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Visit carefirst.com/bluelink to view past issues of BlueLink.

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Important Update: *As a reminder, we have retired the Government Programs Corner and integrated information for all lines of business throughout the newsletter. Each topic is clearly labeled to identify the line(s) of business impacted.*

Trending Now

Action Required: Ensure Your Billing NPI Is Enrolled with CareFirst

All lines of business

CareFirst actively identifies claims submitted with Billing NPIs that were not submitted to us during credentialing and enrollment. The Billing NPI that providers and provider organizations submit with claims **must match** the Billing NPI submitted to CareFirst and registered in our provider system during credentialing and enrollment.

In addition, the Billing NPI must also be the NPI reported by the provider or provider organization to the following:

- **National Plan and Provider Enumeration System (NPPES):** NPPES is the database used by NPI number holders and the Centers for Medicare and Medicaid Services. The NPPES registry is updated regularly; therefore, any changes you make to your CareFirst provider directory information should also be reviewed and updated as appropriate in NPPES. For more information go to NPPES (hhs.gov).
- **CareFirst CHPMD Providers:** To receive payment for services rendered to Maryland Medicaid recipients, MDH requires all providers to maintain an active enrollment status in their electronic Provider Revalidation and Enrollment Portal (ePREP) and, beginning in October, the new Maryland Provider Registration and Information Management Enterprise (MPRIME) portal.
- For more information or if you have questions about the transition to MPRIME, visit MDH's MPRIME provider enrollment page at https://health.maryland.gov/mmcp/provider/Pages/mprime.aspx or email MDH at mdh.mprimegolive@maryland.gov.

Important Next Steps for Providers

1. Verify the Billing NPI you are currently using to submit claims.
2. Confirm that the Billing NPI is reported correctly in NPPES and is active.
3. Confirm that the same Billing NPI was submitted to CareFirst through the credentialing/enrollment process as a new Billing NPI or Location Billing NPI.
    - You can utilize the Provider Updates and Attestation self-service tool within the CareFirst Provider Portal to review your provider data. If you need help, access this resource for step-by-step instructions.
4. If the Billing NPI is not currently enrolled with CareFirst, submit the appropriate credentialing/enrollment information before using that NPI on claims using the following link: Adding a New Billing NPI.

Using the correct Billing NPI consistently across NPPES, credentialing/enrollment portals, CareFirst's provider system and claims helps ensure accurate provider identification and efficient claims processing.

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Upcoming Change: Post-Acute Authorizations Moving Back to CPT/HCPCS Code-Based Review

All lines of business

CareFirst is updating the way post-acute prior authorization requests are submitted and reviewed. This change is intended to support more accurate authorization entry, improve alignment between the requested place of service and level of care and ensure requests receive the appropriate clinical review.

Effective **December 1, 2026,** post-acute prior authorization requests will transition from revenue code-based authorization entry back to CPT/HCPCS code-based authorization entry for skilled nursing facilities and other post-acute settings. This means providers should no longer rely on revenue codes when submitting post-acute authorization requests. Instead, the applicable CPT/HCPCS code should be selected based on the member's post-acute setting and level of care.

CPT/HCPCS Codes Guidance

- **Skilled Nursing Facility (SNF)**
  - Initial Nursing Facility Care: 99304–99306
  - Subsequent Nursing Facility Care: 99307–99310
- **Acute Rehabilitation/Inpatient Rehabilitation Facility (IRF)**
  - Subsequent hospital inpatient or observation care: 99232
- **Hospice**
  - Places of service and level of care are identified using HCPCS Level II codes.
  - Place of Service Codes: Q5003 – Q5010
  - Level of Care Codes: T2042 – T2045
- **Long-Term Acute Care Hospital (LTACH)**
  - Initial Hospital Care: 99221–99223
  - Subsequent Hospital Care: 99231–99233, including 99232

Best Practices for Entering Prior Authorization Requests

- Before submitting a request, providers should verify whether prior authorization is required by using the Prior Authorization Lookup tool.
- If authorization is required, providers should submit the request electronically through the CareFirst Provider Prior Authorization Portal, include the appropriate CPT/HCPCS code and upload the necessary clinical information with the request to support timely review.
- Check the status of submitted requests electronically within the Prior Authorization Portal. Using the portal helps reduce delays by ensuring required clinical information is available for review and allows providers to monitor request progress without needing to call for routine status updates.

