimbursed at 100% of the allowed benefit, and the procedure with the lesser RVU will be reimbursed at 50% of the allowed benefit.

Digital Breast Tomosynthesis

CPT codes 77061, 77062 and 77063 were established to report diagnostic and screening breast tomosynthesis, unilateral and bilateral procedure. The digital breast tomosynthesis images, and if acquired, the conventional mammography images, are utilized for interpretation for screening and diagnostic mammograms. The addition of digital breast tomosynthesis to conventional mammography has been shown to be more sensitive and specific for breast cancer screening.

Instructional parenthetical notes have been added to ensure appropriate reporting of breast tomosynthesis imaging procedures. Report CPT 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT 77055 and 77056 (conventional diagnostic mammography). Report CPT 77063 (bilateral screening breast tomosynthesis) in conjunction with CPT 77057 (conventional bilateral screening mammography).

Exclusionary parenthetical notes have been added to further clarify the reporting of breast tomosynthesis imaging procedures. Do **not** report add-on CPT code 77063 (screening breast tomosynthesis) in conjunction with CPT codes 77055 and 77056 (conventional diagnostic mammography) or CPT 76376 or 76377 (three-dimensional reconstruction). Do **not** report CPT 77061 and 77062 (diagnostic breast

tomosynthesis) in conjunction with CPT 77057 (conventional screening mammography) or CPT 76376 or 76377 (three- dimensional reconstruction).

Diagnostic Ultrasound with Ultrasound Guidance Procedures

Limited diagnostic ultrasound procedures reported with ultrasound guidance procedures.

When a limited diagnostic ultrasound (CPT 76705) and an ultrasonic guidance procedure (CPT 76942) are reported on the same date, our claims system assumes that both were performed during the same session in the same anatomic area. Based on CPT guidelines, an ultrasound guidance procedure includes imaging protocols that are comparable to the limited diagnostic ultrasound. Therefore, when these two procedures are reported together on the same date, the limited ultrasound is considered mutually exclusive to the ultrasound guidance. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

Diagnostic ultrasound procedures reported with ultrasound guidance procedures.

When an ultrasound guidance procedure (CPT 76942) and an ultrasound procedure (CPT 76536) are reported on the same date, our claims system assumes that both were performed during the same session in the same anatomic area. Based on CPT guidelines, an ultrasound guidance procedure includes imaging protocols that are comparable to the ultrasound procedure. Therefore, when these two procedures are reported together on the same date, the ultrasound procedure is considered mutually exclusive to the ultrasound guidance.

Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

Ultrasound guidance procedures reported with ultrasound guidance procedures.

When multiple ultrasound guidance procedures (CPT 76930 and CPT 76942) are reported on the same date, our claims system assumes that both were performed during the same session in the same anatomic area and for similar clinical indications. When these procedures are reported together on the same date, the code with the lower RVU value will be considered mutually exclusive to the code with the higher RVU value. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

In each of these scenarios there may be particular clinical circumstances in which the procedures are performed on separate anatomic sites, and/ or there may be distinct clinical indications for each study. In these circumstances, it will be necessary to append the appropriate modifier(s) to the code(s) to indicate such. Documentation in the medical record must support the reason for multiple reporting of these procedures.

Diagnostic/Therapeutic Imaging Radiopharmaceutical and Contrast Agents

CareFirst will deny imaging agents when billed without the requisite imaging procedures, as defined by National and Regional CMS Guidelines.

Invasive and Non-Invasive Diagnostic Tests and Procedures

Many of these tests and procedures (e.g., cardiac catheterizations, electrophysiological studies, imaging studies) can be reported several ways depending on ownership of equipment, place of service, who is performing the service and who is supervising and/or interpreting the results of the test. Providers must report these services appropriately in order for the claim to be properly adjudicated. Refer to the "Modifier Reimbursement Guidelines" section under the Basic Claim Adjudication Policy Concepts unit earlier in this chapter, regarding reporting global and/or components of these services. (See also "Duplicate Services and Multiple Reviews" listed earlier in this chapter.)

CareFirst
Family of health care plans

Chapter 10: Medicare Advantage

Provider Network Overview

Individual Medicare Advantage

CareFirst Advantage, Inc. is the entity that provides the network and products servicing our Medicare Advantage (MA) Members and integrated Medicare Advantage Prescription Drug (MAPD) plans.

CareFirst BlueCross BlueShield Medicare Advantage participating providers play an integral role in managing and transforming care for our members. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.

The provider network for CareFirst Advantage is different than our other HMO product, BlueChoice. You must sign a separate agreement to be included in the MA HMO network.

Group Medicare Advantage

The Employer Group Waiver Program through the Centers for Medicare and Medicaid Services (CMS) is a customized Medicare Advantage (MA) program that employers may choose to offer their retirees. Under Group Medicare Advantage arrangements, employers or unions contract with a private insurer to provide Medicare benefits and additional retiree health benefits to their Medicare-eligible retirees. Medicare pays the insurer a fixed amount per enrollee to provide benefits covered by Medicare, and the employer/union and/or retiree pays for any additional benefits.

CareFirst Advantage PPO, Inc. is the entity that provides the network and products servicing our Group Medicare Advantage (MA) and Group Medicare Prescription Drug (MAPD) PPO plans. Our product is known as CareFirst BlueCross BlueShield Group Advantage and is a Preferred Provider Organization (PPO) product.

CareFirst BlueCross BlueShield Group Advantage participating providers play an integral role in managing and transforming care for our members. Together, we can arrange for and provide an integrated system of coordinated, efficient and quality care for our members.

The provider network for CareFirst BlueCross BlueShield Group Advantage is different than our commercial PPO network. You must sign a separate agreement to be included in the MA PPO Group Medicare Advantage network.

Dual Special Needs Program (DSNP)

CareFirst BlueCross BlueShield Advantage DualPrime is a Medicare Advantage Prescription Drug HMO Plan for those with both Medicare and Medicaid (Maryland Medical Assistance Program) as a Qualified Medicare Beneficiary (QMB) or a Full Benefit Dual Eligible (FBDE). This plan combines Medical, Hospital and Prescription Drug coverage with extra services and personalized programs focused on improving members' health.

Participating Provider Responsibilities

Providers participating in CareFirst BlueCross BlueShield Medicare Advantage HMO and PPO (CareFirst) must comply with the following responsibilities:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record meeting CareFirst standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special health care needs
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members
- Provide hearing interpreter services on request to members who are deaf or people with hearing loss
- Participate in and cooperate with CareFirst in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by CareFirst
- Comply with Medicare laws, regulations, and Centers for Medicare and Medicaid Services (CMS) instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist, and provide information as requested, and maintain records for a minimum of 10 years
- Participate in and cooperate with the CareFirst appeal and grievance procedures
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Support, cooperate and comply with CareFirst's Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment, and prognosis and give them the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary
- When clinically indicated, contact members as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings

- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care
- Document in a prominent place in medical record if individual has executed advance directives

Provider Network Participation

Enrollment & Participation in the PPO network

CareFirst Advantage PPO, Inc. offers eligible providers an opportunity to participate in the CareFirst PPO network, which is utilized for the CareFirst BlueCross BlueShield Group Advantage product. Network providers provide care to CareFirst BlueCross BlueShield Group Advantage members, and CareFirst reimburses for covered services at the agreed upon payment rate.

