CareFirst
Family of health care plans

Provider Manual

For our professional provider community

CareFirst
Family of health care plans

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This manual provides information for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

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

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

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

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

Benefit Exclusions and Limitations—BlueChoice Only

PM0006-1E (7/19)

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Provider Quick Reference Guide

Products / ID Card Prefixes	Provider Service Phone #	Where to Send Claims	Where to Send Correspondence
BlueChoice—XIK, XIR, XIB, QXG, QXA, XIE, JHZ, XWZ, XIG, QXK **BluePreferred**—XIL, XWV, JHJ, XII, JHI, XIQ, QXM, XIY, XIU **HealthyBlue**—JHG, QXF, JHA, JHC, QXB, QXE, XIF, JHD, JHE, QXD, JHH, QXI, QXL, QXU, QXR, QXS, QXT, QXC, QXH **Indemnity**—XIJ, XWY	800-842-5975	Mail Administrator P.O. Box 14116 Lexington, KY 40512	Mail Administrator P.O. Box 14114 Lexington, KY 40512
The National Account Service Company (NASCO) All prefixes are unique. CareFirst NASCO IDs begin with an 81 or 83.	877-228-7268	Mail Administrator P.O. Box 14115 Lexington, KY 40512	Mail Administrator P.O. Box 14114 Lexington, KY 40512
Federal Employee Program (FEP) R prefix	**DC/Metropolitan Area** 202-488-4900 **MD** 800-854-5256	**DC/Metropolitan Area** Mail Administrator P.O. Box 14113 Lexington, KY 40512 **MD** Mail Administrator P.O. Box 14113 Lexington, KY 40512	**DC/Metropolitan Area** Mail Administrator P.O. Box 14112 Lexington, KY 40512 **MD** Mail Administrator P.O. Box 14111 Lexington, KY 40512
BlueCard Prefixes are unique	**Eligibility** 800-676-2583 **Out-of-area claims** 877-228-7268	**Send claims to your local plan:** Mail Administrator P.O. Box 14116 Lexington, KY 40512	Mail Administrator P.O. Box 14114 Lexington, KY 40512

Resources	Contact Information and Phone #		Link to Website
General Assistance	CareFirst Help Desk: 877-526-8390		
Behavioral Health	CareFirst: 800-245-7013		
Credentialing	**Professional** Mail Administrator P.O. Box 14763 Lexington, KY 40512 Phone: 877-269-9593 or 410-872-3500 Fax: 410-872-4107	**Institutional** CareFirst BlueCross BlueShield 10455 Mill Run Circle Mail Stop CG-51 Owings Mills, MD 21117 Phone: 410-872-3526 Fax: 410-505-2765	**carefirst.com/credentialing**
Pre-cert/Pre-auth	Medical: 866-773-2884 CVS Pharmacy: 855-582-2038	CVS Specialty Pharmacy: 888-877-0518	**carefirst.com/preauth**
Pharmacy	CVS Caremark: 800-241-3371		**carefirst.com/rx**
Lab	LabCorp:** 1-888-LabCorp (522-2677) Quest Diagnostics: 866-697-8378 *(available to PPO members only)* **Note: BlueChoice members must use LabCorp.		**labcorp.com** **questdiagnostics.com**

Resource	Area	Contact Phone #	
Other Party Liability	CareFirst (Small/Medium Group and Consumer Direct)	866-285-2611	
Large Group, Consumer Directed Healthcare (CDH), Administrative Services Only (ASO)	NASCO (Large Groups, CDH, ASO/self-insured)	877-228-7268	
	Workers Compensation/Subrogation	443-471-5589 or 443-471-5585	
	FEP Workers Compensation/ Subrogation	800-854-5256	
	FEP Coordination of Benefits (COB)	**DC**	**MD**
		202-680-7773	410-998-6845
		202-680-7777	410-998-6835
		202-680-7778	410-998-6840
		202-680-7779	410-998-6841

For additional online resources, view our Provider Link List, available at **carefirst.com/providermanualsandguides**.

CUT6010-1E (6/19)

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Administrative Functions

This section provides Administrative Functions information for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

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

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

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

Medical credentialing

Providers wishing to participate in the CareFirst provider networks are required to submit credentialing information. This 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 (DEA) and Controlled Dangerous Substance (CDS) registration
- 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
- 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 an inability to perform the essential functions of a clinical practitioner that could impose significant health and safety risks to members/enrollees; lack of present illegal drug use; history of loss of license and felony convictions; history of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage with minimum limits as indicated on the next page

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	$1/$3M Individual	N/A	$.5/$1.5M Individual	N/A	$1/$3M Shared (up to 24)
2–5	$1/$3M Shared	N/A	$.5/$1.5M Shared	N/A	$1/$3M Shared (up to 24)
6–10	$2/$6M Shared	N/A	$1/$3M Shared	N/A	$1/$3M Shared (up to 24)
11–24	$2/$6M Shared	$5M Shared	$1/$3M Shared	$3.25M Shared	$1/$3M Shared (up to 24)
	$1/$3M Shared	$10M Shared	$.5/$1.5M Shared	$7.5M Shared	
25–50	$2/$6M Shared	$10M Shared	$1/$3M Shared	$5M Shared	Individual Consideration
	$1/$3M Shared	$15M Shared	$.5/$1.5M Shared	$10M Shared	
51+	Individual Consideration	Individual Consideration	Individual Consideration	Individual Consideration	Individual Consideration

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.

CareFirst encourages the use of the Council for Affordable Quality Healthcare (CAQH) ProView application. 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 **provider.carefrst.com** > click *Join Our Networks* > click *How to Apply* > select the **CareFirst Questionnaire**, complete and submit the online form. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

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

If you are a participating primary care provider in CareFirst's network(s), you also have the opportunity to participate in programs that emphasize primary care and work to improve quality through coordinated care and appropriately aligned incentives like the **CareFirst Patient-Centered Medical Home (PCMH) Program**.

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

Verify provider information requirement

If you are already registered with CAQH ProView, please continue to make regular updates any time your provider information changes (or at least once each quarter). You will be contacted by CAQH each quarter with a reminder to review, update and attest to your provider information.

If you are not yet registered with CAQH ProView, learn more and register at **proview.caqh.org**. For details on CAQH ProView, view their Directory Reference Guide, Training Materials and Frequently Asked Questions at **proview.caqh.org**.

Profile 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. **Learn more** about the measures and methodology.

Role of the primary care provider (PCP)—(BlueChoice only)

Providers in the following medical specialties are recognized as primary care providers (PCPs):

- Family practice
- Internal medicine
- Pediatrics
- OB/GYNs (MD only)
- 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 identification 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 are 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 Jan. 20 will be effective Feb. 1. Changes received on Jan. 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 have the opportunity to select obstetrics and gynecology 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 PCP.

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

> Note: NPs must be certified by the relevant approved National Certification Board and meet all licensing/certification guidelines of the state in which the NP practices.

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 covering for Dr. [provider'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.

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, provided your panel includes at least 200 CareFirst BlueChoice members.

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, or 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 relative to billing and/or member satisfaction
- Closure of PCP panels (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 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, his/her right to appeal the determination and the appeal process. The practitioner may appeal the decision by submitting a written notice with relevant materials he/ she considers pertinent to the decision within 30 days of being notified of the decision. The practitioner forfeits his/her right to appeal if he/she fails 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 (NPDB), CareFirst complies with the notification requirements.

Quality of care terminations

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), notifies 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 with CareFirst.

All other sanctions or terminations

The medical director or credentialing manager will reconsider appeals for all other sanctions or terminations on the basis of new information provided by the practitioner. The medical director may seek recommendations from the CAC prior to making a final decision. The medical director notifies the practitioner of the decision in writing and informs the practitioner the decision is final 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. The provider may look to the member for payment of deductibles, copayments, and coinsurance or for services not 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.

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 are 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**.

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**.

Health Insurance Portability and Accountability Act (HIPAA) compliant codes

To comply with the requirements of Health Insurance Portability and Accountability (HIPAA), CareFirst will add the HIPAA-compliant codes and plan allowances to your 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.

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.

According to our standard Participation Agreement, contracted providers must:

- Submit claims to CareFirst for all covered services, including preventive services
- Bill members for payment of applicable deductibles, copayments and/or coinsurance

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

The written notice should be forwarded to your **professional provider relations representative**.

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

> 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.

Administrative services policy

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against subscribers or members for covered services, including those inherent in the delivery of covered services. The practice of charging for office administration and expense is not in accordance with the Participation Agreement and participating provider manual. Such charges for administrative services would include annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses and malpractice coverage increases. These charges could include 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, other expenses related to the overall management of patients and compliance with government laws and regulations, required of health care providers, completion of physical forms, medication forms, preop forms and/or CareFirst requested forms.

The provider may look to the subscriber or member for payment of deductibles, copayments or coinsurance, or for providing specific health care services not covered under the member's Health Benefit Plan as well as fees for some administrative services. Such fees for administrative services may include, by way of example, fees for completion of certain forms including school, work, camp, jury duty, disability forms not connected with the providing of covered services, missed appointment fees, and charges for copies of medical records when the records are being processed for the subscriber or member directly.

Fees or charges for administrative tasks, such as those enumerated above may not be assessed against all members in the form of an office administrative fee, but rather to only those members who utilize the administrative service.

Notice of Payment (NOP)/Electronic Remittance Advice (ERA)

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. A Notice of Payment (NOP) or Electronic Remittance Advice (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 or may not be available depending on whether or not there were payments.

Reimbursement for Limited Licensed Providers

CareFirst reimburses Limited Licensed Providers (LLPs) at a percentage of the standard physician fee schedule. This reimbursement policy applies to all CareFirst provider contracts.

The following is a list of LLPs typically affected by this reimbursement policy:

LLPs affected and related percentages of the standard physician fee schedule

Nurse midwife	90%
Nurse practitioner	85%
Board certified behavior analyst (BCBA)	75%
Dietician/nutritionist	75%
Licensed professional counselor, licensed marriage and family therapist, licensed alcohol and drug therapist	75%
Naturopathic provider	75%
Psychiatric nurse	75%
Licensed clinical social worker	75%
Lactation consultant	75%

Physician assistants, anesthesia assistants, assistant behavior analysts and registered behavior technicians

CareFirst does not contract with physician assistants, anesthesia assistants, assistant behavior analysts and registered behavior technicians.

Covered services rendered by physician assistants, anesthesia assistants, assistant behavior analysts and registered behavior technicians are eligible for reimbursement under the following circumstances:

- The assistant or technician (listed above) is under the supervision of a physician or licensed board-certified behavior analyst as required by local licensing agencies.
- Services rendered by the assistant or technician are to be submitted under the supervising physician's or licensed board-certified behavior analyst's name and provider number.

Services rendered by anesthesia assistants should be listed on the same claim as the supervising physician. The same procedure code can be listed on two different lines of the claim with the appropriate modifier (QK, AD, QX, QY) on each line. The system will accommodate and calculate allowances appropriately.

Services rendered by physician assistants, assistant behavior analysts and registered behavior technicians do not require additional modifiers to distinguish between provider types. Allowances will be based on the fee schedule for the supervising physician or licensed board-certified behavior analyst.

Referrals (BlueChoice only)

Unless otherwise stated, all office services not rendered by a PCP require a written referral, except for OB/GYN services and services rendered for members with the Open Access feature.

A written referral is valid for a maximum of 120 days and limited to three visits except for long-standing referral situations, and in-network services rendered to CareFirst BlueChoice members with the Open Access feature included in their coverage.

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**.

Electronic capabilities

To support our paperless initiative and improve your claims processing experience, CareFirst strongly encourages providers to utilize electronic capabilities.

Electronic claims

We strongly encourage providers to submit all claims electronically. Electronic submission can help your practice save time, money and eliminate incomplete submissions.

We understand certain claims require additional documentation from CareFirst and cannot be submitted electronically. However, we urge you to take advantage of all the benefits by filing electronically whenever possible, including when submitting the following types of claims:

- Initial
- Corrected
- Medicare Secondary that do not automatically crossover from CMS

Your billing **National Provider Identifier (NPI)** must be used to identify your practice when submitting claims.

Throughout the electronic claims submissions process, you will receive reports from both your clearinghouse and CareFirst to confirm if a claim has been received or encountered an error. If an error occurred, you are required to correct and resubmit the claim through your clearinghouse. If you do not, the claim has not been filed with CareFirst and may result in a timely filing rejection.

To locate a claim, start with the initial electronic filing to identify any potential transmission problems. If the claim is not showing on the system, please **contact your clearinghouse**, or contact the CareFirst Electronic Data Interchange (EDI) Help Desk at 877-526-8390, **edi@directsubmission.com** or **edidirectsubmission@carefirst.com**.

Claims receipt reports should be filed and kept for an appropriate period of time for follow up and research activities. CareFirst does not keep copies of these reports.

You can always login at **carefirst.com/carefirstdirect** to check on the status of a claim that has been received but not fully processed. To identify any issues, **contact provider services**. For more information, visit **carefirst.com/electronicclaims**.