Frequently Asked Questions

Do providers need to wait until December 1, 2026, to use CPT/HCPCS codes when submitting prior authorization requests?

No, there is no need to wait. Providers can enter post-acute prior authorization requests using CPT/HCPCS codes today. We encourage providers to begin use the appropriate CPT/HCPCS codes for post-acute requests immediately but will not require this change fully until December 1, 2026.

Are revenue codes going away completely?

Revenue codes will no longer be used as the prior authorization entry method for post-acute requests. However, they may still be communicated when applicable, such as verbally, as an updated claims note or with the approval and level of care.

Which codes should providers use for post-acute prior authorizations?

Providers should use the CPT/HCPCS code that corresponds to the requested post-acute setting and level of care.

What happens if a provider submits a code for a setting they are not affiliated with?

Providers should only enter codes for the post-acute settings with which they are affiliated.

Does this change apply to both initial and continued stay reviews?

Yes. Both initial and subsequent reviews for post-acute stays will require clinical review prior to approval.

Resources Available

- Prior Authorization Lookup Tool Guide
- How to Enter Inpatient Prior Authorizations
- How to Upload Clinical Documentation
- How to Check the Status of a Prior Authorization Request

We encourage providers to begin using CPT/HCPCS codes now and take advantage of the available resources and electronic tools to verify requirements, submit complete authorization requests and monitor request status efficiently ahead of the December 1, 2026, effective date.

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Platform Migration Update

CareFirst continues to make progress on efforts to transition and align accounts to our consolidated platform. We appreciate your patience.

Right now, we're prioritizing outstanding and inaccurate claims, adding operational support, accelerating processing where possible and addressing the root causes of the delays. New claims

are moving through our systems more efficiently, response times are improving each month, and we've reduced our claims backlog by more than 70% (not including denied or aged claims or those under appeal). We expect claims inventory and processing times to return to normal levels soon.

We appreciate your continued partnership and feedback as we complete this work.

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Individual Medicare Advantage PPO Product Changes for 2027

Medicare Advantage

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, "CareFirst"), is announcing upcoming changes to our Individual Medicare Advantage (MA) PPO product portfolio for 2027. Providers can expect updates to current Medicare Advantage PPO products, including changes to service areas, plan offerings, and new plan launch information. For more information, please register for one of our upcoming webinars.

- Thursday, December 17 at 1p.m.
- Wednesday, December 30 at 10 a.m.
- Wednesday, January 13 at 10 a.m.

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Update to Partial Hospitalization and Intensive Outpatient Program Requirements

Commercial

CareFirst BlueCross BlueShield is committed to keeping providers informed of changes that may impact how care is coordinated for our members. **Beginning December 15, 2026**, CareFirst will require prior authorization for Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) for members enrolled in commercial plans.

This requirement applies to PHP and IOP services focused on both mental health and substance use disorder treatment. Providers should verify member eligibility, benefits and prior authorization requirements before services are rendered.

Important notes: This change does not apply to Federal Employee Program (FEP), Medicare Advantage or DualPrime members. CareFirst CHPMD prior authorizations are handled by Carelon – visit **HealthChoice and Behavioral Health Coverage** for more information.

For members currently receiving care

For members who are already receiving PHP or IOP services, prior authorization must be obtained for any services provided on or after December 15, 2026.

Provider action

- Confirm member eligibility and benefits before rendering services through the CareFirst Provider Portal (CareFirst Direct).
- Use the Prior Authorization Lookup Tool in the CareFirst Provider Portal to verify authorization requirements.
- Submit prior authorization requests electronically before services are rendered.
- Upload all required clinical documentation to support medical necessity for the requested level of care.

Resources Available

- Prior Authorization Lookup Tool Guide
- How to Enter Outpatient Prior Authorizations

Authorization approvals are based on medical necessity, appropriateness and covered benefits and are not a guarantee of payment. Payment remains subject to member eligibility, benefit coverage and applicable plan requirements.

Thank you for your continued partnership in coordinating timely, appropriate care for CareFirst members.

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New Electronic Medication Prior Authorization Submission Process Update

CareFirst CHPMD

We are pleased to announce that you will soon be able to submit medication prior authorization requests electronically for CareFirst CHPMD members using the CareFirst Provider Portal (CareFirst Direct).