Providers must be a Medicare eligible provider and a participating provider in traditional Medicare. Providers who have opted out of or have been excluded or precluded from the Medicare program are not eligible.

To avoid confusion and unexpected out-of-pocket expenses for members, all providers in the same practice must participate in the same provider networks.

For questions regarding credentialing or participation, please contact CareFirst's Provider Information and Credentialing Department at 410-872-3500 or 877-269-9593. For more information on credentialing, please refer to Chapter 3: Provider Network Requirements.

Non-contracted providers

If you are not contracted with the CareFirst PPO network, you can still see CareFirst BlueCross BlueShield Group Advantage members if you are a Medicare contracted provider. We highly encourage non-contracted providers to see our CareFirst BlueCross BlueShield Group Advantage members to provide continuity of care.

Marketing of Medicare Advantage

MA plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V, and the CMS Managed Care Manual, Chapter 3, Medicare Communications and Marketing Guidelines (MCMGs), including, without limitation, activities with Health Care Providers or in the Healthcare Setting.

CMS holds plan sponsors such as CareFirst responsible for any marketing materials developed and distributed on their behalf by their contracting providers. Providers are not authorized to engage in any marketing activity on behalf of CareFirst without the prior express written consent of an authorized CareFirst representative, and then only in strict accordance with such consent.

Appointment Wait Time Standards

Members should be able to schedule an appointment for the care they need within the specified time frames. For more information, visit the "Appointment Wait Times" page under Legal/Mandates.

Network accessibility standards (Medicare Advantage plans)	
Appointment type	**Time frame**
Urgently needed services or emergency	Immediately
Primary Care services that are not emergency or urgently needed, but the enrollee requires medical attention	Within 7 business days
Behavioral Health services that are not emergency or urgently needed, but the enrollee requires medical attention	Within 7 business days
Primary Care routine and preventive care	Within 30 business days
Non-urgent specialty care	30 calendar days

Product Information

Individual Medicare Advantage (HMO)

MA, also known as Medicare Part C, is a health plan approved by Medicare and offered by private insurance companies, like us. MA plans bundle Medicare Part A (hospital/facility costs) and Medicare Part B (doctor/labs/other costs) with added benefits and services.

CareFirst Advantage offers two HMO options for MA:

- CareFirst BlueCross BlueShield Advantage Core
- CareFirst BlueCross BlueShield Advantage Enhanced

You can find information about the two plans, organized by service area, on our website.

Note: Service Area 1 includes Anne Arundel, Frederick, Carroll, Harford and Howard counties. Service Area 2 includes Baltimore City, Baltimore, Montgomery and Prince George's counties.

Member Identification

The prefix for CareFirst Advantage is 'MAC'.

Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. CareFirst On Call is not available for MA inquiries.

Referrals are required for services provided by a specialist.

Members have direct access to:

- Mammography
- Influenza vaccinations
- Women's specialists for routine and preventive services

Members have no copay for influenza and pneumococcal vaccines.

Members do not have coverage outside of the CareFirst BlueCross BlueShield (CareFirst) service area, except for emergency and urgently needed services and renal dialysis for members who are temporarily outside the CareFirst service area.

Group Medicare Advantage (PPO)

Medicare Advantage (MA), also known as Medicare Part C, is a health plan approved by Medicare and offered by private insurance companies, like us. MA plans bundle Medicare Part A (hospital/facility costs) and Medicare Part B (doctor/labs/other costs) with added benefits and services.

CareFirst BlueCross BlueShield Group Advantage is a PPO product. While primary care provider (PCP) selection is not required, it is strongly encouraged that members maintain a relationship with a PCP who can manage the member's care. Similarly, PCPs are encouraged to provide referrals to members even though they are not required. Referrals are not required for any service under these plans.

CareFirst is offering a Group Medicare Advantage Plan that includes Part D coverage.

Medicare Covered Benefits

CareFirst BlueCross BlueShield Group Advantage plans cover all Original Medicare-covered benefits including:

- Inpatient hospital
- Podiatry services
- Skilled Nursing Facility
- Outpatient diagnostic procedures of tests
- Cardiac and pulmonary services
- Lab services
- Emergency care / post-stabilization care
- X-ray services
- Urgent care
- Diagnostic and radiological services
- Primary care provider
- Diagnostic therapeutic services
- Specialist visits
- Opioid treatment services
- Psychiatric services
- Mental health specialty services
- Dialysis services
- Outpatient substance abuse
- Chiropractic services
- Outpatient observation
- Occupational, speech pathology, and physical therapy
- DME, medical supplies, prosthetics, diabetes supplies
- Medicare part B drugs
- Medicare-covered preventive services

Non-Medicare Covered Extra Benefits Beyond Medicare

CareFirst BlueCross BlueShield Group Advantage covers additional benefits such as:

- Telehealth (In-network providers with capabilities)
- 24-Hour Nurse Hotline
- In-home assessments
- Fitness Silver Sneakers
- Outpatient blood services
- Routine Hearing Exams
- Hearing aids
- Fitting/evaluation for hearing aids
- Worldwide emergency coverage & urgent coverage
- Preventive and comprehensive dental

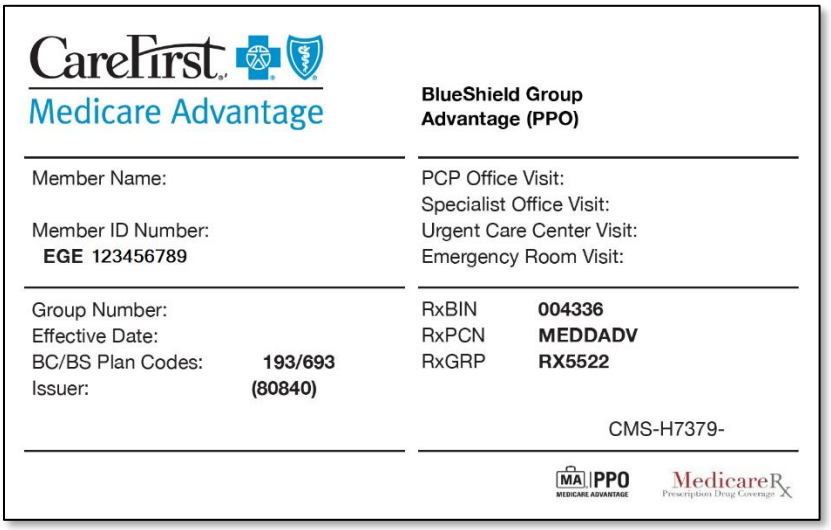
Vision exams and eyewearGroup Medicare Advantage PPO Service Area

As a CareFirst BlueCross BlueShield PPO participating provider, you may render services to patients who are National Account members of other Blue Plans and who travel or live in CareFirst's service area, which is Maryland, the District of Columbia, and Northern Virginia.

Member Identification

The prefix for CareFirst BlueCross BlueShield Group Advantage is EGE. Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. Benefits for MA PPO members are not available through CareFirst on Call.

Sample membership Identification card



PRV MA0331

Role of Primary Care Physician

- Providers in the following medical specialties are recognized as Primary Care Physicians (PCP)s:
  - Family Medicine
  - General Practice
  - Internal Medicine/Pediatrics
  - Preventive Medicine
  - Nurse Practitioner

In accordance with CMS guidelines in limited and rare circumstances:

- Pediatrician
- Nephrologist
- Geriatric Medicine
- OB/GYN

In a managed care program, a strong patient-PCP relationship is the best way to maintain consistent quality medical care. Your role as the PCP is a physician manager who coordinates all aspects of a member's care.