Electronic Remittance Advice (ERA)

If you submit claims electronically, you can receive payment vouchers through an Electronic Remittance Advice (ERA 835). Your clearinghouse will provide the payment details, HIPAA adjustment reason codes and HIPAA remark codes so you can reconcile your patient accounts. Receiving your payment information electronically allows you to realize claim resolution faster and save money. ERA is available online through the portal.

For more information and to set up ERA, please **contact your clearinghouse**.

Electronic Fund Transfer (EFT)

If you are submitting claims electronically and receiving an ERA, you can also take advantage of Electronic Fund Transfer (EFT), which allows you to get paid faster with secure direct deposits from CareFirst and reduce paperwork. All of our **preferred clearinghouses** offer EFT enrollment services. Once you enroll in EFT, you will no longer receive a paper voucher or check.

Paper claims submission process

Paper claims 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 claims submitted to CareFirst. Claims missing information in any of the following fields will be returned:

- 1a: Insured's ID number*
- 2: Patient's name
- 3: Patient's birth date
- 21: ICD-10
- 24a: Dates of service
- 24b: Place of service
- 24d: Procedures, services or supplies
- 24f: Charges
- 24g: Days or units
- 24j: Rendering provider NPI
- 25: Federal tax ID number
- 31: Signature of provider (including degree or credentials)
- 33a: Provider's billing national provider identifier (NPI) (required, or it will be returned to the provider).

*The three-digit prefix must be included if present on the subscriber's identification card. Federal Employee Plan (FEP) member numbers do not have a three-digit prefix, but begin with an R and have eight numeric digits.

All claims must be submitted on an original (red/white) **CMS 1500 form (version 02/12)**. All information must fit properly in the blocks provided.

To expedite quick and accurate claims processing, please report services for only one provider per claim. If more than one provider in your practice renders services for a given member, separate claims must be submitted for each provider.

Timely filing of claims

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

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 screen print 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

Guidelines for ancillary claims filing

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

- Billing DME on a CMS 1500 claim form
- DME rental periods for a one month rental period should be billed as 1 unit, not 30 units with an RR modifier
- Correct billing of Healthcare Common Procedure Coding System (HCPCS) codes for Lancets, per box of 100 should only be billed as 1 unit, not 100 units of 100 lancets
- Bill a modifier of NU for purchase of DME
- Unlisted CPT and HCPCS codes should only be reported when there is no established code to describe the service
- Submissions of claims containing unlisted procedure codes must be submitted with a complete description of the service or procedure code provided. Any applicable records or reports must be submitted with the claim
- The following services are reimbursed on a daily basis according to the terms of the CareFirst provider contract, and the RR (Rental) modifier must be appended to the claim
  - Enteral nutrition infusion pump—with or without an alarm
  - Parental nutrition infusion pump—portable or stationary
- Phototherapy (bilirubin) light with the photometer
- Continuous passive motion exercise therapy device for use on the knee only
- Negative pressure wounds therapy electrical pump, stationary or portable
- Repair or non-routine service for DME other than oxygen equipment requiring the skill of a technician
- Repair or non-routine service for oxygen equipment requiring the skill of a technician

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 are now 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.

Effective follow-up for 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 provider customer service unit for assistance

Claims overpayment

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. Claims will be processed and a new check will be issued. In such a situation, the provider should complete the **provider refund submission form**.

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.

Inquiries

Inquiries may include issues pertaining to: authorizations, correct frequency, ICD-10, medical records, procedures/codes and referrals. Prior to submitting an inquiry, consider sending a **corrected claim**.

Instructions for submitting an inquiry

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, please use the **provider inquiry resolution form** (PIRF) to submit your Inquiry.

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
- A copy of the form can be located on the website at **carefirst.com/providerforms**

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

- Correspondence address:
  - **Mail Administrator**
    P.O. Box 14114, 14112, or 14111 (see below)Lexington, KY 40512
- Select the appropriate P.O. Box:
  - 14114—MD, national capital area (NCA), BlueChoice, local BlueCard and NASCO
  - 14112—federal employee program (FEP) providers in Montgomery & Prince George's counties, Washington, DC and Northern Virginia
  - 14111—All other MD FEP inquiries

Note: Before sending an Inquiry, consider submitting a corrected claim to replace the original claim submitted.

Appeals

An appeal is a formal written request to the plan for reconsideration of a medical or contractual adverse decision.

Instructions for submitting an appeal

An appeal must be submitted in letter form on your office letterhead describing the reason(s) for the appeal and the clinical justification/rationale. Please be sure to include:

- Patient name and 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.

Written appeals should be mailed to:

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

An appeal must be submitted within 180 days from the date of the EOB or adverse decision notice. All appeal decisions are answered in writing. Please allow 30 days for a response to an appeal.

IMPORTANT: Do not use a PIRF to submit an appeal. Visit carefirst.com/inquiriesandappeals for more information.

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

Please 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

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

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 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

Coordination with other payers

Coordination of benefits (COB)

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.

Please 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)

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 EOB from the primary carrier.

Subrogation

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

No-fault automobile insurance

The no-fault automobile insurance laws may require the automobile insurer to provide benefits for accident-related expenses without determination of fault. A copy of the record of payment from the automobile insurer must be attached to the claim form submitted to CareFirst.

Workers' compensation

Health benefits programs administered by CareFirst exclude benefits for services or supplies if the participant obtained or could have obtained benefits under a Workers' Compensation Act, the Longshoreman's Act, or a similar law. Affected claims should only be filed if workers' compensation benefits have been denied or exhausted. In the event that CareFirst benefits are inadvertently or mistakenly paid despite this exclusion, CareFirst will exercise its right to recover its payments.

Office injectable drugs

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.

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.

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

Standard reimbursement methodology

If you obtain office injectable drugs, the following standard reimbursement methodology applies. Injectable drugs are reimbursed at a 6 percent above the average sales price (ASP). Injectable drugs without an ASP may be reimbursed at a 15 or 20 percent off the lowest average wholesale price (AWP). The ASP is calculated by the Centers for Medicare and Medicaid Services (CMS) and available at **CMS.gov**. The AWP is based on the most cost effective product and package size as referenced in Truven's Red Book.

Standard 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 (i.e., Flu), then standard 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 to standard reimbursement.

Exemptions to standard pricing methodology

Exemption to the standard pricing methodology include:

- Pediatric vaccines are reimbursed at 100 percent of AWP.
- Select vaccines are reimbursed at 12 percent above ASP.

Medical injectables

Certain medical injectables 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. Refer to the Policy Document of the medications that require prior authorization to determine if a Site of Care Policy is notated. This requirement applies to both BlueChoice and Indemnity. The complete list of medications that require prior authorization is available at **carefirst.com/pharmacyresources** > *Pharmacy Prior Authorizations*.

You should request prior authorization:

- Online: Log in at **carefirst.com/providerlogin** and click the *Pre-Auth/Notifications* tab to begin your request.

CareFirst
Family of health care plans

Place of Service Code Assignments

For use with CMS 1500

Place of service code assignments are used by CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) providers when submitting claims for payment. These assignment codes are located at carefirst.com/providerguides.

Updated professional place of service codes (for freestanding ambulatory surgery center (ASC) and non-facility) for certain services are effective for dates of service on or after Dec. 1, 2012. These professional services will be reimbursed based on the applicable rate for the Place of Service Code billed for the claim.

Facility payment rate

This rate is applied when a professional provider performs covered services in a facility setting (i.e., hospital or skilled nursing facility) and the practice expenses associated with providing that service are the responsibility of the facility. In this scenario, payments would be made:

- To the professional provider for the professional services
- To the facility where the service was performed for the overhead costs and supplies

For covered services, the following place of service codes will be reimbursed at the facility payment rate:

Place of Service Code	Place of Service Description
05	Indian Health Service Freestanding Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-Based Facility
19	Off Campus—Outpatient Hospital
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
34	Hospice
41	Ambulance—Land
42	Ambulance—Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center

Place of Service Code	Place of Service Description
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
61	Comprehensive Inpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility

Freestanding ambulatory surgery center (ASC) rate

This rate is applied when the provider performs certain covered services in a freestanding ASC. This allowance will be higher than the facility allowance but lower than or equal to the non-facility allowance.

For covered services, the following place of service code will be reimbursed at the freestanding ASC payment rate:

Place of Service Code	Place of Service Description
24	Ambulatory Surgery Center

Non-facility payment rate

This rate is applied when the provider performs covered services in a non-facility setting (i.e., office or urgent care facility) and the professional practice incurs the full expense of providing the service such as labor, medical supplies, and medical equipment.

For covered services, the following place of service codes will be reimbursed at the non-facility payment rate:

Place of Service Code	Place of Service Description
01	Pharmacy
02	Telemedicine
03	School
04	Homeless Shelter
09	Prison-Correctional Facility
11	Office
12	Patient's Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk In Retail Health Clinic
18	Place of Employment—Worksite
20	Urgent Care Facility
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
60	Mass Immunization Center
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

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CareFirst
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Care Management

This section provides information on care management programs available for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

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

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

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

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

Quality improvement (QI) program

The goal of the quality improvement (QI) program is to continuously improve the quality and safety of clinical care, including behavioral health care, and the quality of services provided to members within and across health care organizations, settings and levels of care. CareFirst strives to provide access to health care that meets the Institute of Medicine's aim of being safe, timely, effective, efficient, equitable and patient-centered.

QI program goals and objectives

1. Support and promote all aspects of the CareFirst Patient-Centered Medical Home (PCMH) program and the Total Care and Cost Improvement (TCCI) programs as a means to improve quality of care, safety, access, efficiency, coordination and service.
2. Maintain a high-quality network of providers and practitioners to meet the needs of the population we serve.
3. Implement methods, tracking, monitoring, and oversight processes for all TCCI programs to measure their value and impact for appropriate patients with complex health care needs.
4. All elements of the CareFirst TCCI program will be operating at targeted levels.
5. Establish collaborative partnerships to proactively engage clinicians, providers and community hospitals and organizations to implement interventions that address the identified (medical and behavioral) health and service needs of our membership throughout the entire continuum of care and those who are likely to improve desired health outcomes.
6. Deliver data and support to clinicians to promote evidence-based clinical practice and informed referral choices and members to use their benefits to their fullest.

7. 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.
8. Assess the race, ethnicity, language, interpreters, cultural competency, gender identity and sexual orientation needs of our diverse populations while considering such diversity in the analysis of data and implementation of interventions to reduce health care disparities, improve network adequacy and improve cultural competency in materials and communications.
9. Monitor and oversee the performance of delegated functions.
10. Develop and maintain a high quality network of health care practitioners and providers who meet the needs and preferences of the membership by maintaining a systematic monitoring and evaluation process.
11. 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.
12. Provide insight based on SearchLight data to increase the knowledge base of the medical panels in the evaluation of their outcome measures.
13. Address health needs of all patients along the health care continuum, including those with complex health needs (advanced developmental, chronic physical and/or behavioral illness or complicated clinical situation).
14. Support quality improvement principles throughout the organization; acting as a resource in process improvement activities.

CareFirst recognizes that large racial and ethnic health disparities exist and communities are becoming more diverse. Racial, ethnic and cultural background influence a member's view of health care and its results. CareFirst uses member race, ethnic and language data to find where disparities exist, and we use the 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 practitioners, including designated behavioral health care practitioners, provide input and feedback on quality improvement program activities through participation in the following committees:

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

Performance data

A status of performance and evaluation of meeting goals of the QI program can be found at **carefirst.com**. CareFirst and CareFirst BlueChoice retain the right, at their discretion, to use all provider and/or practitioner performance data for QI activities including but not limited to, activities to increase the quality and efficiency to members (or employer groups), public reporting to consumers and member cost sharing.

National Committee for Quality Assurance (NCQA)

All CareFirst's health maintenance organization (HMO) and preferred provider organization (PPO) products are accredited. 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 service they need?
- **Qualified providers**—does the health plan assess each doctor's qualifications and what health plan members say about its providers?
- **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?

Patient-Centered Medical Home (PCMH) program

CareFirst's PCMH program is designed to provide primary care providers (physician or nurse practitioner) with a more complete view of their patients' needs and services they receive from other providers to better manage their individual risks, keep them in better health and produce better outcomes. The program requires greater provider-patient engagement and it meaningfully compensates providers for that engagement.

As part of CareFirst's PCMH program, the chronic care coordination program provides coordination of care for patients with multiple chronic illnesses and is carried out according to care plans developed under the direction of the PCP. While care plans may result from a case management or HTC episode, they also originate from a review of the trailing 12 months of health care use by an attributed member who is identified as likely to benefit from a care plan.

Care coordination for these patients is carried out through the local care coordinator (LCC) who is assigned to each provider/practice within a panel. The LCC assists the PCP in coordinating all elements of the patient's health care, ensuring all action steps in the plan are followed up and carried out. CareFirst provides online tailored care plan templates that are suitable for the needs of members with various chronic diseases (i.e., diabetes, asthma, COPD, coronary artery disease, congestive heart failure, hypertension, childhood obesity), or for members with condition clusters (i.e., a member with diabetes, obesity and congestive heart failure; or a member with coronary artery disease with myocardial infarction and hypertension).