Important Update: The planned October 1, 2026, implementation has been temporarily delayed. Please watch for additional communication announcing the new implementation date.

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Reminder: Medical Drug Prior Authorization Guidance for Members with Commercial and Medicaid Coverage

As part of CareFirst's transition to CVS Health and their Novologix prior authorization for medical drug prior authorizations, we are providing guidance regarding the prior authorization process for members with both commercial and Medicaid coverage.

Beginning October 1, 2026, when a member has dual eligibility with commercial insurance as the primary payer and Medicaid as the secondary payer, providers should follow the commercial plan's prior authorization requirements before seeking coverage consideration under Medicaid.

Key Requirement

- Prior authorization requests for medical drugs must first be submitted and reviewed according to the member's commercial plan guidelines, as the commercial plan is the primary payer.
- Medicaid coverage consideration should occur only after the commercial plan's determination has been obtained.
- Documentation supporting the commercial plan's authorization decision may be requested to facilitate coordination of benefits and coverage review.
- This process aligns with standard coordination of benefits requirements and will support accurate and efficient medical drug prior authorization determinations under the CVS delegated model.

Please begin following this guidance to ensure a smooth transition and avoid delays in member care.

Thank you for your continued partnership and commitment to serving our members.

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Upcoming Medicaid Changes - What Providers Should Know

CareFirst CHPMD and DualPrime

Beginning January 1, 2027, some Maryland Medicaid members may need to meet new federal work and renewal requirements to maintain coverage. Providers play a vital role in helping members understand what’s changing, stay informed, and connect them with official state resources. Early awareness can help members avoid confusion or gaps in coverage.

What providers can do now:

- Encourage members to visit the Medicaid Check-In website to learn about upcoming changes and see what steps they may need to take.
- Review and use the Maryland Department of Health provider toolkit, which includes provider-specific information, FAQs, and outreach materials to support member conversations.

Read the full article.

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Prior Authorization Requirement Update for PT, OT and SLP Services for CareFirst BlueCross BlueShield Medicare Advantage Members

Medicare Advantage

As a reminder, beginning September 15, 2026, CareFirst BlueCross BlueShield Medicare Advantage plans (CareFirst BlueCross BlueShield Advantage Essential (PPO), Complete (PPO), Salute (PPO), and CareFirst BlueCross BlueShield Group Advantage (PPO)) require prior authorization for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services beginning with the first visit.

Important Note: Prior authorization is not required for the initial evaluation or a re-evaluation. For members currently receiving care, prior authorization must be obtained for any services provided on or after September 15, 2026.

Frequently Asked Questions

Do initial evaluations require prior authorization?

No. Initial evaluations for PT, OT and SLP services do not require prior authorization. Evaluation codes should return a “no authorization required” message when checked through the Prior Authorization Lookup Tool or authorization portal.

Do re-evaluations require prior authorization?

No. Re-evaluations do not require prior authorization.

Can the initial evaluation and first treatment visit occur on the same day?

Yes. Providers may complete the initial evaluation and the first PT, OT or SLP treatment visit on the same date of service when clinically appropriate.

If the first treatment visit is performed on the same day as the evaluation, when should the authorization be submitted?

If the first treatment visit is performed on the same day as the evaluation, the provider must submit the authorization request within three calendar days of the date of service. The authorization portal counts the day after the date of service as day one.

What documentation should be included with the authorization request?

Providers must include all required clinical documentation to support the medical necessity of the services requested. This may include the evaluation findings, treatment plan, goals, requested services, frequency and duration and any relevant clinical notes or referral information.

Read the full article.

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Important Utilization Management Process Update

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

We have streamlined operations and enhanced efficiency when faxing forms by transitioning from our current system to just two forms to handle all request types, along with one dedicated fax number for each line of business. The new forms can be accessed here:

- Medical Forms Page
- General Forms Page

***New updates are available for this effort:** Learn more here.

Electronic submission through the CareFirst Provider Portal remains the most efficient way to submit prior authorization requests.