Choosing a PCP – HMO Only

Each CareFirst member in the HMO selects a PCP upon enrollment and receives an individual member ID card with the name of the PCP on the card.

If a member chooses to change PCPs, the member must call the selected provider's office to confirm they still participate with CareFirst and that their new PCP is accepting new patients. The member then notifies member services of this change. The member may also notify us online at carefirst.com/Medicare.

Requests received on or before the 20th of the month will be effective the first day of the following month. Requests received after the 20th will be effective on the first day of the second month following the request. **For example:** Changes received by January 20 will be effective February 1. Changes received on January 21 will be effective March 1. New cards will be issued after the PCP change is processed.

Back-up coverage

When you are not available to provide service to patients, you must arrange effective coverage through another practitioner who is a PCP in the CareFirst network. The covering practitioner must indicate on the claim that they are covering for a particular provider, and include the doctor's name, when submitting the claim.

After hours care

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week, so you can appropriately respond to members and other providers concerning after hours care. 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 members and should not be used by participating physicians.

Claims Submission

We encourage providers to submit claims electronically as you do today for other CareFirst products. We will also accept paper claims which can be submitted to the address found in the Provider Quick Reference Guide.

Billing & Payment

Billing Process

Collecting deductible, copayments or coinsurance

Providers should collect the applicable cost-sharing from the member at the time of service, when possible. After collecting these amounts, submit the bill for covered services. For additional guidance, refer to Chapter 5: Claims, Billing and Payments.

Balance billing is not allowed

You may only collect applicable cost-sharing from members for covered services and may not otherwise charge or bill them.

Cost-sharing for Qualified Medicare Beneficiaries is not allowed

The Qualified Medicare Beneficiary (QMB) is a Medicaid benefit that pays Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. As mandated by CMS, providers who inappropriately bill individuals enrolled in QMB are potentially subject to sanctions. Any wrongfully collected deductibles should be refunded to the patient. Providers needing to verify a member's QMB status should contact Provider Service.

Refund over-billed members

If you collect more from a member than the applicable cost-share, you must refund the difference to the member.

Coordination of benefits

If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we pay depends on the amount paid by the primary plan. We follow all Medicare secondary-payer laws.

Preclusion

CMS adopted a rule in April 2018 that stipulates providers cannot receive payment from a Medicare plan if they appear on a preclusion list managed by CMS. CMS made the preclusion list available to Part D sponsors and Medicare Advantage plans beginning January 1, 2019.

In addition, under the new rule:

- Part D sponsors are required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the preclusion list.
- Medicare Advantage plans are required to deny payment for a healthcare item or service given by an individual or entity on a preclusion list.

The preclusion list is a list created by CMS of providers and prescribers who cannot receive payment for Medicare Advantage items and services, or Part D drugs furnished or prescribed to Medicare members. CMS created this list to replace the Medicare Advantage and prescriber enrollment requirements, to ensure patient protections, and to protect Medicare funds from providers identified as bad actors. You can find more information on the CMS website.

Provider Inquiries About the HMO and PPO Network

If you have any CareFirst provider-related questions, please call one of the numbers below or visit our Contact Us page.

- 1-855-290-5744 for Individual Medicare Advantage (HMO)
- 1-833-320-2664 for Group Medicare Advantage (PPO)

Filing Claims

Claims for CareFirst members should be filed directly to CareFirst. Do not file claims to Medicare, except for the following:

- Services related to hospice care
- Services related to clinical trials

For more information on claims filing, please refer to Chapter 5: Claims, Billing and Payments.

Appeals and Grievances

Introduction

CareFirst encourages our members to let us know if they have questions, or concerns about covered services or the care they receive. Members are encouraged to first contact Member Services at 855-290-5744.

Federal law guarantees a plan member's right to make complaints about any part of their medical care. The Medicare program has set requirements for filing and processing member complaints.

If a member or authorized representative files a complaint, we must:

- Follow certain processes when we receive it,

- Be fair in how we handle it, and
- Not disenroll or penalize a member for making a complaint.

What are Appeals and Grievances?

When denied coverage for a requested item or service, members have a right to appeal the decision. They can also file a grievance (or complaint) about the health plan.

Appeals

A member can file an appeal to ask CareFirst to review a decision on healthcare services or benefits under Part C or D that they believe they're entitled to receive. This includes a delay in providing, arranging for, or approving the healthcare services or drug coverage.

CareFirst will accept appeals made by:

- The member or authorized representative
- The prescribing/treating physician or other prescribers
- A nonparticipating provider involved in the member's care

As an example, a member may file an appeal if:

- We refuse to pay for services a member thinks we should cover.
- We (or a provider) refuse to provide a service a member believes should be covered.
- We (or a provider) reduce services or benefits a member has been receiving.
- The member believes we are stopping coverage of a service or benefit too soon.

Grievances

A grievance is a complaint about with any part of our operations. This includes dissatisfaction with our Medicare plans, Member Services, providers, or treatment facilities. Grievances do not involve decisions about coverage.

As an example, a member may file a grievance if they're experiencing a problem with:

- Quality of care or waiting times for appointments
- The behavior of a provider or their office staff
- Reaching someone by phone to get the information they need
- Cleanliness or condition of a provider's facilities

Acting as an Authorized Representative

A member may appoint an authorized representative to act on their behalf, including:

- A family member
- A friend
- A lawyer

- An unrelated party (such as an advocate)
- Physician or provider
- Court appointed guardian
- Durable Power of Attorney
- Healthcare Proxy

To appoint a representative, both the member and their representative must complete either:

- The Centers for Medicare & Medicaid Services (CMS) Appointment of Representative (AOR) form
- Or an equivalent written notice, which includes:
  - Name, address and phone number of the member
  - Name, address and phone number of the authorized representative
  - Member's Medicare Beneficiary Identifier or Plan ID number
  - The authorized representative's professional status or relationship to the member
  - A written explanation of the purpose and scope of the representation
  - A statement the member is authorizing the representative to act on their behalf for the claim(s) at issue
  - A statement authorizing disclosure of individually identifying information to the representative
  - A statement by the authorized representative they accept the appointment

Note: The notice must be signed and dated by both the member and authorized representative

Members must fax (443-753-2298) or mail their form or written notice to:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

We will:

- Not require information beyond what's in the AOR form.
- Not require information beyond what's outlined above for an equivalent written notice.
- Treat AOR forms as protected information.
- File and make accessible a copy of the signed AOR form or written notice for future grievances, coverage requests or appeals submitted within the compliant timeframe.
- Include a copy of the AOR form or written notice when sending a case file to an **Independent Review Entity (IRE)** or any other entity other than CareFirst.

The AOR form is valid for one year from the date it was signed (unless sooner revoked). If the member wants the same person to serve as their representative after one year, they must submit a new AOR form.

If a grievance, coverage request or appeal is received within one year of the date the AOR form is signed, it will remain valid for the life of the grievance, request or appeal.

Providers as an Authorized Representative

A provider that has administered services or items to a member may represent that member on the appeal; however, the provider may not charge the member a representation fee. Providers who do not have a contract with CareFirst must sign a "Waiver of Liability" statement. This asserts the provider will not require the member to pay for the medical service under review, no matter the outcome of the appeal.