The vast majority of patients for whom care plans are most appropriate have multiple morbidities. Each care plan template is based on the latest evidence-based clinical care guidelines for the condition or cluster.

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

Disease management programs

CareFirst offers **disease management** programs designed to reinforce and support the physician's plan of care. All programs are voluntary and confidential.

CareFirst uses claims data to identify members with the following chronic conditions who are eligible for disease management: asthma, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), heart failure, chronic low back pain, osteoarthritis, atrial fibrillation, irritable bowel syndrome (IBS), and fibromyalgia. The programs help educate members about their diseases and how to manage them, which will improve medical outcomes and quality of life. Services range from quarterly educational mailings to case management and access to a support nurse by phone 24 hours a day, seven days a week.

To obtain more information or to enroll patients into one of these programs administered by Sharecare, call 800-783-4582.

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

Respiratory diseases (asthma, COPD)

CareFirst offers comprehensive disease management programs for members with asthma and chronic obstructive pulmonary disease (COPD). These confidential, voluntary programs:

- Help members learn how to self-manage their condition
- Reinforce the physician's plan of care
- Are administered by Sharecare

Enrolled members:

- Can access a nurse by phone 24-hours a day, 7 days a week
- Are assigned a nurse care manager, if disease is severe
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information, refer a patient or if you are a member and want to self-refer, call the asthma management program at 800-783-4582.

COPD resources/related links

CareFirst follows the Asthma and COPD guidelines established by National Heart Lung and Blood Institute and World Health Organization. The COPD guidelines can be obtained from **goldcopd.**org.

Diabetes

CareFirst offers a comprehensive disease management program for members with diabetes. This confidential, voluntary program:

- Provides routine updates to keep physicians informed about patients' progress and adherence to the plan of care
- Reinforces the physician's plan of care
- Is administered by Sharecare

Enrolled members:

- Can access a nurse by phone 24 hours a day, seven days a week
- Are assigned a nurse care manager
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information or to refer a patient, please call the diabetes management program at 800-783-4582.

Diabetes resources/related links

The following information/journals can be found at http://care.diabetesjournals.org/.

- Standards of medical care in diabetes
- Nutritional recommendations and interventions for diabetes

Heart disease

CareFirst offers a comprehensive disease management program for members who have or are at risk for congestive heart failure (CHF) and coronary artery disease (CAD). This confidential, voluntary program:

- Provides routine updates to keep physicians informed about patients' progress and adherence to the plan of care
- Takes note of the high rate of heart disease among persons with diabetes
- Reinforces the physician's plan of care
- Is administered by Sharecare

Eligible members:

- Can reach a nurse by phone 24 hours a day
- Are assigned a nurse care manager (if greater disease severity exists)
- Receive educational materials, including condition-specific workbooks, action plans and newsletters

To obtain more information or to refer a patient, please call the CHF/CAD management program at 800-783-4582.

CareFirst supports the American Heart Association Clinical Guidelines. You may obtain a copy of these guidelines at **americanheart.org**.

Heart disease resources/related links

- **Clinical guidelines for the management of heart failure**
- **ACC/AHA/HFSA Focused Update of the ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America**
- **AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol**
- **AHA/ACC guideline on lifestyle management to reduce cardiovascular risk**
- **ACC/AHA guideline on the assessment of cardiovascular risk**

Note: Additional heart health resources and links can be found in the clinical guidelines section of provider.carefirst.com.

Oncology

CareFirst's cancer management program seeks to ensure the best possible outcomes for members with cancer.

Enrolled members are assigned to an experienced oncology care manager who:

- Monitors their progress in conjunction with the physician's plan of care
- Provides educational and emotional support
- Is available by calling 888-264-8648, Monday–Friday from 8:30 a.m. to 4:30 p.m.

Providers may refer a member to the oncology program by calling 888-264-8648.

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 c**linical practice guidelines** and p**reventive service guidelines**.

Medical record documentation standards

The following resources are developed under our QI program and support our providers in maintaining office operations.

- **Medical record documentation standards**
- **Practitioner office standards**

Complex case management (CCM)

CareFirst has assembled a team of highly qualified registered nurses who work directly with our sickest members to manage the care of their complicated conditions. Using the web-based care management system, case managers have the ability to create a care management plan in our online portal. Recognizing the need for targeted capabilities for complex conditions, CareFirst has developed specialized case management for the following patient needs:

- Adult oncology
- Pediatric oncology

- Complex medical
- Trauma/rehabilitation
- Special needs/complex pediatrics
- High risk obstetrics
- Hospice/palliative/end of life care

Health care providers, patients, family members, employers or anyone familiar with the case may refer candidates for CCM by calling 888-264-8648.

Outpatient pre-treatment authorization plan (OPAP)

OPAP is a pre-treatment program that applies to outpatient physical, speech and occupational therapy. Providers should use **CareFirst Direct** to enter their pre-treatment authorizations.

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.

Hospital transition of care (HTC)

HTC monitors admissions of CareFirst members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC program assesses member need upon admission and during a hospital stay with focus on post discharge needs. It begins the care plan process for members who will be placed in the complex case management (CCM) or chronic care coordination (CCC) programs. The HTC process also categorizes members based on the level of their severity of need and the nature of their illness or condition so they can be placed in the best possible track for follow-up care coordination services. Cases that will likely result in high costs will be flagged to ensure the member receives the attention they need to avoid costly breakdowns in care.

Comprehensive medication review (CMR) program

The CMR 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 (BSD)

CareFirst's 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**.

Intake, Assessment and Appointment team

CareFirst's Intake, Assessment and Appointment team assists members and providers seeking medical, behavioral health and/or substance use disorder support. Services offered includes crisis intervention, needs assessment, program referrals, as well as assistance with locating providers and setting initial appointments.

Mandatory second surgical opinion program (MSSOP)

MSSOP is aimed at containing costs by reducing unnecessary diagnostic and surgical procedures. It also provides reassurance to patients having elective surgery by either confirming the need for the surgery or advising them of other forms of treatment. Some employer groups elect voluntary second surgical opinion (VSSOP), while others choose MSSOP for certain procedures. If a subscriber's contract requires MSSOP, a penalty is applied if the VSSOP is not obtained. A practitioner who is qualified to perform the surgery must perform the VSSOP. The program applies to a specific list of diagnostic and surgical procedures when they are performed on an elective, non-emergency basis. The procedures on the MSSOP list vary from account to account.

Utilization Control Program (UCP)/ Utilization Control Program Plus (UCP+)

These programs feature pre-admission review, admission review, continued stay review, retrospective review, and discharge planning. A notification of admissions to the CareFirst utilization management department is required. This notification is done in **CareFirst Direct**.

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CareFirst
Family of health care plans

Arranging for Care—BlueChoice Only

CareFirst BlueChoice, Inc. (CareFirst BlueChoice) only

This section provides information on Care Management for your CareFirst BlueChoice, Inc. (CareFirst BlueChoice) patients.

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

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

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

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

Referral process

Unless stated in member coverage, 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 participating specialist for care. The member should not be instructed to call CareFirst BlueChoice for the referral.

If a particular specialist or provider cannot be found, call provider services to determine the participatory status of the specialist or provider.

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

- Member's name, date of birth and member identification number
- Your name, phone number and CareFirst BlueChoice provider identification number
- The specialist's name and CareFirst BlueChoice provider identification 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

Extended (long-standing) referrals

PCPs may issue an extended, or long-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 of 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, you may modify an extended referral to limit the number of visits or the period of time for which visits are approved. In addition, the referral may require that the specialist communicate regularly with you 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 410-605-2413 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.
- A written referral is not required for members with the Open Access feature included in their coverage.

Services not requiring a written referral

- Ambulatory surgery centers (ASCs)
- Participating 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 practitioner to members with the Open Access feature included in their coverage

Laboratory Corporation of America (LabCorp)

LabCorp is the only network national lab that BlueChoice (HMO) members can use. Please do not refer HMO members to a lab other than LabCorp. LabCorp requisition forms that include the member's identification number must be used when ordering lab testing or directing members to a drawing station. Some exceptions may apply in Western Maryland and the Eastern Shore.

No written referral is necessary.

Members referred to a participating radiology facility require a written order on the practitioner's letterhead or prescription pad. No written referral form is necessary.

Visit the **carefirst.com/qualityandaffordability** for additional information related to National Laboratories.

Specialist

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.

Entering referral information on an electronic CMS 1500

- 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.

Authorization

Services requiring an authorization

The 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 CPT code and/or description of the procedure being performed

The hospital will then request the authorization. The 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
- 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 provider other than the practitioner
- 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 health care, 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/medicalpolicy**.

Medical injectables

Certain medical injectables require prior authorization when administered in an outpatient hospital and home or office settings. Intravenous immune globulin (IVIG) 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 both BlueChoice and Indemnity. 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/providerlogin** and click the *Pre-Auth/Notifications* tab to begin your request.

Necessary information

The hospital will provide the following information to CareFirst for services requiring authorization:

- Member's name, address and telephone number
- CareFirst BlueChoice member identification 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 ambulatory surgical/care center (ASC) does not require authorization. When members are referred appropriately to ASCs, health care 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 Provider**.

Care management

Care management reviews clinical information regarding health care and/or procedures for appropriateness of care, length of stay and the delivery setting for specific diagnoses.

Care management links health care providers, members and CareFirst in a collaborative relationship to achieve medically-appropriate, cost-effective health care in all delivery settings within the framework of covered benefits.

Emergency room services

In-area emergencies

The covering physician is contractually obligated to be available by telephone 24 hours a day, seven days a week for member inquiries and follow these guidelines:

- For all life-threatening emergencies, call 911
- For 24 hour medical advice and/or the specialist in urgent/urgent situations, call the PCP

CareFirst BlueChoice members may arrive at the emergency room (ER) under one of the following circumstances:

- PCP or specialist referral
- FirstHelp referral
- Self-referral
- Ambulance

Referred by PCP or specialist

Members are encouraged to contact their PCP and/ or specialist to seek guidance in urgent or emergency medical conditions. When a PCP or specialist refers a member, the ER professionals will triage, treat and bill in their customary manner. An authorization number or written referral from the PCP or specialist is not required.

Referred by FirstHelp

When FirstHelp refers a member to the ER, the professionals there will triage, treat and bill in their customary fashion. An authorization number or written referral from FirstHelp is not required.

FirstHelp is available toll-free, 24 hours a day at 800-535-9700.

Self-referral

When a member self-refers, the ER professionals will triage the member. If the condition is deemed emergent, treatment is rendered and billed. An authorization number or written referral is not required. Please remember that all subsequent follow-up care must be provided or coordinated by the member's PCP or authorized by care management.

If the condition is deemed non-emergent, the ER professionals should encourage the member to call his/her PCP, specialist or FirstHelp for advice regarding treatment at the appropriate level of care. Professional services should be billed appropriately.

Ambulance

If a member arrives at the emergency room department via ambulance, the emergency room professionals will triage, treat and bill in their customary manner. An authorization number or written referral is not required for ground transportation.

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 Emergency Admission Authorization Process to verify and/or secure authorization.

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, it is the hospital's responsibility to obtain the pre-authorization.

Hospital services

Inpatient hospital services—elective authorization process

- Through **CareFirst Direct**, the hospital is responsible for initiating all requests for authorization for an inpatient admission. 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 calls from the admitting physician at least **five** business days prior to all 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 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 hospital

transition of care (HTC) coordinator nurse 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.

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 by LabCorp* **labcorp.com** or performed at participating freestanding radiology** centers.

* Some exceptions may apply in Western Maryland.
** Some exceptions may apply on the Eastern Shore.

Discharge planning process

The hospital or attending physician is responsible for initiating a discharge plan as a component of the member's treatment plan. The hospital, under the direction of the attending physician, should coordinate and discuss an effective and safe discharge plan with the hospital transition coordinator (HTC). The HTC program assesses discharge needs on admission and during the hospital stay with the focus on initiating referrals to the appropriate TCCI program upon discharge. Referrals to hospital social workers, long-term care planners, discharge planners or hospital case managers should be made promptly after admission and coordinated with the HTC.

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 health care 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 (i.e., surgery, false-labor/observation stays)
- 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.

* Some exceptions may apply in Western Maryland.
** Some exceptions may apply on the Eastern Shore.

Utilization Management (UM) decisions are based on the following criteria

- Modified appropriateness evaluation protocol (AEP) criteria
- Apollo managed care physical therapy, occupational therapy, rehabilitation care and pain management criteria
- CareFirst Medical Policy reference manual
- The MCG care guidelines
- The Dental Criteria Guidelines (care management staff are trained in procedures for applying criteria. The criteria are not absolute but designed to be used in conjunction with the assessment of individual patient needs)

- CareFirst makes physician reviewers available to discuss utilization management (UM) decisions. Physicians 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 utilization review for denials of coverage or service. Additionally, financial incentives for UM decision makers do not encourage underutilization of coverage or service.

Case management referral process

Case management is designed to identify patients who require more involved coordination of care due to a catastrophic, chronic, progressive or high risk acute illness, as early as possible. Case management also coordinates the use of health care benefits to create a plan of care that maximizes benefits effectively without compromising the quality of care. PCPs should refer members who would benefit from these services as soon as they are identified.