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Take Note: Maryland Medicaid Transitioning to MPRIME

CareFirst CHPMD

Maryland Medicaid will transition from its online Electronic Provider Revalidation and Enrollment Portal (ePREP) to the Maryland Provider Registration and Information Management Enterprise (MPRIME) portal on October 13, 2026. For more information or questions, go to https://health.maryland.gov/mmcp/provider/Pages/mprime.aspx or email mdh.mprimegolive@maryland.gov.

Register for MDH's MPRIME System Training: https://www.cognitoforms.com/MDH3/RegistrationMPRIMESystemTraining

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DualPrime Provider Resources Webpage Sunset

DualPrime

DualPrime providers should note that the resources currently available on the Provider Resources page are also available on the Learning and Engagement Center and provider.carefirst.com to create a more streamlined experience and make it easier to find what you need.

As part of this transition, providers should use the CareFirst Provider website as their central destination for resources and updates. To assist you in locating resources currently available on the DualPrime Provider Resource page, please review the information below:

Resource Name	Where to locate:
Learning and Engagement Center	www.carefirst.com/learning
Annual Model of Care (MOC) Training and Attestation	Available on the Learning and Engagement Center: Government Programs - On-Demand Training | CareFirst BlueCross BlueShield Direct link to training: Model of Care Training
CareFirst Direct User Guides	Available on the Learning and Engagement Center: CareFirst Essentials - On-Demand Training | CareFirst BlueCross BlueShield
BlueLink Provider Newsletter	Provider Newsletters
Provider News Archive	News Archives
Quality Toolkit	https://individual.carefirst.com/carefirst-resources/pdf/my-carefirst-quality-toolkit.pdf
Clinical Practice Guidelines	Clinical Guidelines
Payment Policy Database	Payment Policy | CareFirst BlueCross BlueShield
Inpatient and Outpatient Authorization Forms	Medical Forms
Provider Dispute Form	DSNP-Provider-Dispute-Form.pdf
DSNP Medical PA Drug List	https://www.carefirst.com/medicare-options/attachments/dsnp/2026-dsnp-medicare-part-b-prior-authorization-drug-list.pdf
Practice Contact Information	Provider Profile Contact Information Request

Form	
Waiver of Liability Statement	https://www.carefirst.com/medicare-options/attachments/dsnp/dsnp-model-waiver-of-liability-formv508.pdf

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Virginia Mandate Lowers Cost Sharing for Insulin, Diabetic Supplies

Commercial Risk (Virginia)

Effective January 1, 2027, the *maximum* out-of-pocket cost for covered prescription insulin drugs and diabetes equipment/supplies in Virginia will be lowered to $35 for a 30-day supply. There is an aggregate cap of $35 that applies to all insulin drugs and all diabetes equipment/supplies prescribed to the same covered member in a 30-day period, regardless of type or quantity. This includes situations where the member is prescribed more than one insulin drug.

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Helping Members Identify Top Performing Specialists

Commercial

To better serve our members and promote transparency around cost and quality performance, CareFirst BlueCross BlueShield has developed a new designation to identify specialists who demonstrate strong performance in cost efficiency, quality and appropriateness of care. The designation will be applied at the individual provider (NPI) level **for the following specialties only:**

- Cardiothoracic surgery
- Cardiology
- Endocrinology
- Gastroenterology
- Nephrology
- Neurology
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic surgery
- Otolaryngology

- Pulmonology
- General Surgery
- Rheumatology
- Urology

Eligible providers who receive the **Top Specialist** designation will be identified with a **Top Specialist indicator** next to their name in the provider directory that eligible commercial members can access after logging in.

The Top Specialist designation reflects an assessment of:

- Cost efficiency
- Quality performance, which includes clinical outcomes and appropriateness of care

Specialists are evaluated against peers within their specialty and geographic region using an established methodology and available performance data. The designation is intended to support informed healthcare decision-making while recognizing providers who demonstrate strong performance across these measures. Provider payments and member cost sharing are not currently impacted by the designation.

For more information about the methodology used to determine the designation, please review the Top Specialist Designation Methodology (**Note:** You will be prompted to login using your CareFirst Provider Portal credentials.)

If you would like additional information about your Top Specialist assessment, email Provider_Designations@carefirst.com and include your NPI.