Note: The appeals process will not start until CareFirst receives a valid AOR form. Or, for payment appeals from non-participating providers, a valid Waiver of Liability statement.

Hospital Stay and Discharge Appeals

If a member feels CareFirst coverage for a hospital stay is ending too soon, the member or authorized representative can appeal directly to a Quality Improvement Organization (QIO). QIOs are groups of health professionals paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review.

Note: QIOs are assigned regionally by CMS. The QIO for the state of Maryland is Livanta.

Members can find the appeal information on "The Important Message from Medicare" document they receive within two days of admission. It also includes the QIO name and telephone number.

Quality Improvement Organization Review

To request a QIO review for a hospital discharge, the member or authorized representative must contact them no later than the planned discharge date and before leaving the hospital.

If the deadline is met:

The member can stay in the hospital past the planned discharge date without financial liability.

If the QIO reviews the case, they will provide a decision within one calendar day after receiving the request and all the medical information necessary.

- If the QIO decided the planned discharge date is medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision.
- If they decided it's not medically appropriate, we will continue to cover the hospital stay for as long as medically necessary.

If the deadline is missed:

The member or authorized representative may request an expedited appeal.

However, if the member stays in the hospital past the planned discharge date, they may have to pay for services provided beyond that date.

- If the expedited appeal decision is in the member's favor, we will continue to cover the hospital stay for as long as medically necessary.
- If it's not in the member's favor, we will not cover any hospital care provided beyond the planned discharge date (unless and IRE review overturns our decision).

Skilled Nursing Facility, Home Health Agency or Comprehensive Outpatient Rehabilitation Facility Appeals

If a member feels the coverage for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF) service is ending too soon, they can appeal directly a QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

Notice of Medicare Non-Coverage

If CareFirst and/or the provider decide to end coverage for SNF, HHA or CORF, a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in their records.

Beneficiary and Family Centered Care - Quality Improvement Organization Review

For hospital, SNF, HHA, or CORF services, members may ask for an appeal if their coverage was terminated. The member will be issued a notice advising that their coverage for the stay was terminated. The member or authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency.

- If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received.
- If the notice is received more than two days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, they will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will look at medical information, talk to the doctor, and review other information that we provide.

Note: The provider must fax all the member's medical records immediately to the QIO for their review. CareFirst will provide the member and the QIO a copy of the explanation for termination of coverage.

The QIO will make a decision within one full day of receiving all the necessary information.

- If they decide the termination of coverage is not medically appropriate, we will continue to cover the stay for as long as medically necessary.
- If they decide it is medically appropriate, the member will be responsible for paying the hospital, SNF, HHA, or CORF charges after the termination date that appears on the advance notice.

Note: Neither Original Medicare nor CareFirst will pay for these services.

If the member agrees to stop receiving services on or before the date given on the notice, there will be no financial liability.

If the member or authorized representative does not ask for a QIO review in a timely manner, they may request an expedited appeal. However, the member may have to pay for services provided beyond the termination date.

- If the decision is in the member's favor, we will continue to cover the care for as long as medically necessary
- If the decision is not in the member's favor, we will not cover any of the care provided beyond the termination date, and the member may be financially responsible.

Member Appeals for Coverage or Payment of Other Medical Services

If CareFirst does not approve services a member believes should be covered or provided, the member or authorized representative may file an appeal.

This would be a standard appeal for payment of a claim (payment appeal) or benefits (pre-service appeal).

Filing Standard Payment Appeals

Members can file a standard payment appeal within 60 calendar days of the date of the notice of the initial decision. That timeframe may be extended if good cause exists.

All standard claims payment appeals must be submitted in writing to:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

Filing Standard Pre-Service Appeals

Members can file a standard pre-service appeal within 60 calendar days of the date of the notice of the initial determination. That timeframe may be extended if good cause exists.

All standard pre-service appeals for a service or Part B drug must be submitted in writing to:

Appeals and Grievances Department
10455 Mill Run Circle
Room 11113-A
Owings Mills, MD 21117

Appeal Timeframes and Decisions

Standard Payment Appeals

For payment appeals, we will send a decision within 60 days for payment for a service or Part B drug that was already received. If the payment is approved upon appeal, the payment must be issued within the 60 days. If the payment denial is upheld in full or in part, the case must be forwarded to the IRE for review.

Standard Pre-Service Appeals

If a standard appeal is filed, we will send a decision within:

Timeframe	Scenario
7 days	For a request for a pre-service Part B drug that the member wants to receive (drug has not yet been provided)
30 days	For a pre-service request for coverage of a benefit or service that the member wants to receive. (Care has not yet been provided)

If additional information is needed to complete the benefit or service appeal review, the timeframe may be extended up to 44 calendar days.

Note: There are no extensions for Part B prescription drug appeals.

Expedited Appeals

Expedited Pre-Service Appeals

If waiting for a decision will seriously harm the member's health, they can request an expedited appeal.

To file an expedited pre-service appeal, members can call Member Services at **855-290-5744.** They can also fax (410-605-2566) or mail it to:

Appeals and Grievances Department
10455 Mill Run Circle
Room 11113-A
Owings Mills, MD 21117

CareFirst has up to 72 hours to decide. We will make it sooner if the member's life, health, or ability to regain maximum function requires it. If we need additional information, the timeframe for review may be extended up to 14 calendar days.

All adverse reconsideration decisions are automatically forwarded to the IRE for review. Also, if we do not issue a decision within the standard or expedited timeframes as outlined above, the appeal will be automatically forwarded to the IRE for review.

Note: The IRE has a contract with CMS and is not part of CareFirst.

Once a decision is reached, everyone involved in the appeal will be notified. If the decision is a denial, the member or authorized representative will be verbally notified their appeal has been forwarded to the IRE.

Independent Review Entity

CareFirst will automatically forward all adverse reconsideration decisions where the original denial is upheld in part or in full to the IRE. The member may request a copy of the file provided to the IRE for review. The IRE will notify the member of the receipt of the appeal. They will also review the request and decide if we must provide service or payment.

Timeframes for the IRE to issue a decision include:

Appeal Type	Timeframe	Extension
Payment of services already received	60 calendar days	14 calendar days if more information is needed and it's in the member's best interest.
Standard appeals regarding medical care not yet provided	30 calendar days	
Expedited appeals regarding medical care	72 hours	
Part B Prescription drug	7 calendar days	Not applicable

The IRE will issue its decision in writing to the member or authorized representative and CareFirst.

- If the decision is not in the member's favor, the member pursue an administrative law judge review.

Administrative Law Judge Review

The ALJ works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

Note: The ALJ will not review an appeal if the dollar value of the medical care is less than the minimum requirement and there are no further avenues for this appeal. Refer to The Amount in Controversy, Federal Minimum Requirements for Filing section in this chapter.

During an ALJ review, the member may present evidence. They may also review the record and be represented by an attorney. The ALJ will hear the case, weigh all the evidence, and make a decision as soon as possible.

The ALJ will notify all parties of the decision.

- If the decision is not in the member's favor, they can request a review by the Medicare Appeals Council (MAC)/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The MAC is part of the federal department that runs the Medicare program. It does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review.

- If the MAC decides not to review the case, either party may request a review by a Federal Court Judge.

Federal Court

Members have the right to file the case with Federal Court. The dollar value of the services must meet the minimum requirements. Otherwise, the case will not be reviewed, and the member will have no further right of appeal.