Case management intervention is appropriate for members:

- With catastrophic, progressive, chronic or life-threatening diseases
- Who require continuing care due to a catastrophic event or an acute exacerbation of a chronic illness
- With extended acute care hospitalizations
- With repeat hospital admissions within a limited time period

The case manager prepares and coordinates a care plan in collaboration with the member, his/her PCP, other providers and family. The case manager will ensure that the care plan is within the member's existing benefits.

If you are interested in case management services or to obtain more information or to refer a member, please contact CareFirst at 888-264-8648.

A quick reference guide when arranging for care

Care Services	
Service	**CareFirst BlueChoice**
Obtain benefits	CareFirst Direct
Inpatient/outpatient hospital authorization	Hospital is required to obtain authorization at least five business days prior to admission
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

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CareFirst
Family of health care plans

Policies and Procedures

This section provides information on policies and procedures for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

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

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

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

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

Medical policy and technology assessment

Medical policies and medical policy operating procedures

CareFirst evidence-based medical policies and medical policy operating procedures can be found in the **Medical Policy Reference Manual** (MPRM). This manual is an informational database, which, along with other documentation, is used to assist CareFirst reach decisions on matters of medical policy and related member/subscriber 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/subscriber coverage will vary from contract to contract and by line of business, and 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 CMS Healthcare Common Procedure Coding System (HCPCS, Level II codes), the International Classification of Diseases (ICD), and the American Medical Association's Current Procedural Terminology (CPT) (HCPCS Level I codes).

The **MPRM** 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 **MPRM** 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.

It should be noted that 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 NASCO system, and subscribers with federal employee program (FEP) benefits, may defer to policies promulgated by the Blue Cross and Blue Shield Association. Therefore, there may be differences in medical policy and technology assessment determinations depending on the subscriber contract; and benefits and coverage determinations should be verified prior to providing services.

Technology assessments

Technology assessment is a process in which current or new/emerging technologies are thoroughly researched, evaluated and formulated, as appropriate, into evidenced-based CareFirst medical policy. Technologies include drugs, devices, procedures, and techniques. CareFirst has adopted the criteria of the Blue Cross and Blue Shield 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 **MPRM** under *Definitions and Interpretive Guidelines*.

Technology assessments are presented, with supportive data, to the CareFirst technology assessment committee (TAC) which meets on a regular basis. TAC is comprised of members of the health care policy department, CareFirst medical directors, and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether or not 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.

Confidentiality

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 (a person who signs a policy with CareFirst) 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 (PHI) in accordance with the Privacy Rule as outlined in the Health Insurance Portability and Accountability Act (HIPAA) and our notice of privacy practices (NPP).

Member access to medical records

The member must follow the provider's procedures for accessing medical information. Members may access their medical records by contacting the primary care provider's (PCP) office or the provider of care (such as a hospital).

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. CareFirst reviews practitioner confidentiality processes during pre-contractual site visits for primary care physicians.

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 practice

CareFirst is committed to keeping the confidential information of members private. Under HIPAA, we are required to send our notice of privacy practices 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.

Reimbursement policy statements

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 (i.e., current procedural terminology, CPT)
- Centers for Medicare and Medicaid Services (CMS) policies
- Professional specialty organizations (i.e., American College of Surgeons, American Academy of Orthopedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Current health care trends
- Medical and technological advances
- Specialty expert consultants

Therefore, our policies and clinical rules are developed through a compilation of information from a variety of sources. The clinical rules we utilize are designed to verify the clinical accuracy of procedure code relationships on professional (non-institutional) claims. CareFirst utilizes McKesson ClaimsXten® software as a part of the overall editing process for claims. The ClaimsXten software is updated quarterly 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 policy changes through **BlueLink**, weekly News You Can Use emails and/or newsflash updates at **carefirst.com/providernews**. It is recommended that providers also regularly access and review these policy statements to keep current with changes and updates.

Inclusion of codes from CPT, HCPCS, or ICD-10 reflect the use of nationally published and recognized clinical coding systems of definitions and clinical rationales for use in claims processing to fully communicate and accurately identify the services being rendered by the health care provider. Each is a HIPAA compliant code set, and reference to and/or use or interpretation of the codes does not represent an endorsement of any procedure or service or any related consequences or liability by the organizations that developed the codes.

Professional services and procedures are identified by the appropriate and current CPT or HCPCS

reporting code. The descriptor of the code is used to fully communicate and accurately identify the services provided to the subscriber. ICD-10 diagnosis codes are utilized to indicate the appropriate patient diagnoses for which these services or procedures were provided. Claims are filed utilizing these reporting codes and are reviewed to determine eligibility for reimbursement. If services are determined 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 edited for:

- Services reported together on the same claim
- Services reported on separate claims
- Services performed on the same date or within global periods
- Procedure code/modifier validity
- Age conflict
- Gender conflict
- Allowed frequency
- Duplicate procedures
- Unbundled procedures
- Incidental, integral, included in procedures
- Mutually exclusive procedures
- Assistant at surgery
- Cosmetic procedures
- Experimental/investigational procedures

The inclusion of a code in CPT, HCPCS, or ICD-10 does not imply that the service is a covered benefit, or that it will be reimbursed by CareFirst. Codes are not reassigned into another code or considered ineligible for reimbursement based solely on the format of code descriptions in any codebook (i.e., indentions). In addition, codes are not automatically changed to ones reflecting a reduced intensity of service when codes are among or across a series that include those that differentiate among simple, intermediate, and complex; complete or limited; and/or size.

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; or
- Select services as outlined in the federal employee health benefit plan (FEHBP) manual

Reporting ICD-10 diagnosis codes

Carefully follow coding guidelines outlined in the most current ICD-10 coding book. Guidelines of particular importance include:

- Code to the highest level of specificity, as appropriate;
- List the primary or most important diagnosis 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.

For additional information, visit **carefirst.com/icd10**.

Requests for clinical information

In order to accurately adjudicate claims and administer subscriber benefits, it is necessary to request medical records. The following is a list of 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 pre-certification/pre-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 cosmetic or 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 (i.e., data collection as required by accrediting agencies, such as NCQA/HEDIS/ 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.

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 (i.e., NASCO) depending on the account's home plan.

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; and 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; and multiple surgery situations,

when one or more procedures are considered to be an integral part of the major procedure or service. An example of this is a procedure code designated by CPT as separate procedure. 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 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.

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.

Add-on procedures

Procedure codes designated as add-on (or list separately in addition to the code for primary procedure for CPT), are only reported in addition to the specific code for the primary (or parent) procedure. These add-on codes are not eligible for separate reimbursement when reported as stand-alone codes or, in some instances, when the primary procedure is not covered.

Add-on codes are not subject to multiple procedure fee reductions as the RVUs assigned to these add-on procedure codes have already been reduced to reflect their secondary procedure status.

If several procedures are performed during the same session by the same physician, and the primary (or parent) code needs to be distinguished as a distinct procedure (i.e., CPT modifier-59 is appended to the primary code), then CPT modifier-59 must also be appended to any add-on codes related to the parent code.

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), 59 (distinct procedural service), 76 (repeat procedure or service by same physician or other qualified health care professional), 91 (repeat clinical diagnostic laboratory test), or CPT 76140 (consultations on X-ray exams performed at other sites.)

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.

Unlisted procedures

In the Federal Register, Center for Medicare and Medicaid Services (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

CareFirst accepts all valid CPT and HCPCS modifiers. A modifier enables the provider to indicate that a service or procedure performed has been altered in some way but that the standard definition and associated reporting code remains unchanged. modifiers may be used to indicate that:

- A service or procedure was provided more than once
- A service or procedure was performed on a specific anatomical site
- A service or procedure has both a professional and technical component
- A bilateral procedure was performed
- A service or procedure was performed by more than one provider and/or in more than one location
- A service was significant and separately identifiable from other services or procedures

Up to four modifiers may be reported per claim line. CareFirst claims systems are capable of adjudicating multiple modifiers. modifiers that may affect reimbursement should be listed first.

Services reported with an invalid modifier-to-procedure code combination will be denied. Claims must be resubmitted with the correct modifier (or without the invalid modifier) in order to ensure appropriate claim adjudication.

modifiers may or may not affect reimbursement. Certain modifiers are for informational purposes only and assist in correct application of benefits.

The following CPT modifiers may affect reimbursement:		
-22	-54	-77
-24	-55	-78
-25	-56	-79
-26	-57	-80
-50	-59	-81
-51	-62	-82
-52	-66	-91
-53	-76	

The following HCPCS modifiers may affect reimbursement:			
RT	TA-T9	TC	GC
LT	LC	AA	QK
E1-E4	LD	AD	QX
FA-F9	RC	AS	QY

Examples of modifiers that are used for informational purposes and do not affect reimbursement are:		
-23	-33	-90
-32	-63	-99

The following CPT modifiers do not affect reimbursement:	
-47	-63
P1-P6	-92

Examples of modifiers that may affect how member benefits are determined and reimbursed:			
BR	BP	KI	UE
BU	KA	K2	QE
KI	KH	K3	QF
KJ	KM	K4	QG
KR	KN	NR	QH
LL	KS	NU	GO
MS	KX	RA	GP
RR	KO	RB	

CareFirst follows the CMS guidelines when determining if particular diagnostic or therapeutic tests and procedures can be reported as a global (total) service, or if they can also be reported as either a technical or professional component of the service. It is important to report these services according to the following guidelines:

- Report the procedure as a global (total) service, without a modifier. If you own the equipment, administer the test and provide the interpretation
- Report the procedure as a technical component (along with HCPCS modifier TC) if you only perform the technical portion of the procedure
- Report the procedure as a professional component (along with CPT modifier-26) if you only perform the interpretation and/or supervision portion of the procedure

In instances where one provider is reporting the technical component and another is reporting the professional component, both providers should submit separate claims, with the same procedure code(s), with the appropriate modifier, and with the same date of service. As noted above, services reported with an invalid modifier-to procedure code will be denied and must be resubmitted.

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 evaluation and management (E/M) codes. Pertinent medical records that clearly demonstrate the reason that the procedure/service requires "substantial additional work" than that of the reported procedure must accompany the claim. This modifier should be reported only when the procedure or service 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 made 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, subscriber 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**
- 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 CPT guidelines.

CPT modifiers -58, -76, -77, -78, and -79 identify procedures performed during the global surgical period. Follow CPT reporting guidelines for these modifiers. Submissions of claims containing CPT modifier-78 are reviewed by our medical review department and should be submitted

with a complete operative record in order to be appropriately adjudicated.

CPT modifier-24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT reporting guidelines for this modifier.

Bilateral procedures reimbursement guidelines

Bilateral procedures are defined as surgeries rendered by the same provider, during the same operative session, on paired anatomical organs or tissues.

Bilateral procedures are typically reimbursed at 150 percent of the allowance of the unilateral procedure (i.e., 100 percent for one side, and 50 percent for the other side). For bilateral secondary surgical procedures, bilateral surgical adjudication edits are applied first, and then multiple surgical edits are applied. The primary bilateral procedure is reimbursed at 150 percent (100 percent for the first side, and 50 percent for the second side). The second bilateral procedure is reimbursed at 100 percent (50 percent for the first side and 50 percent for the second side).

Policy guidelines for reporting bilateral procedures

Bilateral procedures are reimbursed based on either CPT coding guidelines or the CMS list of procedure codes that are eligible for CPT modifier-50. When CPT modifier-50 is valid, the appropriate code for the bilateral procedure should be reported on one line with the CPT-50 modifier appended and a frequency of one in the unit field. If a claim for a bilateral procedure is not submitted this way, the claim will be returned with a request to resubmit it properly. Claims submitted with a procedure that is invalid with CPT modifier-50 will be returned with a request to resubmit a corrected claim.

When reporting bilateral primary and secondary procedures, CPT modifier-50 should be reported in the first modifier position. CPT modifier-51 may be reported in the second modifier position.

HCPCS Level II modifiers -RT (right side) and -LT (left side) are used when a procedure is performed either on one side of the body rather than both sides, or when CPT modifier-50 is not valid for a procedure code but the procedure is performed on both sides of paired organs. When -RT and -LT modifiers are both used for the same procedure, report the procedure code on two lines with the -RT and -LT appended to each code.

If the description of the procedure code contains the phrase bilateral, it is eligible for reimbursement only once on a single date of service. Report the single procedure code with a frequency of one in the Unit field.

If the description of the procedure code contains the phrase unilateral/bilateral, it is eligible for reimbursement only once on a single date of service. If the code includes unilateral/bilateral in the description, it is not appropriate to report the code with CPT modifier-50. The fee schedule allowance is the same regardless of whether it is performed on one side or both sides. Report the single procedure code with a frequency of one in the Uunit field.

If the description of the procedure code specifies unilateral and there is another code that specifies bilateral for the same procedure, the bilateral code will replace the unilateral codes when they are reported more than once for the same date of service. Code replacements will also occur when one procedure code specifies a single procedure and a second procedure code specifies multiple procedures. Do not report CPT modifier-50 in this circumstance. Always report the most comprehensive code for the procedure(s) performed.