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Administrative Support

Reminder: Follow Claims Submission Best Practices

To help prevent delays and support accurate, efficient processing, follow these claims submission best practices:

- Ensure coding follows national guidelines, particularly for codes based on patient age, patient sex, and new versus established patient status.
- Submit the single comprehensive code that most accurately describes the service provided instead of billing multiple codes.

Beginning in December, claims that do not meet these criteria will be rejected; once necessary corrections are made the claim can be resubmitted.

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Coming Soon: Additional Enhancements to the CareFirst Provider Portal (CareFirst Direct)

All lines of business

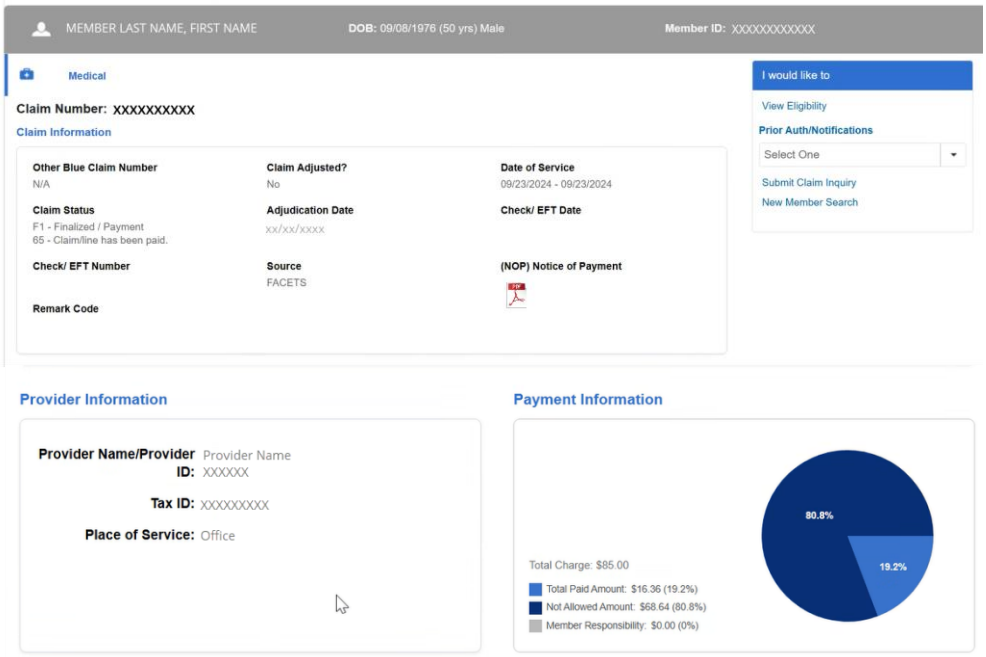
CareFirst is continuing to enhance the CareFirst Provider Portal (CareFirst Direct) to make it easier for you and your staff to do business with us and access more information electronically.

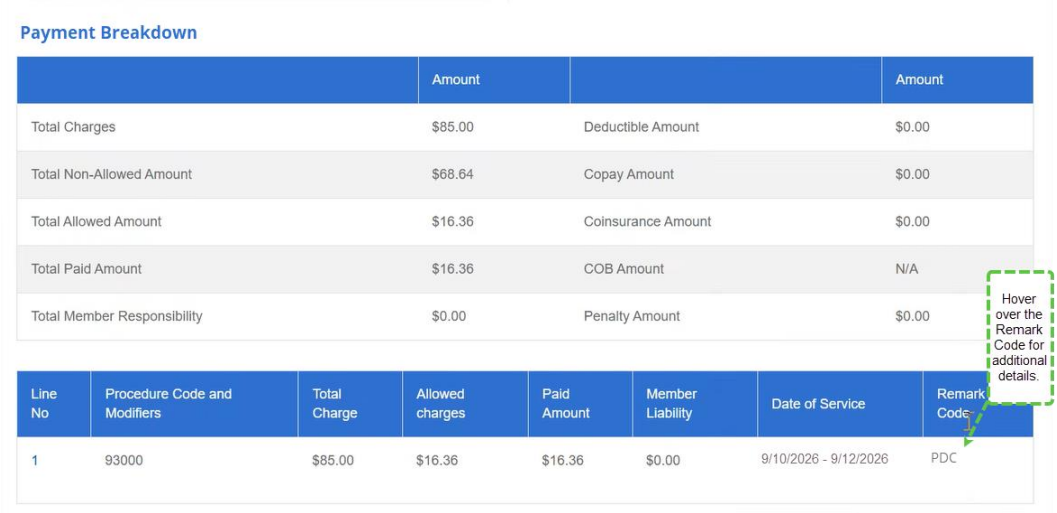
The latest enhancement is an improved claims status experience, designed to provide clearer, more timely, and more detailed claim information, helping you quickly understand where a claim is in the process, review available payment details and identify whether additional action may be needed.