Appeals for Coverage of Part D Drugs

CareFirst encourages its members to contact us through Member Services with any questions or concerns related to prescription drug coverage. As with medical services, we have processes to address various complaints regarding drug benefits.

The member or authorized representative may submit a Part D prescription drug appeal for the following scenarios:

- The member is not able to get a prescription drug that may be covered.
- The member has received a Part D prescription drug that may be covered, but we have refused to pay for the drug.
- We will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary.
- The member disagrees with the copayment amount.
- Coverage of a drug is being reduced or stopped.
- There is a requirement to try other drugs before the prescribed drug is covered.
- There is a limit on the quantity or dose of the drug.

Note: If CareFirst approves a member's exception request for a non-formulary drug, the member may not request an exception to the copayment that applies to that drug.

Submitting Part D Appeals

Providers who feel a member's life or health is in serious jeopardy may start the Part D appeal process by calling **888-970-0917**. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

All appeals must be filed within 60 calendar days from the date of the coverage determination. If the member's life, health, or ability to regain maximum function is in jeopardy, they may request an expedited appeal. CareFirst will make every effort to gather all the information needed to make a decision about the appeal. Qualified individuals not involved in making the coverage determination will review each request. Members have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing to:

CVS Caremark Coverage Determinations/Exceptions
P.O. Box 52000
Phoenix, AZ 85072-2000

You may also provide this information by phone at **1-888-970-0917**.

Members also have the right to ask us for a copy of the information pertaining to their appeal. They can request this information by calling the phone number listed above.

Decisions on Part D appeals

For standard pre-service decisions about a Part D drug:

- We have up to seven calendar days to issue a decision and approve the drug in question. If the member's health condition requires it, we will issue the decision sooner.
- If we do not issue a decision within seven calendar days, the request will automatically be forwarded to the IRE for review.

Note: Everyone involved in the appeal will be notified of the decision once it is made.

If we approve the appeal for a Part D drug, we must authorize payment for the drug within 14 calendar days from the date we received the request. The payment must be sent no later than 30 calendar days after the date we received the request.

For expedited appeal regarding Part D drugs that have not been prescribed:

- We have up to 72 hours to issue a decision and approve the requested medication. If the member's health condition requires it, we will issue the decision sooner.
- If we do not comply with the 72-hour timeframe, the case will automatically be forwarded to the IRE for review.

Note: If the appeal is denied, the member may ask for an IRE review. However, a review is not guaranteed since IRE is typically for medical services. Information on requesting an IRE review will be in the member's initial denial notice.

Independent Review Entity

The member or authorized representative must submit a request to the IRE in writing within 60 calendar days of the appeal decision notice. The IRE's name and address will be included in this notice. The IRE will review the request and decide about whether CareFirst must cover or pay for the medication.

Note: The IRE has a contract with CMS and is not part of CareFirst.

An expedited IRE is also available if the member's condition requires it. For an expedited IRE review, the IRE must issue a decision within 72 hours. For a standard IRE review, the IRE has up to seven calendar days to issue the decision.

The IRE will issue its decision in writing, explaining the reasons for the decision. Refer to the CareFirst Actions Based on Review Decisions table below for favorable decision outcomes.

- If the member is not satisfied with the result of the IRE review, they may request an ALJ review.

Administrative Law Judge Review

To request an ALJ review, the value of the drug in question must meet minimum requirements. To calculate the amount in controversy, the dollar value will be projected based on the number of refills prescribed for the requested drug during the plan year. This projected value includes:

- co-payments,
- all expenses incurred after the member's expenses exceed the initial coverage limit, and
- any expenses paid by other entities.

Claims may also be combined to meet the dollar value requirement if:

- the claims involve the delivery of Part D drugs to the member,
- all claims have been reviewed by the IRE,
- each of the combined requests are filed in writing within the 60-day filing limit, and
- the hearing request identifies all the claims to be heard by the ALJ.

An ALJ review must be submitted in writing within 60 calendar days of the date of the IRE decision. The member may request an extension of the deadline for good cause.

During the ALJ review, the member or authorized representative may present evidence. They may also review the record and be represented by counsel.

The ALJ will hear the member's case, weigh all the evidence submitted, and issue a decision as soon as possible.

The ALJ will issue a decision in writing to all parties. Refer to the CareFirst Actions Based on Review Decisions table below for favorable decision outcomes.

- If the ALJ rules against the member, a MAC review may be requested. The ALJ notice will provide instructions on how to request a review.

Medicare Appeals Council

The MAC is part of the federal department that runs the Medicare program. There is no minimum dollar value for the MAC to conduct a review. The MAC does not review every case it receives. When it gets a case, it decides whether to review the case.

If the MAC decides not to review the case, a written notice will be issued. This notice will advise the member if further action can be taken with respect to the request for review. The notice will instruct the member how to request a review by a Federal Court Judge.

If the MAC reviews the case, it will inform all parties of its decision in writing. Refer the CareFirst Actions Based on Review Decisions table below for favorable decision outcomes.

- If the decision is not in the member's favor, they may request a judicial review. But only if the dollar value of the medication meets minimum requirements.

Federal Court

If the member isn't satisfied with the MAC's decision, they can file civil action in a U.S. District Court to request judicial review of the case. The MAC letter will explain how to do this. The dollar value of the drug in question must meet the minimum requirement to go to a Federal Court. The federal judiciary is in control of the timing of any decision.

If the Judge decides in the member's favor, CareFirst must approve or pay for services under the same time constraints outlined above. Otherwise, the decision is final and there is no further right of appeal.

Amount in Controversy, Federal Minimum Requirements for Filing

To view the Amount in Controversy, Federal Minimum Requirements for Filing, visit the CMS website.

CareFirst Actions Based on Review Decisions

The actions we must take depend on the decision from the IRE, ALJ, and MAC reviews.

Timeframe	Scenario	Action
30 calendar days	Decision is in the member's favor. The member has already received and paid for the drug in question	We will reimburse the member within the specified timeframe of receiving the decision.
72 hours	Decision is in the member's favor. The member has not yet received the drug in question	We will approve the medication within the specified timeframe of receiving the decision.
24 hours	Decision is in the member's favor. An expedited review was requested	We will approve the medication within the specified timeframe of receiving the decision.

Note: For IRE reviews, we must send the member confirmation that we have honored their decision for standard appeals.

Member Grievances

Grievances are member complaints. They do not involve coverage or payment for benefits. Concerns about failure to pay for a certain drug or service should be addressed through the appeals processes.

The member grievance process may be used to address other problems related to coverage, such as:

- Problems with waiting on the phone or in the office
- Disrespectful or rude behavior by providers or their staff
- The cleanliness or condition of a provider's office or facility
- If a member disagrees with our decision not to expedite a request for coverage determination
- If CareFirst does not provide a decision within the required timeframe
- If we do not forward a case to an IRE if we do not comply with required timeframes for reconsideration
- If we do not provide the member with required notices

Members can file a grievance within 60 calendar days of the date of the circumstance giving rise to the complaint.

The grievance will be sent to our Appeals and Grievance department for handling. A response may take 30 days. Or if more information is needed, up to 44 days.

Members can file an expedited grievance under certain conditions.