Certain procedures may only be reported a specified number of times on a single date of service. Once the maximum number is reached, all additional submissions of the procedure code will not be eligible for reimbursement.

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 percent 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 percent of the allowed benefit; and the second and subsequent procedure(s), at 50 percent 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, 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. Carefully 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 practice expense (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.) It should be noted that beginning in 2007, CMS has changed the way it determines the resource-based direct and indirect practice expenses. As a result of the changes to the Physician Fee Schedule described above, CareFirst will utilize the transitioned non-facility total RVU (Column P) as published by CMS for both new and pre-existing codes beginning in mid-April 2007 at the time of our next claims software upgrade.

For additional information on this methodology, visit the CMS website at **cms.hhs.gov/PhysicianFeeSched/**.

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. In accordance with multiple procedure editing, 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.

Multiple provider participation in surgical procedures

Certain procedures may require the participation of more than one provider in order to accomplish the desired outcome. Information outlining policies and reporting guidelines for these situations are as follows:

Surgical assistant or assistant at surgery

Assistants at surgery are distinct from team and co-surgery, as described below. For information on this topic refer to **Medical Policy Reference Manual** operating procedure 10.01.00 8A, Surgical Assistants. The American College of Surgeons (ACS) is the primary source for determining reimbursement for assistant at surgery designations of always or never. The ACS utilizes clinical guidelines (instead of statistical measures) to determine the appropriateness of assistants at surgery. A variety of sources, including expert clinical consultants, specialty organizations (i.e., American Academy of Orthopedic Surgeons and CMS) are used to determine reimbursement for assistant at surgery ACS designations of sometimes.

CPT modifiers -80, -81, or -82 are reported for the services of an MD or DO. HCPCS modifier -AS is reported for the services of the non-physician assistant (i.e., physician assistant, nurse practitioner).

CPT modifiers -80, -81, -82, and HCPCS modifier -AS are currently reimbursed at 16 percent of the allowance for the procedure(s) for which assistant services are eligible for reimbursement.

All applicable reimbursement policies will apply to an assistant at surgery the same as it would apply to the primary surgeon (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods).

Team surgery

The term "team surgery" describes circumstances in which two or more surgeons of the same or different specialties are required to perform separate portions of the same procedure at the same time. Examples of these circumstances include procedures performed during organ transplantation or re-implantation of limbs, extremities or digits. In these instances, the surgeons are not acting as an assistant at surgery, but rather as team surgeons.

To report as team surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT modifier -66 to the specific procedure code(s) used for reporting the services provided.

Submissions of claims containing CPT modifier -66 are reviewed by our medical review department, and should be submitted with the complete operative record in order to be appropriately adjudicated. The unique surgical services and level of involvement of each surgeon should be documented in a single operative report that is signed by all participants.

If a surgeon functions as both a team surgeon and an assistant at surgery for different portions of the total operative procedure, then CPT modifier -66 should be appended to the procedure applicable to team surgery and CPT modifier -80, -81, or -82, as appropriate, should be appended to the procedure(s) in which the surgeon acted as an assistant.

The percentage of the allowed benefit apportioned to each of the team surgeons will be determined based on several factors, including but not limited to:

- The complexity of the individual surgical services performed
- The amount of involvement in the operating room
- The amount of pre- and post-operative care required
- Whether the procedures performed are related, incidental, or unrelated to each other

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT modifier -66.

Co-surgeon

The term "co-surgery" describes circumstances in which the individual skills of two or more surgeons, often of different specialties, are required to perform the same procedure. In these instances, the surgeons are not acting as an assistant at surgery, but rather as a co-surgeon.

To report as co-surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT modifier-62 to the specific procedure code(s) used for reporting the services each provided.

Effective with claims processed on and after Jan. 1, 2012, providers will no longer be required to submit operative reports or other clinical records to be reimbursed for claim lines containing modifier-62 alone. Our revised policy will be to reimburse each surgeon at 50 percent of the allowed amount for the procedure after all other edits (i.e., multiple surgery reductions, incidental, mutually exclusive, etc.) have been applied.

Providers will need to send in the appropriate clinical documentation for claim lines that contain modifier-62 and any other modifier on the same line that would potentially impact reimbursement. If an additional modifier, such as modifier-22 or -78 is appended to a procedure also containing modifier-62, then the appropriate clinical documentation will be reviewed to determine an appropriate reimbursement.

If a surgeon functions as both a co-surgeon and an assistant-at surgery for different portions of the total operative procedure, then CPT modifier-62 should be appended to the procedure(s) applicable to co-surgery, and CPT modifier -80, -81, or -82, as appropriate, should be appended to the procedure in which the surgeon acted as an assistant.

If additional procedures (including each additional procedures) are performed during the same operative session by one of the surgeons, the additional procedure code(s) should be reported by that surgeon only, without CPT modifier-62 appended.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT modifier-62.

Multiple provider participation in patient care

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 a 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.

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 begin reporting 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 subscriber'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 procedures, 10.01.004A, Standby Services), except for attendance at delivery when requested by the obstetrician (see our **Medical Policy Reference Manual**, procedure 10.01.002A, Attendance at Delivery).

Evaluation and management (E/M) services

Benefits are available for E/M services according to the terms of the subscriber'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**.

CPT modifier-25

In many instances, E/M services are considered included in or mutually exclusive to other procedures and services reported on the same date, and are therefore not eligible for separate reimbursement.

CPT modifier-25 is used to describe a significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service. CPT modifier-25 is only valid with E/M codes.

Reporting with a CPT modifier-25 does not require a different diagnosis as the procedure or other service, but documentation in the medical record must support that a significant, separately identifiable E/M service was provided. To be eligible for reimbursement for CPT modifier-25, the key components of the E/M service (i.e., history, physical, decision-making, as outlined in CPT) must be performed and documented in the medical record.

There are many instances in which CPT modifier-25 may be appropriately reported, as described throughout these reimbursement guidelines.

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 subscriber contracts include a benefit for these preventive examinations, many of which are limited to once per benefit year/annually. It is important, therefore, that preventive services (CPT 99381-99397) are only 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). 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** available in the Resources tab at **provider.carefirst.com**.

Preventive services under the Affordable Care Act (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 however, that a patient may be present for 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 it may be appropriate to report the appropriate level E/M code 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 (i.e., 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 (i.e. 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

Carefully 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) to 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 (i.e., time spent per 30 days) 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 health care 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 evaluation and management service.

Chronic care coordination services

CareFirst provides a benefit for complex chronic care coordination services (CPT 99487–99490), effective Jan. 1, 2015. These services are reported in accordance with CPT guidelines (i.e., 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

Transitional care management services

CareFirst provides a benefit for transitional care management services (CPT 99495-99496), effective Jan. 1, 2013. These services are reported in accordance with CPT guidelines (i.e., calendar days between discharge and a face-to-face visit, who may report these services, 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 timeframes during which transitional care management services are reported, also as outlined in the CPT code book.

Online/internet and telephone services

CareFirst does not provide benefits for non-face-to-face services via telephone or internet (CPT 99441-99443; 99444; 98966-98968; 98969; or effective 1/1/2014, Inter-professional Telephone/ Internet Consultations (CPT 99446-99449). All of these services are considered integral to/included in all other services, whether reported alone or in addition to other services or procedures. Integral to/included in services are not eligible for reimbursement.

Telemedicine

Telemedicine services refers to the use of a combination of interactive audio, video, or other electronic media used by a licensed health care provider for the purpose of diagnosis, consultation, or treatment consistent with the provider's scope of practice. Use of audio-only telephone, e-mail, online questionnaires or FAX is not considered a telemedicine service. Services for diagnosis, consultation or treatment provided through telemedicine must meet all the requirements of a face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services. Diagnostic, consultative and treatment telemedicine services should be reported with the appropriate category I CPT code and the HCPCS modifier-GT (via interactive audio and video telecommunication systems). Diagnostic consultative and treatment telemedicine services

should be reported with the appropriate category I CPT code and the HCPCS modifier-GT (via interactive audio and video telecommunication systems) or CPT modifier-95 (synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system).

CareFirst does provide benefits for telemedicine services under certain circumstances. Refer to medical policy 2.01.072, Telemedicine (Unified Communications), in the **Medical Policy Reference Manual**, for details.

E/M services during the global periods

E/M services reported on the same date as zero day global period procedures are edited as follows

- Initial/new Patients: the E/M service is eligible for reimbursement in addition to the procedure
- Follow-up/established patients: only the procedure is eligible for reimbursement unless CPT modifier-25 is appended to the visit code to indicate that a significant, separately identifiable E/M service was provided at the time of the procedure

E/M services for new or established patients reported on the same date as a 0/10 and 1/90 day global period procedure are not eligible for reimbursement. An exception to this is when CPT modifier-57 (see below) or CPT modifier-25 is appended to the visit code to indicate that a significant, separately identifiable E/M service was provided in conjunction with the procedure. The E/M service is then eligible for separate reimbursement.

CPT modifier-24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT reporting guidelines for this modifier.

See also *Collecting copayments/coinsurance during global surgical periods*.

CPT modifier-57

When an E/M visit results in the initial decision to perform surgery for a major (i.e., 1/90 global period) procedure, CPT modifier-57 should be appended to the E/M service code. The E/M service is then eligible for separate reimbursement. Refer to CPT reporting guidelines.

CPT modifier-57 is not eligible for reimbursement in the following circumstances:

- When reported with non-E/M codes;
- When the initial decision to perform surgery is a minor surgical procedure (i.e., a procedure with a 0 or 10 day global period); or
- When E/M visit code is used for the preoperative history and physical exam prior to the surgical procedure

E/M services in conjunction with immunizations

If immunization(s) and administration of the drug are reported together, both are eligible for separate reimbursement. Covered E/M services are also eligible for separate reimbursement at the same visit as the immunization, with the exception of CPT code 99211. If a significant, separately identifiable CPT code 99211 is rendered at the time of the immunization/injection, CPT modifier-25 should be appended.

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 (i.e., office staff discussing dietary concerns with a patient).

Carefully 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 no longer 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.

General and specialty-related claim adjudication policies and reimbursement guidelines

The following represent highlights of certain policies, edits, and reimbursement guidelines that may be of interest to many providers in the CareFirst networks. Since there is no way we can address all editing scenarios in this document, please contact your provider services representative with questions of a more specific nature.

Multiple specialties

Billing for services rendered to patients

Except for very limited circumstances ((i.e., 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, 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 health care 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, one 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. It is advised that providers ensure that benefits are available prior to rendering these services.

Additional information is available in the **Medical Policy Reference Manual** (i.e., medical policy 5.01.001) and the **CareFirst Preventive Services Guidelines**, both of which are located on **provider.carefirst.com**.

For information regarding procurement of office administered medications, refer to *Injectable drugs in the administrative functions* section of this manual.

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 subscriber/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 to primary care providers (PCPs) for after hours service. After hours is defined as medical office services rendered after 6 p.m. and before 8 a.m. weekdays; or weekends and national holidays. This code may be reported in addition to other services on the claim. The following types of practitioners are considered PCPs: general practice, family medicine, internal medicine, pediatrics and geriatrics. CPT 99050 and 99051 are not eligible for separate reimbursement at urgent care centers.

Cerumen removal

Removal impacted cerumen (ear wax) using irrigation/lavage unilateral, CPTcode 69209 (effective 1/1/2016), 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 Removal impacted cerumen requiring instrumentation, 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 health care 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 (i.e., office or other outpatient, hospital care, nursing facility services) as instructed in the parenthetical notes following CPT 69209 and 69210.

Critical care services

CPT describes reporting guidelines for the time-based, critical care services codes (CPT 99291-99292) that are consistent with CareFirst policy. These guidelines also define procedures and services that are considered incidental to critical care. Examples of additional procedures that CareFirst considers to be incidental to critical care are as follows:

- Venipuncture, under age 3 (CPT 36400, 36405, 36406)
- Venipuncture (CPT 36415)
- Insertion of needle/catheter (CPT 36000)
- Transfusion procedures (CPT 36430)
- Intravenous fluid administration (i.e., CPT 96360–96379)
- Incidental services and procedures are not eligible for reimbursement.

Handling and conveyance

Handling and conveyance (CPT 99000–99002) is considered integral to most procedures and services including, but not limited to E/M, surgery, 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, 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 (i.e., 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.

CPT codes reported for supervision and interpretation and radiologic guidance (i.e., 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 (i.e., review of x-ray or biopsy analysis or ultrasound guidance), only one qualified provider/health care 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*)

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

Carefully 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 (i.e., 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 (i.e., CPT 96372) are usually eligible for separate reimbursement when reported with office E/M services (exception CPT 99211) and a covered pharmaceutical agent. Carefully 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).

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.)