Submitting a Grievance

For immediate attention, call **855-290-5744.** Members may also fax (443-753-2298) or mail grievances to:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

Members are encouraged to contact Member Services first for immediate assistance to resolve their concern. If Member Services cannot resolve the complaint, our Grievance team will review it.

Note: Grievances received verbally will be followed up verbally. Grievances received in writing will be followed up in writing. Grievances regarding quality of care will always receive a written response.

If the member would like to have someone else file a grievance on their behalf, an AOR form must be completed.

Standard Grievances

The member or authorized representative will submit any information, documentation or evidence regarding the grievance. Many grievances are resolved within the original phone call. If the grievance is in writing, our Grievance team will research the grievance and follow up on the findings. We may extend the timeframe by up to 14 calendar days if the member requests the extension. Or, we justify a need for additional information and the delay is in the member's best interest.

Expedited Grievances

It may be necessary to expedite the review of a grievance because the member's life, health or ability to regain maximum function is in jeopardy. Members may file an expedited grievance if they disagree with instances when we have:

- Extended the timeframe to make an Organization Determination
- Extended the timeframe to resolve an appeal
- Refused to grant their request for an expedited Organization Determination
- Refused to grant their request for an expedited appeal

Note: Expedited grievance review is only available for the circumstances outlined above.

The member or authorized representative will receive a decision within 24 hours of receiving the request. We will notify all affected parties of the decision by phone within 24 hours of filing the grievance. A letter explaining the decision will follow within three days.

Provider Payment Disputes

Member Appeals vs. Provider Payment Disputes

Contracted providers do not have appeal rights on the provider's behalf. If there is a member liability or for any pre-service denials, a provider can file an appeal on a member's behalf. In these instances, the provider should follow the member appeal process above.

Providers can dispute a payment they believe was not paid or paid incorrectly. If a provider receives a service that is denied in part or in whole, with no member liability, and the provider disagrees with the decision then the provider can dispute that payment.

CareFirst Has a Two-Level Payment Dispute Process

First Level Contracted Provider Disputes

When a provider disagrees with a payment amount or with a payment denial with no member liability the provider may call CareFirst provider service for a review of the payment. The provider must give a reason for the payment dispute. Our customer service team will research the issue and follow up with the provider.

- If the response satisfies the provider, the verbal dispute is considered closed.
- If the provider continues to disagree with the payment, they may file a second level provider dispute.

Second Level Provider Disputes

Contracted providers must make a written request for a second level provider dispute. We must receive the request within 180 calendar days of the date of the notice denying a post-service claim.

- When an authorization has been denied, the provider must adhere to the 60-day timeframe. The 180 days, once the claim has been denied, does not apply.

To request a second level dispute, the provider must submit all supporting documentation including:

- a copy of the denied claim,
- the reason for the appeal, and
- the member's medical records containing all pertinent information regarding services rendered.

All reviews will be completed within 60 days of the date the written request was received.

Quality Improvement

Overview

As part of CareFirst, providers, and Medicare Advantage plans must adhere to regulations set by CMS. Please note that all providers are responsible for adhering to CMS regulations that are outlined in this manual, as well as CMS policies.

Star Rating Program

CMS uses the Star Rating system to measure MA plan performance. Star Ratings measure the quality of healthcare provided by plans and its providers, including member experience, health and clinical outcomes, and health plan administrative functions for Part C and Part D. Star Ratings range from 1 to 5 Stars, with 1 being the lowest and 5 being the highest. CareFirst has a goal of achieving a 4+ Star Rating to provide the highest quality of care to our members, and partnership with providers is critical to achieving that goal.

The Star Ratings that are impacted by providers are:

- Healthcare Effectiveness Data and Information Set (HEDIS) – Measure that ensure members are receiving preventative care such as screenings and tests, as well as managing chronic conditions.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A survey that asks members to evaluate their health care experiences including obtaining appointments and care quickly, getting needed care, care coordination, and overall rating of healthcare.
- Health Outcomes Survey (HOS) – A survey that asks members to evaluate their health outcomes year over year, including improving or maintaining physical and mental health, monitoring physical assessment, improving bladder control, and reducing the risk of falling.
- Clinical Pharmacy – Measures that focus on measuring member adherence to medication and appropriate medication management.

How are Star ratings derived?

A health plan's rating is based on measures in five categories:

- Staying Healthy Screenings, Tests and Vaccines
- Managing Chronic (Long Term) Conditions
- Member Experience with Health Plan
- Member complaints and Changes in the Health Plan's performance
- Health Plan Customer Service

To learn more about the CMS five start quality rating system, visit CMS's website. You can find more information about Quality Improvement activities outlined in Chapter 7: Care Management of this manual.

Audits

CareFirst conducts audits in accordance with Medicare laws, rules and regulations. Other audits will be conducted as needed, such as diagnosis-related groups validation, site of care, readmission, etc. CareFirst may contract with a vendor as a business associate that is covered by the Health Insurance Portability and Accountability Act to conduct specific audits and/or reviews. Examples of possible reviews include:

- Risk adjustment
- Healthcare Effectiveness Data and Information Set

Medical records may be requested by mail or obtained by on-site imaging at the provider's office and/or facility. The on-site reviewer will have the capability to scan and copy medical records as well as the technology to access electronic medical records. Providers are required to provide medical records for

CareFirst to fulfill state and federal regulatory and accreditation obligations. If a reviewer cannot copy records, CareFirst will reimburse providers at a reasonable cost for the duplication of the medical records.

For more information on Audits, refer to the Requests for Charts section in Chapter 3: Provider Network Requirements.

Practice Transformation

What is Practice Transformation?

For more information on Practice Transformation, refer to the Practice Transformation section in Chapter 3: Provider Network Requirements.

Health Systems and Accountable Care Organizations

In 2011, CareFirst began its own PCMH Program to improve health outcomes and value for our members. In 2019, we initiated separate Adult and Pediatric PCMH Programs to meet the needs of these two diverse populations. In 2020, we launched our Total Care Accountable Care Organization (ACO) model; CareFirst offers ACO programs for providers in our MA networks. To participate in CareFirst MA Total Care program, ACOs must operate within the network's geography and provide primary care, multi-specialty, inpatient care, and emergency department access.

Some key elements of the MA Total Care Program:

- Performance-Based Incentives: At the beginning of every month, each ACO will receive a monthly budget for their attributed member population based on CMS' payment to CareFirst. This budget will be compared to the actual total cost of care for attributed members at the end of the year.
  - If an ACO keeps their member costs below the budget, it will receive a portion of the savings as bonuses.
  - If an ACO is over the budget, it must repay a portion of the losses.
- Quality: To ensure that cost savings do not come at the expense of quality, ACOs must meet specific quality performance thresholds to be eligible for shared savings. These thresholds are based on a subset of Star Rating System quality metrics for the MA population. These evidence-based measures focus on addressing health needs across the continuum of care, including preventive screenings, diabetes management, hospital readmissions, and access to behavioral healthcare. In other words, providers are rewarded for keeping their patients healthy and out of the hospital.

ACOs are an integral part of CareFirst's volume to value strategy. They allow CareFirst and providers to be jointly accountable for our members' health and create greater value for those we collectively serve.

In addition, our MA Total Care Program provides PCPs and health systems with significant clinical expertise, analytical resources, and financial incentives to help them transform their system. Each enrolled health system receives the following:

- A care coordinator
- Access to a suite of clinical support programs
- A practice consultant trained to identify and implement transformation opportunities
- Robust performance and quality data available online 24/7

ACO Transformation Opportunities

CareFirst has equipped health systems with additional resources to enable transformation activities. In addition to field-based practice consultants, CareFirst has a team of enterprise managers serving a similar role for leadership of most large, engaged health systems in our network. Regular meetings between CareFirst enterprise managers and health system executives help give leadership a closer view of their MA Total Care ACO progress as well as opportunities to implement transformation strategies that improve their outcomes. Health system executive sponsorship is key to improving access and affordability of healthcare to CareFirst members.

Examples of transformation strategies for health systems:

- Modify site of service and other cost inefficiencies commonly found in specialist groups and other ambulatory services.
- Leverage robust CareFirst claims data available through the MA Total Care Program to prescribe lower cost medications, close gaps in care, understand cost and utilization, and reduce variance in program performance across providers and practice sites.
- Facilitate collaboration between embedded care coordinators to reduce duplication and strengthen continuity of care.
- Integrate with a two-way data sharing platform to improve quality reporting performance, decrease records requests, and achieve a complete view of existing patients including visits outside of the system.


All Provider Types

Medicare Pharmacy Management

Pharmacy Network

Members are required to use pharmacies that are in network. CareFirst has a nationwide network of 60,000+ pharmacies that includes major chains, independents, supermarkets, and more. The Pharmacy Directory is available at carefirst.com/Medicare.

Formulary

A formulary is a list of drugs that we cover.

CareFirst delegates formulary creation to its Pharmacy Benefits Manager (PBM). The formulary is reviewed and approved by an independent national committee comprised of physicians, pharmacists, and other healthcare professionals who make sure the drugs on the formulary are safe and clinically

effective. The Medicare formulary is also reviewed and approved by the CMS. CareFirst chooses the 5-tier generic strategy formulary. This means that there are generic options available on each tier, but also multiple tiers that have varying copays. These include:

- Tier 1-Preferred Generics (lowest copay)
- Tier 2-Generics (more expensive)
- Tier 3-Preferred Brand (lowest copay for brand names)
- Tier 4-Non-Preferred Brand (more expensive brands and generics)
- Tier 5-Specialty Tier (highest copay)

To ensure members are receiving the most appropriate medication for their condition(s), certain medications on the formulary may be subject to utilization management (UM). Below are some descriptions of the types of UM used in the formulary.

- Prior Authorization (PA) – We require providers to submit clinical information to ensure the medications written are appropriate for the situation. There is a PA on part B and part D drugs. This information may include diagnosis, lab results, your medical specialty, and use of prior medications.
- Quantity Limit (QL) – For certain drugs, we limit the amount of the drug that a member can have. This may include the amount of medication that may be obtained per day or the amount of medication that can be obtained over a length of time. Quantity limits can apply to formulary and non-formulary drugs.
- Step Therapy (ST) – In some cases, we require members to try certain drugs before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, we may then cover Drug B.

CareFirst allows for extended day supplies, meaning up to 90-day fills, at both retail and mail order. We encourage providers to write for these longer fill lengths for members with established histories of chronic medications such as those for hypertension, diabetes, and hypercholesterolemia.

CareFirst also uses CVS Caremark for mail order pharmacy. There are lower copays for members who use mail order to obtain 90-day supplies of their medications. The exception is drugs on Tier 5, of which only 30-day supplies are available via the mail. Certain drugs are not available via mail order, and those are indicated on the formulary by the initials NM.

You can find the searchable and printable formularies, as well as PA and ST criteria at carefirst.com/Medicare.

Exception Requests

Members and their providers may submit the following requests for a drug exception:

- Non-Formulary Drug Exception – A request to cover a medication that is not on the formulary (drug must be Part D eligible)
- Tier Exception – A request to cover a medication that is on the formulary under a lower cost-sharing tier

- PA or UM Exception – A request to waive UM criteria such as PA, QL, and ST

Generally, we will only approve a request for an exception if the alternative drugs included on the formulary would not be effective in treating the members' condition, or there is a safety concern.

Requirements for Part B Drugs

Part B drugs include drugs that are administered in a provider's office, diabetes monitoring supplies, some vaccines, and others. Just like part D drugs, part B medications may be governed by UM. CareFirst has certain medications that require PA and/or ST. Our PBM handles the initial request while CareFirst is responsible for appeals. Lists of medications, including those with PA or ST, are available at carefirst.com/Medicare.

Ensuring Appropriate Utilization of Opioids

A topic applicable and relevant for any population, CareFirst has safety edits on top of existing formulary listings and UM. While those are posted in documents on carefirst.com/Medicare, these edits occur at the point of claim adjudication in three scenarios:

- Opioid naïve edit: Using a lookback period of 108 days, if a member is opioid naïve, their initial opioid prescription will be limited to a 7-day supply. The intent is to limit members who have not been exposed to opioids in order to help prevent problematic or habitual use.
- Care coordination edit: When members opioid prescriptions written by three different prescribers and are at or above 90 Morphine Milligram Equivalent (MME), the claim will reject and allow for the pharmacist to review the situation. This helps to ensure communication between providers once high opioid levels are met to help prevent over prescribing.
- High MME edit: When members have opioid prescriptions written by three different prescribers and are at or above 200 MME, the claim will reject and require a coverage determination in order to process.

There are situations that override these edits (i.e., cancer diagnosis, multiple prescribers are all part of the same practice), but the intent is to help keep our members safe.

Transition Fills

Transition is a process to help ensure Medicare members can continue to receive medications they may have been taking before joining CareFirst, or for active members who have a history of medication use but now formulary coverage has changed. Below you will find a summary of information on transition.

Description	Transition Fill Days' Supply
New & Renewing Members	
Not in long-term care (LTC)	30 days' supply within the first 90 days in the plan; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed.
In LTC	31 days' supply within the first 90 days in the plan, oral brand solids are limited to 14 days' supply with exceptions as required by CMS guidance, multiple fills for a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed/first 90 days.
Non-LTC Resident Level of Care Change	
Member released from LTC facility within the past 30 days	30 days' supply; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed.

The transition supply allows you time to talk to your member about pursuing other options available within our formulary or for you to submit the necessary information to obtain an exception or coverage determination.

Medication Therapy Management Program

A medication therapy management (MTM) program is a requirement for Medicare Advantage Prescription Drug plans. Pharmacists in various settings work with members to review their current medication regimens in order to:

- Ensure optimum therapeutic outcomes through improved medication use.
- Reduce the risk of adverse events
- Help identify issues where medications may not work well together and address these issues with providers.

Members qualify for the program by having:

- Three or more of the following chronic illnesses:
  - Osteoporosis
  - Chronic Health Failure (CHF)

- ☐ Diabetes
- ☐ Depression
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disorder (COPD)
- ☐ Cardiovascular Disorders
- ☐ HIV/AIDS

- Take eight or more chronic medications for the illnesses mentioned above
- Total drug spend annually on medications based on the dollar amounts announced on the CMS Website, which is projected from three months' worth of claims

Qualifying members will be enrolled automatically and can opt-out. Members will receive a comprehensive annual review of medications, as well as outreach for potential targeted medication reviews. You may receive letters requesting changes to medication regimens pursuant to these reviews.

Preservice Review & Compliance/Utilization Management

Healthcare providers may be required to submit requests for prior approval in advance for services such as medical, behavioral health/substance abuse, and pharmacy health care services for our members.