Supplies and equipment

CareFirst follows the CMS guidelines in terms of what is included in the practice expense for each procedure code. A portion of a procedure code's relative value unit (RVU) and associated reimbursement allowance is practice expense. The practice expense portion includes medical and/or surgical supplies and equipment commonly furnished in a practice, and are a usual part of the surgical, medical, anesthesiology, radiology, or laboratory procedure or service. This includes, but is not limited to:

- Syringes, biopsy and hypodermic needles (A4206–A4209, A4212–A4215)
- IV catheters and tubing (A4223)
- Gowns/gloves/masks/drapes (A4927–A4930)
- Scalpels/blades
- Sutures/steri-strips
- Bandages/dressings/tape (A4450–A4452, A6216–A6221)
- Alcohol/betadine/hydrogen peroxide (A4244–A4248)
- Sterile water/saline (A4216–A4218)
- Thermometers (A4931–A4932)
- Trays and kits (A4550)
- Oximetry and EKG monitors
- Blood pressure cuffs (A4660–A4670)

Therefore, additional charges for routine supplies and equipment used for a procedure, service, or office visit, and reported with CPT 99070, HCPCS code A4649 and any other code that describes these supplies or equipment, are considered incidental to all services and procedures. This is applicable whether or not the supply is reported with other procedures/services or is reported alone. Incidental services are not eligible for reimbursement and subscribers may not be balance-billed for them.

Note: Supplies and equipment used while treating a patient in an institutional or outpatient facility should not be reported by the professional provider, as these supplies are reported on the facility claim.

Miscellaneous 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), and collection/interpretation/analysis of data stored in computers (CPT 99090–99091) are considered incidental to all services. CareFirst subscriber contracts do not provide benefits for these services, and 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. Venipunctures may be eligible for separate reimbursement when reported with an E/M service or alone.

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.

Visual acuity testing

Visual acuity screening (CPT 99173) is considered incidental to new and established office or other outpatient E/M services. Incidental procedures are not eligible for reimbursement. However, this procedure is eligible for separate reimbursement when reported with a new or established preventive medicine E/M service.

Medical/clinical photography

Photographs taken for any purpose are considered the same as the 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 (i.e., nurses, respiratory therapists, phlebatomists, 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 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 (CPT 31500)
- 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 *E/M Services During the Global Periods*). 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.

Surgery/orthopedics

Anesthesia by operating surgeon

Administration of anesthesia by the surgeon, assistant surgeon, nursing staff or any other provider within the same clinical practice (same tax ID number) during a procedure is considered included in the allowance for the surgical procedure. This includes any method of anesthesia (i.e., general anesthesia, moderate (conscious) sedation, local or regional anesthesia, nerve blocks). Included in procedures are not eligible for reimbursement.

Fracture care, strapping/casting

Carefully 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 (i.e., HCPCS A4580, A4590) are eligible for separate reimbursement when reported with fracture care, and casting and strapping procedures.

Gender reassignment and transgender services

Gender reassignment and transgender services are often defined by the subscriber 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**.

Lesion removals and biopsies

Covered, non-cosmetic lesion removals are eligible for separate reimbursement according to the terms of the subscriber 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 because the claims systems assumes same site. 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 practice expense. 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 (FESS) 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 subscriber 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.

Carefully 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 assignment (i.e., 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 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. It is not appropriate, therefore, for the professional provider (physician) to 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. Physician 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 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 subscriber contract. Carefully 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

Carefully 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 that 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 & 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 by providing lactation support and counseling. Refer to medical policy 4.01.005, Lactation Consultations in the **Medical Policy Reference Manual**.

Maternity services

Maternity benefits are defined by the subscriber contract. Carefully follow CPT guidelines for reporting maternity services, including reporting non-global services (i.e., separate antepartum, delivery, and/or postpartum care). Refer to medical policy operating procedure 4.01.006A, Global Maternity Care in the **Medical Policy Reference Manual**.

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 subscriber contract. Established patient E/M services reported with insertions and removals of intrauterine devices (IUD) (CPT 58300-58301) are considered to be included in the surgical package for the procedure, and thus 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 subscriber contract. Depending on the subscriber 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 percent of the allowed benefit, and the procedure with the lesser RVU will be reimbursed at 50 percent of the allowed benefit.

Digital breast tomosynthesis

CPT codes 77061 digital breast tomosynthesis; unilateral, 77062 digital breast tomosynthesis; bilateral and 77063 screening digital breast tomosynthesis, bilateral were added effective 1/1/2015. These codes 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. It is appropriate to report CPT 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT 77055 and 77056 (conventional diagnostic mammography). It is appropriate to 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. It would not be appropriate to 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). It would not

be appropriate to 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 (US) 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, it is assumed by our claims system that both were performed during the same session in the same anatomic area. Based on CPT guidelines, an ultrasound (US) guidance procedure includes imaging protocols that are comparable to the limited diagnostic US. Therefore, when these two procedures are reported together on the same date, the limited US is considered mutually exclusive to the US 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 US guidance procedure (CPT 76942) and an US procedure (CPT 76536) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area. Based on CPT guidelines an US guidance procedure includes imaging protocols that are comparable to the US procedure. Therefore, when these two procedures are reported together on the same date, the US procedure is considered mutually exclusive to the US 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 US guidance procedures (i.e., CPT 76930 and CPT 76942) are reported on the same date, it is assumed by our claims system 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.

Invasive and non-invasive diagnostic tests and procedures

Many of these tests and procedures (i.e., 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 basic claim adjudication policy concepts section, under modifier reimbursement guidelines, regarding reporting global and/or components of these services. (See also *Duplicate Services and Multiple Reviews*)

CareFirst
Family of health care plans

Benefit Exclusions and Limitations—BlueChoice Only

CareFirst BlueChoice, Inc. (CareFirst BlueChoice) only

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

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

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

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

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

Covered services and benefit guidelines

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

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

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

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

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

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

Abortion

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

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

Allergy

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

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

Ambulance

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

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

Anesthesia

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

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

Away From Home Care®

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

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

Behavioral health/substance use disorder services

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

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

Cardiology

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

Chemotherapy

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

Chiropractic services

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

Dental care

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

Durable medical equipment (DME) and prosthetics

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

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

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

Immediate needs

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

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

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

Emergency services

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

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

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

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

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

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

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

Endocrinology

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

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

Gastroenterology

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

Hearing aid devices

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

Hematology/oncology

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

Hemodialysis

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

Home health services

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

Home infusion therapy

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

Hospice care

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

House Calls

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

Laboratory services

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

LabCorp

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

Quest Diagnostics

(Available for PPO members only)

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

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

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

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

Nephrology

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

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

Nutritional services

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

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

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

Obstetrics & gynecology

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

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

Reporting for obstetrical services

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

Obstetrical radiology/laboratory services

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

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

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

Amniocentesis/CVS

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

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

Genetic testing/counseling (excludes amniocentesis)

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

Maternal and child home assessment

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

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

CareFirst must authorize the postpartum home visit.

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

Infertility services

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

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

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

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

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

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

Gynecologic services

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

Mammograms

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

Contraceptive Services

IUD/Diaphragm

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

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

Depo-Provera®

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

OB/GYN services quick reference guide

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

* Some exceptions apply in western Maryland.

** Some exceptions apply on the Eastern Shore.

Oral surgery

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

Orthopedics

(Includes hand and pediatric orthopedics)

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

Physical, occupational and speech therapy

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

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

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

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

Podiatry

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

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

Prescription drugs

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

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

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

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

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

To request a prior authorization, login through the **Provider Portal** or call 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 the following procedures. All other radiology services must be performed by CareFirst BlueChoice contracted radiology facility.

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

Rheumatology

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

Routine office visits

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

Transplants

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

Urgent care services

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

Urology

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

Vision Care

Medical

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

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

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

Routine vision and eyewear

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

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

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

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

Wellness discount program

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

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

PM0011-1E (6/19)

CareFirst
Family of health care plans

Procedure Code Exception Charts

The procedure codes listed below 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.

Procedure Code	Effective Date
Cardiology	
76825	added prior to 1/1/08
76826	added prior to 1/1/08
76827	added prior to 1/1/08
76828	added prior to 1/1/08
78414	added prior to 1/1/08
78428	added prior to 1/1/08
78445	added prior to 1/1/08
78451	added 1/1/10
78452	added 1/1/10
78453	added 1/1/10
78454	added 1/1/10
78455	invalid as of 1/1/08
78456	added prior to 1/1/08
78457	added prior to 1/1/08
78458	added prior to 1/1/08
78459	added prior to 1/1/08
78460	invalid as of 1/1/10
78461	invalid as of 1/1/10
78464	invalid as of 1/1/10
78465	invalid as of 1/1/10
78466	added prior to 1/1/08
78468	added prior to 1/1/08
78469	added prior to 1/1/08
78472	added prior to 1/1/08
78473	added prior to 1/1/08
78478	invalid as of 1/1/10
78480	invalid as of 1/1/10
78481	added prior to 1/1/08
78483	added prior to 1/1/08
78491	added prior to 1/1/08
78492	added prior to 1/1/08
78494	added prior to 1/1/08
78496	added prior to 1/1/08
78990	invalid as of 1/1/08
A9500	invalid as of 12/30/14
A9501	invalid as of 12/30/14
A9502	invalid as of 12/30/14

Procedure Code	Effective Date
A9503	invalid as of 12/30/14
A9505	invalid as of 12/30/14
A9508	invalid as of 12/30/14
A9510	invalid as of 12/30/14
A9600	invalid as of 12/30/14
A9700	invalid as of 12/30/14
Chiropractic Services	
72010	invalid as of 12/31/15
72020	added 6/9/08
72040	1/1/08
72050	added 6/9/08
72052	added 6/9/08
72069	invalid as of 12/31/15
72070	added 6/9/08
72072	added 6/9/08
72074	added 6/9/08
72080	added 6/9/08
72081	added 1/1/16
72082	added 1/1/16
72083	added 1/1/16
72084	added 1/1/16
72090	invalid as of 12/31/15
72100	added 6/9/08
72110	added 6/9/08
72114	added 6/9/08
72120	added 6/9/08
72200	added 6/9/08
72202	added 6/9/08
72220	added 6/9/08
Endocrinology	
76536	added prior to 1/1/08
76075	invalid as of 1/1/08
77080	added prior to 1/1/08
77081	added prior to 1/1/08
77085	added 1/1/15
77086	added 1/1/15
79005 (with modifier 26)	2/17/12
88172	9/5/08
Gastroenterology	
89100	invalid as of 12/31/10
89105	invalid as of 12/31/10
89130	invalid as of 12/31/10

Procedure Code	Effective Date
89132	invalid as of 12/31/10
89135	invalid as of 12/31/10
89136	invalid as of 12/31/10
89140	invalid as of 12/31/10
89141	invalid as of 12/31/10
G0262	invalid as of 1/1/08
Hematology	
82565	added prior to 1/1/08
85007	added prior to 1/1/08
85008	added prior to 1/1/08
85022	invalid as of 1/1/08
85023	invalid as of 1/1/08
85024	invalid as of 1/1/08
85029	invalid as of 1/1/08
85030	invalid as of 1/1/08
85031	invalid as of 1/1/08
85032	6/15/2003
85041	added prior to 1/1/08
85044	added prior to 1/1/08
85046	added prior to 1/1/08
85049	added prior to 1/1/08
85095	invalid as of 1/1/08
85097	added prior to 1/1/08
85102	invalid as of 3/31/02
85535	invalid as of 1/1/08
85536	added prior to 1/1/08
85576	added prior to 1/1/08
85585	invalid as of 1/1/08
85590	invalid as of 1/1/08
Infertility Services	
58323	added prior to 1/1/08
59840	added prior to 1/1/08
59841	added prior to 1/1/08
59850	added prior to 1/1/08
59851	added prior to 1/1/08
59852	added prior to 1/1/08
72190*	added prior to 1/1/08
76376	9/5/2008
76641	added 1/1/15
76642	added 1/1/15
76705***	added prior to 1/1/08

Procedure Code	Effective Date
76801*	added prior to 1/1/08
76802*	added prior to 1/1/08
76805*	added prior to 1/1/08
76810*	added prior to 1/1/08
76811*	added prior to 1/1/08
76812*	added prior to 1/1/08
76813*	added prior to 1/1/08
76814*	added prior to 1/1/08
76815*	added prior to 1/1/08
76816*	added prior to 1/1/08
76817*	added prior to 1/1/08
76818*	added prior to 1/1/08
76819*	added prior to 1/1/08
76820*****	3/1/2007
76821*****	3/1/2007
76825*	added prior to 1/1/08
76826*	added prior to 1/1/08
76827*	added prior to 1/1/08
76828*	added prior to 1/1/08
76830***	added prior to 1/1/08
76856**	added prior to 1/1/08
76857**	added prior to 1/1/08
76946*	added prior to 1/1/08
76948***	added prior to 1/1/08
82670	added prior to 1/1/08
83001	added prior to 1/1/08
83002	added prior to 1/1/08
84144	added prior to 1/1/08
84146****	added prior to 1/1/08
84443****	added prior to 1/1/08
84702	added prior to 1/1/08
84703	added prior to 1/1/08
84704	1/18/2008
85610	added prior to 1/1/08
87480	added prior to 1/1/08
87510	added prior to 1/1/08
89240	added prior to 1/1/08
89250	added prior to 1/1/08
89251	added prior to 1/1/08
89252	invalid as of 1/1/08
89253	added prior to 1/1/08
89254	added prior to 1/1/08

Procedure Code	Effective Date
89255	added prior to 1/1/08
89256	invalid as of 1/1/08
89257	added prior to 1/1/08
89258	added prior to 1/1/08
89259	added prior to 1/1/08
89260	added prior to 1/1/08
89261	added prior to 1/1/08
89264	added prior to 1/1/08
89268	added prior to 1/1/08
89272	added prior to 1/1/08
89280	added prior to 1/1/08
89281	added prior to 1/1/08
89291****	added prior to 1/1/08
89300	added prior to 1/1/08
89310	added prior to 1/1/08
89320	added prior to 1/1/08
89321	added prior to 1/1/08
89322	added 1/1/08
89325	added prior to 1/1/08
89329	added prior to 1/1/08
89330	added prior to 1/1/08
89331	added 1/1/08
89352	added prior to 1/1/08
89353	8/1/2014
89354	8/1/2014
89356	8/1/2014
93325*	added prior to 1/1/08
87660	9/15/10
89290	9/15/10

*Limited to obstetrical services such as normal delivery, abortion, ectopic pregnancy, miscarriage and infertility.

**Limited to infertility and medical services

***Limited to obstetrical services such as normal delivery, abortion, ectopic pregnancy, miscarriage, infertility and medical services

****Limited to infertility only

*****Limited to obstetrical services such as normal delivery, abortion, ectopic pregnancy and miscarriage

Nephrology Services	
75710	5/9/2008
75790	5/9/2008
75791	invalid as of 12/31/16
75820	5/9/2008
75822	5/9/2008

Procedure Code	Effective Date
75825	5/9/2008
75827	5/9/2008
75894	5/9/2008
75902	5/9/2008
75978	5/9/2008
75982	invalid as of 8/1/2009
76937	added prior to 1/1/08
81001	added prior to 1/1/08
81003	added prior to 1/1/08
81005	added prior to 1/1/08
81007	added prior to 1/1/08
Obstetrics & Gynecology Services	
58323	added prior to 1/1/08
59840	added prior to 1/1/08
59841	added prior to 1/1/08
59850	added prior to 1/1/08
59851	added prior to 1/1/08
59852	added prior to 1/1/08
72190	added prior to 1/1/08
76376	9/5/2008
76641	added 1/1/15
76642	added 1/1/15
76705	10/15/2006
76801	added prior to 1/1/08
76802	added prior to 1/1/08
76805	added prior to 1/1/08
76810	added prior to 1/1/08
76811	added prior to 1/1/08
76812	added prior to 1/1/08
76813	added prior to 1/1/08
76814	added prior to 1/1/08
76815	added prior to 1/1/08
76816	added prior to 1/1/08
76817	10/15/2006
76818	added prior to 1/1/08
76819	added prior to 1/1/08
76820	added prior to 1/1/08
74740	10/28/11
76821	added prior to 1/1/08
76825	added prior to 1/1/08
76826	added prior to 1/1/08
76827	added prior to 1/1/08

Procedure Code	Effective Date
76828	added prior to 1/1/08
76830	added prior to 1/1/08
76856	added prior to 1/1/08
76857	added prior to 1/1/08
76946	added prior to 1/1/08
76948	10/15/2006
84146	10/15/2006
84443	10/15/2006
86901	6/8/2009
84703	6/8/2009
87480	added prior to 1/1/08
87510	added prior to 1/1/2008
87660	added 9/15/10
89260	added prior to 1/1/2008
89261	added prior to 1/1/2008
89290	added 9/15/10
89291	10/15/2006
89300	1/18/2008
89310	1/18/2006
89320	1/18/2008
89321	10/15/2006
89322	added 1/18/2008
89330	added prior to 1/1/08
89331	1/18/2008
89352	added prior to 1/1/08
89353	8/1/2014
89354	8/1/2014
89356	8/1/2014
93325	added prior to 1/1/08
Opthamology	
83516	added 12/15/15
Oral Surgery	
70140	added prior to 1/1/08
70150	added prior to 1/1/08
70300	added prior to 1/1/08
70310	added prior to 1/1/08
70320	added prior to 1/1/08
70350	added prior to 1/1/08
70355	added prior to 1/1/08
Special Note: Oral surgeons will be reimbursed for 70300, 70310 and 70320 only in the case of accidental injury to the teeth. Note: Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply.	

Procedure Code	Effective Date
Orthopedics	
71020	invalid as of 12/31/17
71045	1/1/18
71100	added prior to 1/1/08
71101	added prior to 1/1/08
71110	added prior to 1/1/08
71111	added prior to 1/1/08
71120	8/17/2007
71130	8/17/2007
72010	invalid as of 12/31/15
72020	added prior to 1/1/08
72040	added prior to 1/1/08
72050	added prior to 1/1/08
72052	added prior to 1/1/08
72069	invalid as of 12/31/15
72070	added prior to 1/1/08
72072	added prior to 1/1/08
72074	added prior to 1/1/08
72080	added prior to 1/1/08
72081	added 1/1/16
72082	added 1/1/16
72083	added 1/1/16
72084	added 1/1/16
72090	invalid as of 12/31/15
72100	added prior to 1/1/08
72110	added prior to 1/1/08
72114	added prior to 1/1/08
72120	added prior to 1/1/08
72170	added prior to 1/1/08
72190	added prior to 1/1/08
72200	added 2/1/15
72220	3/28/2008
73000	added prior to 1/1/08
73010	added prior to 1/1/08
73020	added prior to 1/1/08
73030	added prior to 1/1/08
73040	added prior to 1/1/08
73050	added prior to 1/1/08
73060	added prior to 1/1/08
73070	added prior to 1/1/08
73080	added prior to 1/1/08
73085	added prior to 1/1/08

Procedure Code	Effective Date
73090	added prior to 1/1/08
73092	added prior to 1/1/08
73100	added prior to 1/1/08
73110	added prior to 1/1/08
73115	added prior to 1/1/08
73120	added prior to 1/1/08
73130	added prior to 1/1/08
73140	added prior to 1/1/08
73500	invalid as of 12/31/15
73501	added 1/1/16
73502	added 1/1/16
73503	added 1/1/16
73510	invalid as of 12/31/15
73520	invalid as of 12/31/15
73521	added 1/1/16
73522	added 1/1/16
73523	added 1/1/16
73525	added prior to 1/1/08
73530	invalid as of 12/31/15
73540	invalid as of 12/31/15
73542	invalid as of 12/31/11
73550	invalid as of 12/31/15
73551	added 1/1/16
73552	added 1/1/16
73560	added prior to 1/1/08
73562	added prior to 1/1/08
73564	added prior to 1/1/08
73565	added prior to 1/1/08
73580	added prior to 1/1/08
73590	added prior to 1/1/08
73592	added prior to 1/1/08
73600	added prior to 1/1/08
73610	added prior to 1/1/08
73615	added prior to 1/1/08
73620	added prior to 1/1/08
73630	added prior to 1/1/08
73650	added prior to 1/1/08
73660	added prior to 1/1/08
76040	added 2/1/15
76090	added 2/1/15
77072	9/15/10
77073	9/15/10

Procedure Code	Effective Date
Podiatry	
73600	added prior to 1/1/08
73610	added prior to 1/1/08
73620	added prior to 1/1/08
73630	added prior to 1/1/08
73650	added prior to 1/1/08
73660	added prior to 1/1/08
76880	invalid as of 12/31/10
76881	1/1/11
76882	1/1/11
Pulmonology	
71010	invalid as of 12/13/17
71015	invalid as of 12/13/17
71020	invalid as of 12/13/17
71021	invalid as of 12/13/17
71022	invalid as of 12/13/17
71023	invalid as of 12/13/17
71030	invalid as of 12/13/17
71034	invalid as of 12/13/17
71035	invalid as of 12/13/17
71045	1/1/18
71046	1/1/18
71047	1/1/18
71048	1/1/18
76000	1/1/18
76001	1/1/18
82800	added prior to 1/1/08
82803	added prior to 1/1/08
82805	added prior to 1/1/08
82810	added prior to 1/1/08
82820	added prior to 1/1/08
85022	invalid as of 1/1/08
Rheumatology	
71100	8/17/07
71101	8/17/07
71110	8/17/07
71111	8/17/07
71120	8/17/07
71130	8/17/07
72010	8/17/07
72020	8/17/07

Procedure Code	Effective Date
72040	8/17/07
72050	8/17/07
72052	8/17/07
72069	8/17/07
72070	8/17/07
72072	8/17/07
72074	8/17/07
72080	8/17/07
72090	8/17/07
72100	8/17/07
72110	8/17/07
72114	8/17/07
72120	8/17/07
72170	8/17/07
72190	8/17/07
73000	7/15/07
73010	7/15/07
73020	7/15/07
73030	7/15/07
73040	7/15/07
73050	7/15/07
73060	7/15/07
73070	7/15/07
73080	7/15/07
73085	7/15/07
73090	7/15/07
73092	7/15/07
73100	7/15/07
73110	7/15/07
73115	7/15/07
73120	7/15/07
73130	7/15/07
73140	7/15/07
73500	7/15/07
73510	7/15/07
73520	7/15/07
73525	7/15/07
73530	7/15/07
73540	7/15/07
73542	invalid as of 12/31/11
73550	7/15/07
73560	7/15/07

Procedure Code	Effective Date
73562	7/15/07
73564	7/15/07
73565	7/15/07
73580	7/15/07
73590	7/15/07
73592	7/15/07
73600	7/15/07
73610	7/15/07
73615	7/15/07
73620	7/15/07
73630	7/15/07
73650	7/15/07
73660	7/15/07
76075	invalid as of 1/1/08
76880	invalid as of 12/31/10
77080	added prior to 1/1/08
77081	added prior to 1/1/08
77085	added 3/23/15
83872	7/15/07
85652	7/15/07
87075	7/15/07
89051	7/15/07
89060	7/15/07
76881	1/1/11
76882	1/1/11
Specialists & PCPs	
36400	11/1/2004
36405	11/1/2004
36406	added prior to 1/1/08
36415	added prior to 1/1/08
36416	added prior to 1/1/08
71090	invalid as of 12/31/11
72240	added prior to 1/1/08
72255	added 4/1/09
72265	added 4/1/09
72270	added 4/1/09
72275	added 4/1/09
72285	added 4/1/09
72295	added prior to 1/1/08
75820	added 9/18/09
75827	added 9/18/09

Procedure Code	Effective Date
75894	added prior to 1/1/08
75962	invalid as of 12/31/16
75998	invalid as of 1/1/08
75600	added 4/1/09
75605	added 4/1/09
75625	added 4/1/09
75630	added 4/1/09
75635	added 4/1/09
75650	added 4/1/09
75658	added 4/1/09
75660	added 4/1/09
75662	added 4/1/09
75665	added 4/1/09
75671	added 4/1/09
75676	added 4/1/09
75680	added 4/1/09
75685	added 4/1/09
75705	added 4/1/09
75710	added 4/1/09
75716	added 4/1/09
75722	invalid as of 12/31/11
75724	invalid as of 12/31/11
75726	added 4/1/09
75731	added 4/1/09
75733	added 4/1/09
75736	added 4/1/09
75741	added 4/1/09
75743	added 4/1/09
75746	added 4/1/09
75756	added 4/1/09
75774	added 4/1/09
75790	invalid as of 1/1/10
75822	7/1/10
75825	7/1/10
75978	7/1/10
75902	7/1/10
76000	added 4/1/09
76001	invalid as of 1/1/08
76003	invalid as of 1/1/08
76005	invalid as of 1/1/08
76006	invalid as of 1/1/08

Procedure Code	Effective Date
76012	invalid as of 1/1/08
76013	invalid as of 1/1/08
76095	invalid as of 1/1/08
76096	invalid as of 1/1/08
76098	added prior to 1/1/08
76375	invalid as of 1/1/08
76641	effective 1/1/15
76642	effective 1/1/15
76825	added prior to 1/1/08
76826	added prior to 1/1/08
76827	added prior to 1/1/08
76828	added prior to 1/1/08
76831	added prior to 1/1/08
76872	added prior to 1/1/08
76930	invalid as of 12/31/19
76932	added prior to 1/1/08
76934	invalid as of 1/1/08
76936	added prior to 1/1/08
76937	added 9/18/09
76938	invalid as of 1/1/08
76941	added prior to 1/1/08
76942	added prior to 1/1/08
76945	added prior to 1/1/08
76946	added prior to 1/1/08
76948	added prior to 1/1/08
76950	added prior to 1/1/08
76960	invalid as of 1/1/08
76965	added prior to 1/1/08
76970	invalid as of 1/1/08
76975	added prior to 1/1/08
76977	added prior to 1/1/08
76986	invalid as of 1/1/08
76998	added prior to 1/1/08
77001	added prior to 1/1/08
77002	added prior to 1/1/08
77003	added prior to 1/1/08
77031	added prior to 1/1/08
77032	added prior to 1/1/08
77071	added prior to 1/1/08
77387	added 1/1/15
78800	added 4/1/09