What is a Prior Authorization?

A prior authorization, or prior approval, is a review and assessment of planned services that helps to distinguish the medical necessity and appropriateness to utilize medical costs properly and ethically. Prior authorizations are not a guarantee of payment or benefits.

General Requirements

- Services must be covered under the member's benefit plan
- Services must be medically necessary and appropriate
- Services must be performed in the appropriate setting

Services Requiring Authorization

An authorization is required for the following services pending verification of eligibility requirements and coverage under the member's health benefit plan:

- Any service provided in a setting other than a physician's office, except for lab and radiology facilities, and freestanding Ambulatory Surgery 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
- 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 provider following discharge from the hospital
- Hemodialysis (unless performed in a participating free-standing facility)
- Home healthcare, home infusion 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.

Services Not Requiring Authorization

Any service performed at a participating freestanding Ambulatory Surgery Center (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.

How to submit a Prior Authorization Request

Online

Log onto the CareFirst Provider Portal to input requests. Have the following information available to complete the request:

- Member's name, address, and telephone number
- MA Member ID number
- Member's gender and date of birth
- Attending provider'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

Fax

Requests can be faxed to the following numbers:

- Inpatient Services: 443-753-2341
- Outpatient Services: 443-753-2342
- Durable Medical Equipment: 443-753-2343
- Home Care: 443-753-2343
- Outpatient Pre-Treatment Authorization Program (OPAP for outpatient PT/OT/ST): 443-753-2346
- Outpatient Behavioral Health: 443-753-2347

Phone

Requests can be made by phone by calling **866-PRE-AUTH (773-2884)**

Mail

Preservice Review Department
10455 Mill Run Circle
Room 11113-A
Owings Mills, MD 21117

Note: In order to better service our providers and members, please download the appropriate prior authorization form found here. This will help us process the request more efficiently; however, it is not required for CareFirst members.

Emergency Hospital Admissions

When ER professionals recommend emergency admission for a 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 outlined below.

When to Submit Prior Authorization Requests

We advise that you submit advance notification requests with supporting clinical documentation as soon as possible, but at least two weeks before the planned service. After a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.

It may take up to 15 calendar days (14 calendar days for standard MA requests and 72 hours for expedited requests) for us to make a decision. We may be required to extend this time if additional information is needed. Submitting requests through the Guiding Care Utilization Management Authorization system assists in timely decisions.

We prioritize case reviews based on:

- Case details
- Completeness of the information received
- CMS requirements
- State or federal requirements

If you require an expedited review, please call the number listed on the back of the member's ID card. You must explain the clinical urgency. You will need to provide required clinical information the same day as your request.

We expedite reviews upon request when the member's condition:

- Could, in a short period of time, put their life or health at risk
- Could impact their ability to regain maximum function
- Causes severe, disabling pain (as confirmed by a physician)

Durable Medical Equipment

Durable Medical Equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to service a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

Criteria for Utilization Management Decisions

CareFirst uses the MCG Medicare Compliance Guidelines, MCG Medical/Inpatient/Surgical, Ambulatory Care, Home Health Care Guidelines 24th edition, The MCG Behavioral Health Care Guidelines 24th edition, and the American Society of Addiction Medicine (ASAM) criteria.

MCG Behavioral Health Guidelines: Evidence-based criteria guidelines are used to determine the appropriate course of treatment and level of care for behavioral health diagnoses including recommended clinical pathways such as recovery course with expanded recovery milestones, continued stay through discharge criteria to ensure proactive management and support delivery of quality managed health care to members.

MCG Medical/Inpatient/Surgical, Ambulatory Care, Home Health Care Guidelines: Evidence-based criteria guidelines are used to determine the appropriate course of treatment and level of care for medical diagnoses, inpatient hospital, surgical procedures, outpatient, and home health services to apply the recommended medically necessary clinical pathways to ensure proactive management and support delivery of quality managed health care to members.

MCG Medicare Compliance Guidelines: The Medicare Compliance Guidelines are based on the Center for Medicaid and Medicare Services (CMS) Medicare coverage clinical policies for Medicare beneficiaries to facilitate the use and apply the guidelines determined by CMS to provide guidance on the justification of necessary or not necessary services in a variety of circumstances and settings using the 3 types in Medicare Compliance: National Coverage Analysis guidelines (NCA), National Coverage Determinations guidelines (NCD) and Local Coverage Determinations (LCD) guidelines to ensure efficient use, proactive management and support delivery of quality managed health care to members.

The ASAM criteria are evidenced based criteria and guidelines used in making substance use disorder medical necessity determinations and includes guidelines for placement, continued stay, transfers and discharges of patients with addiction and substance use disorders

CareFirst's Dental Clinical Criteria have been developed, revised, and updated periodically and reviewed and approved by the CareFirst Dental Advisory Committee (DAC) and/or the Oral and Maxillofacial Surgery Advisory Committee (OMSFAC). The DAC is comprised of the Dental Director who acts as

chairperson for the committee and 12 practicing network dentists. The OMSFAC is comprised of the Dental Director who acts as chairperson for the committee and six network oral surgeons.

The criteria are derived from reviews of the current dental literature, subject textbooks, other insurance companies, and

- Practice Parameters, American Association of Periodontology (www.perio.org)
- Parameters of Care, American Association of Oral and Maxillofacial Surgery (www.aaoms.org)
- Oral Health Policies and Clinical Guidelines, American Academy of Pediatric Dentistry (www.aapd.org)
- Position Statements, American Association of Dental Consultants (www.aadc.org)
- Dental Practice Parameters, American Dental Association (www.ada.org)

Dental Clinical Criteria is posted on carefirst.com under the Providers tab in the Programs/Services section.

CareFirst physician reviews are available to discuss UM decisions. Providers may call **833-707-2287** to speak with a physician reviewer or to obtain a copy of any of the above-mentioned criteria free of charge. All cases are reviewed on an individual basis.

Important note: CareFirst affirms that all UM decision-making is based only on appropriateness of care and service and existence of coverage. CareFirst does not specifically reward practitioners or other individuals for issuing denials of coverage, care, or service. Additionally, financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to coverage, care, or service.

Coordinating and Arranging Care

Note: For any requests, there must be a referral from the PCP *in addition* to the servicing/rendering provider.

When an admitting physician calls the hospital to schedule an inpatient or outpatient procedure, they 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.

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

Electronic Provider Access along with general pre-certification/pre-authorization for out-of-area providers can be found in Chapter 2: Product Descriptions.

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 valid ICD-10 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 five business days prior to any elective admissions. 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 if additional information is needed before approving the authorization.

Important note: 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 monitors admissions of plan members to hospitals anywhere in the country.

If the admission date for an elective admission changes, 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.

Prior Authorization Requests from Out-of-Network Providers

CareFirst members are not required to request pre-certification/pre-authorization when visiting an out-of-network (OON) provider. However, OON providers are encouraged to submit a pre-certification/pre-authorization or encourage the member to do the same, as we have the right to deny claims if the service is deemed not medically necessary during review.

Out-of-Network Reimbursement Guidance

If an OON provider sees a CareFirst member, the provider will be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e. the provider would get paid at the same rate if the member was enrolled in Traditional Medicare).

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.

Clinical Programs for Medicare Advantage Members

For specific information regarding care management, refer to Chapter 7: Care Management