Procedure Code	Effective Date
78801	added 4/1/09
80061*	effective 1/1/19
81000	added prior to 1/1/08
81001	added prior to 1/1/08
81002	added prior to 1/1/08
81003	added prior to 1/1/08
81015	added prior to 1/1/08
81020	added prior to 1/1/08
81025	added prior to 1/1/08
81050	added prior to 1/1/08
82044	8/1/2005
82247	added prior to 1/1/08
82250	invalid as of 1/1/08
82270	added prior to 1/1/08
82272	1/6/2006
82274	1/6/2006
82438	added prior to 1/1/08
82465*	effective 1/1/19
82570	8/1/2005
82757	added prior to 1/1/08
82948	added prior to 1/1/08
82962	added prior to 1/1/08
83014	added prior to 1/1/08
83026	added prior to 1/1/08
83036	added prior to 1/1/08
83037	3/7/2008
83655	6/1/2014
83718*	effective 1/1/19
84030	added prior to 1/1/08
84830	added prior to 1/1/08
85002	added prior to 1/1/08
85007	added prior to 1/1/08
85013	added prior to 1/1/08
85014	added prior to 1/1/08
85018	6/1/2014
85021	invalid as of 1/1/08
85023	invalid as of 1/1/08
85024	invalid as of 1/1/08
85025	added prior to 1/1/08
85027	added prior to 1/1/08
85380	added 12/1/14

Procedure Code	Effective Date
85610	added prior to 1/1/08
86580	invalid as of 1/1/08
86585	invalid as of 1/1/08
86588	invalid as of 1/1/08
86759	added prior to 1/1/08
87081	added prior to 1/1/08
87177	added prior to 1/1/08
87205	added prior to 1/1/08
87208	invalid as of 1/1/08
87210	added prior to 1/1/08
87211	invalid as of 1/1/08
87220	added prior to 1/1/08
87430	added prior to 1/1/08
87449	added prior to 1/1/08
87450	added prior to 1/1/08
87451	added prior to 1/1/08
87480	added 6/15/03
87510	added 6/15/03
87651	7/1/19
87797	added prior to 1/1/08
87804	added prior to 1/1/08
87807	added effective 4/10/09
87880	added prior to 1/1/08
88170	invalid as of 1/1/08
88171	invalid as of 1/1/08
88341	effective 9/15/16
88342	added prior to 1/1/08
88738	6/1/2014
89100	invalid as of 12/31/10
89105	invalid as of 12/31/10
89130	invalid as of 12/31/10
89132	invalid as of 12/31/10
89135	invalid as of 12/31/10
89136	invalid as of 12/31/10
89140	invalid as of 12/31/10
89141	invalid as of 12/31/10
89190	added prior to 1/1/08

Procedure Code	Effective Date
89220	added prior to 1/1/08
89230	added prior to 1/1/08
89350	invalid as of 1/1/08
89360	invalid as of 1/1/08
Special Note: *For ages 21 years old or younger	
Urology	
51798	added prior to 1/1/08
74455	added prior to 1/1/08
76000	added prior to 1/1/08
76705	added prior to 1/1/08
76775	added prior to 1/1/08
76776	added prior to 1/1/08
76857	added prior to 1/1/08
76872	added prior to 1/1/08
76873	added prior to 1/1/08
76942	added prior to 1/1/08
76870	3/9/12
78267	added prior to 1/1/08
78268	added prior to 1/1/08
81003	added prior to 1/1/08
0025T	invalid as of 3/31/04
76510	added prior to 1/1/08
76511	added prior to 1/1/08
76512	added prior to 1/1/08
76513	added prior to 1/1/08
76514	added prior to 1/1/08
76516	added prior to 1/1/08
76519	added prior to 1/1/08
76529	added prior to 1/1/08
S0830	invalid as of 1/1/08
83861	3/9/12

CareFirst
Family of health care plans

Membership Information

This section provides Membership Information for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

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

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

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

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

Membership

Members' Rights and Responsibilities

Members have a right to:

- Be treated with respect and recognition of their dignity and right to privacy
- Receive information about the health plan, its services, its practitioners and providers, and members' rights and responsibilities
- Participate with practitioners in making decisions regarding their health care
- Discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Make recommendations regarding the organization's members' rights and responsibilities policies
- Voice complaints or appeals about the health plan or the care provided

Members have a responsibility to:

- Provide, to the extent possible, information that the health plan and its practitioners and providers need in order to care for them
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Follow the plans and instructions for care that they have agreed on with their practitioners
- Pay member copayments or coinsurance at the time of service
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled

BlueCard

Out-of-area program—BlueCard

The BlueCard program allows members to seek care from health care providers participating in any Blues Plan across the country and abroad. The program allows participating providers to submit claims for out-of-area members to their local Blues Plan.

BlueCard member identification

To identify BlueCard members, look on the member's ID card for an empty suitcase, or for PPO members, a PPO in a suitcase. BlueCard® members also have alpha prefixes on their member number so the processing plan can identify the plan to which the member belongs.

If you see a member's ID card without an alpha prefix, call the member's home plan. The phone number will be on the back of the member ID card.

How the BlueCard program works

If you participate with CareFirst only and the member has a contract with another Blues plan, submit claims to CareFirst.

CareFirst will be your contact for claims submission, claims payments, adjustments, services and inquiries. Call 800-676-BLUE or log on to CareFirst Direct for eligibility information on out-of-area members.

BlueCard program claims submission

Submit BlueCard claims and correspondence to:

BlueCard Claims
Mail Administrator
P.O. Box 14116
Lexington, KY 40512-4116

BlueCard Correspondence
Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

BlueCard Reimbursement

Once CareFirst receives the claim, it electronically routes the claim to the member's Blue Cross and Blue Shield home plan. After the member's home Plan processes the claim and approves the payment, you will receive payment from CareFirst.

Payment may not be sought from the member for any balances remaining after CareFirst's payment, unless it is to satisfy the member's deductible, copayment or coinsurance, or for services not covered under the member's plan.

In some cases, a member's plan suspends a claim because medical review or additional information is necessary. When resolution of claim suspension requires additional information from you, CareFirst may ask you for information or give the member's plan permission to contact you directly.

BlueCard and health care exchanges

CareFirst members enrolled through the Exchanges will still have access to the BlueCard program.

The PPO basic network is a combination of BlueCard PPO networks and new Exchange networks created by certain plans. The PPO basic network does not affect local providers since the PPO Basic network includes all doctors and facilities that are included in the entire regional provider network.

Member ID cards for public Exchange members with access to the PPO Basic network will include the new PPO B suitcase logo, below.

The standard BlueCard PPO network is used in all but the following states where the Exchange network (PPO basic) will be used for 2016: Arizona, Florida, Kansas, Kentucky, Missouri, Washington and Wyoming.

Contiguous areas

In some cases, your office or facility may be located in an area where two Blue Cross and Blue Shield plans share a county. Outlined below are processes for filing claims under these circumstances:

- If you provide care to a member from a county bordering CareFirst's service area (MD, DC, and Northern VA), you do not contract with that member's Blues plan, submit the claim to CareFirst

- If you provide care to a member of a Blues' Plan in a county bordering CareFirst's service area and you contract with both CareFirst and the Plan in the bordering area, submit the claim to the Plan in the bordering area

Exclusions

The program excludes federal employee health benefit plan (FEHBP) member claims and routine vision exam, vision correction material, dental and prescription drug coverage.

Ancillary claim filing guidelines

All Blues plans are mandated by the Blue Cross and Blue Shield Association (BCBSA) to use the following guidelines when submitting ancillary claims for independent clinical lab, durable/home medical equipment and supplies (DME), and specialty pharmacy providers. For specific information and a chart of claims filing examples, visit **carefirst.com/ancillaryclaims**.

Utilization review (UR)

Out-of-area members are responsible for obtaining pre-authorization for their services from their Blue Cross and Blue Shield Plan. Providers may choose to contact the member's plan on behalf of the member. If you choose to do so, refer to the phone number on the back of the member's ID card.

The National Account Service Company (NASCO)

The National Account Service Company (NASCO) is exclusively available through Blue Cross Blue Shield (BCBS) plans nationwide. NASCO offers solutions for administering traditional, point-of-service, preferred provider, HMO, dental, vision, prescription drug and other health services to national, regional and local employers. It allows national account customers to meet their market requirements for processing and administering health care benefits consistently for employees at numerous locations.

NASCO member identification

- Member identification cards issued by CareFirst have the CareFirst logo and national accounts on the card
- The membership number has a unique three character alpha/numeric prefix, RAS

NASCO claim submission

- Submit claims following the instructions on the reverse side of the member's identification card
- Submit the alpha/numeric prefix and the CareFirst provider number on all claims to help expedite processing
- Medical policy and claims processing guidelines may differ from CareFirst "local" business
- Many accounts follow Blue Cross and Blue Shield Association (BCBSA) national medical policy, which may influence claims processing edits
- If no BCBSA medical policy exists, it may default to local policy
- Claims processing edits and rules are approved by all plans in the NASCO network

PM0013-1E (6/19)

CareFirst
Family of health care plans

Member Identification Card Quick Reference Guide

Member identification cards contain important membership and coverage information that help you correctly route your claims. Be sure to verify eligibility using **CareFirst Direct** or **CareFirst on Call** prior to rendering care.

Front of card

The front of the member ID card contains information about the member, the primary care provider (PCP), copayments/coinsurance and some member benefits.

1. Member Name
2. Member ID Number
3. Group Number
4. Product Name
5. Primary Care Provider's Name
6. Copayments/Coinsurance:

   D—Deductible
   CD—Combined Medical and Prescription Drug Deductible
   P—PCP
   S—Specialist
   OV—Office Visit
   CC—Convenience Care
   UC—Urgent Care
   ER—Emergency Room

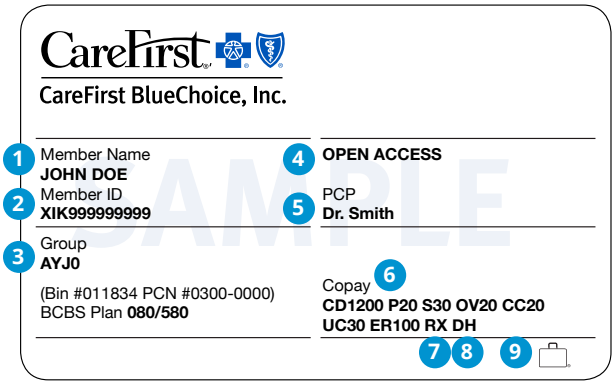
7. Prescription Drug Program:

   RX—Formulary 1
   RX2—Formulary 2
   RX3—Formulary 3

8. Dental or vision coverage, if applicable

   DT—Dental Traditional
   DP—Dental Preferred (PPO)
   DH—HMO Dental
   PD—Pediatric Dental
   AV—Adult Vision
   PV—Pediatric Vision
   VC—BlueVision
   VU—BlueVision Plus

9. Type of out-of-area coverage



Back of card

The back of the member ID card includes medical emergency assistance and mental health/substance use disorder telephone numbers, as well as instructions and an address for filing claims and sending correspondence.

Member ID cards may include one of several logos identifying the type of coverage the member has and/or indicating the provider's reimbursement level.

Product information

	Products	Prefixes	Logo
Health Maintenance Organization (HMO)	■ BlueChoice HMO ■ BlueChoice HMO Open Access	XIK, XIR, XIB, QXG, QXA, XIE, JHZ, XWZ, XIG, QXK, XIC, XIH	CareFirst CareFirst BlueChoice, Inc.
Point of Service (POS)	■ BlueChoice Opt-Out ■ BlueChoice Opt-Out Plus Open Access* ■ BlueChoice Opt-Out Open Access* ■ BlueChoice Advantage ■ BlueChoice Plus * Open Access = no referral needed if the provider is in the BlueChoice Network		
Preferred Provider Organization (PPO)	■ BluePreferred PPO	XIL, XWV, JHJ, XII, JHI, XIQ, QXM, XIY, XIU	CareFirst
Federal Employee Program (FEP)	■ FEP Basic Option ■ FEP Standard Option	R	BlueCross BlueShield Federal Employee Program
HealthyBlue	■ HealthyBlue Advantage ■ HealthyBlue 2.0 Open Access ■ HealthyBlue Plus Open Access	JHG, QXF, JHA, JHC, QXB, QXE, XIF, JHD, QXD, JHH, QXI, QXL, QXU, QXR, QXS, QXT, QXC, QXH	CareFirst CareFirst BlueChoice, Inc. HealthyBlue
	■ HealthyBlue PPO		CareFirst HealthyBlue
	■ HealthyBlue HMO		CareFirst BlueChoice HealthyBlue
Maryland Point of Service (MPOS)	■ Maryland Point of Service	Varies	CareFirst
National Account Service Company (NASCO)	■ All products, except FEP	Unique	BlueCross BlueShield National Accounts
MedPlus	■ Medigap Plan A, B, F, G, L, M, N ■ Medigap Plan High Ded F	XWC	CareFirst MedPlus

Out-of-area coverage (BlueCard)

Logo description	What it looks like	What it means (type of out-of-area coverage)
A blank (empty) suitcase icon		Member has out-of-area coverage for urgent or emergency care.
A suitcase icon with PPO inside		Member has PPO or EPO benefits available for medical services received inside or outside of the U.S.

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