Here is a preview of the new information you'll see when checking claim status.

New Claim Summary Screen Available

Within the Claims Summary section, you will notice a clearer view into specific claims status information including access to the notice of payment, clearer remark codes information along with their description, a clear payment breakdown, along with claims line details and more. There will be more enhancements to the claim status information coming later in October that will provide even more helpful information.





For step-by-step instructions, access the Checking Claims Status in CareFirst Direct course. Be on the lookout for more details, including timing and resources to support your team, as additional enhancements become available.

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Stay Informed: Add Your Email Address Within the Provider Updates and Attestation Tool

All lines of business

CareFirst uses the provider information on file to help ensure important updates and communications reach the right people at your practice. Adding and maintaining a current email address in the Provider Updates and Attestation tool helps us communicate with you more effectively and supports your ability to stay informed about information that may impact your practice, your patients and your CareFirst participation.

Benefits of Adding Your Email Address

- **Receive important updates faster:** A current email address allows CareFirst to share timely information directly with you and your practice.
- **Help reduce missed communications:** Email helps ensure important notices, reminders and follow-up information reach the appropriate contact.
- **Support timely action:** Receiving updates electronically can help your practice respond more quickly to new updates and information.
- **Improve provider directory accuracy:** Keeping email and other contact information current supports accurate practice information for CareFirst members and operational teams.

How to Add or Update Your Email Address

1. Go to provider.carefirst.com and log into to the CareFirst Provider Portal.
2. From the home page, select **Medical Provider Updates and Attestation**.
3. Select the applicable practice or practitioner record.
4. Review the provider, office contact and location information for accuracy.
5. Add or update the appropriate email address where available, such as the group email, office manager email, primary office contact email, practitioner email or location email.
6. Review your changes, submit them and complete the attestation when all information is accurate.

Need Help?

Step-by-step training is available through the Provider Directory Updates and Attestations course on the Learning and Engagement Center.

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Streamline Your Prior Authorization Requests: Take Advantage of CareFirst's Electronic Self-Service Tools

All lines of business

By utilizing the CareFirst Prior Authorization System and Prior Authorization Lookup (PAL) Tool, you can manage nearly every aspect of the prior authorization process online, eliminating the need for unnecessary phone calls and fax submissions.

1. Verify Prior Authorization Requirements Instantly

Before submitting a request, use the Prior Authorization Lookup (PAL) Tool to determine if authorization is required for a service. The tool provides:

- Real-time authorization requirement results with a clear "Yes" or "No" response.
- The ability to verify requirements based on member information, date of service, place of service and service codes.
- Direct links to the appropriate prior authorization system when authorization is required.
- The ability to access, view and print historical verification results for your records.

2. Submit Prior Authorization Requests Electronically

When authorization is required, you can submit your request directly through the CareFirst Provider Portal. Electronic submission offers:

- 24/7 access to enter prior authorization requests online.
- Faster and more efficient review and decision-making.
- Reduced reliance on fax submissions and phone calls.
- The ability to include all required clinical information at the time of submission.

3. Upload Clinical Documentation Electronically

Providers can attach supporting documentation directly to authorization requests eliminating the need to fax them to us including:

- Clinical records and supporting documentation during initial submission.
- Additional documentation after submission when requested for concurrent or ongoing review.

Documentation uploads directly to the authorization record for streamlined review.

4. Use the MCG Interface to Support Real-Time Decisions

Using the MCG interface helps ensure the clinical criteria selected for members are attached to the authorization request and included in your request. Complete and accurate clinical documentation entered through MCG can increase the likelihood of receiving a real-time approval when the request meets medical necessity criteria.

Currently, the following services may be eligible for real-time approval when submitted for Medicare Advantage and DualPrime members and the clinical documentation entered in MCG supports medical necessity:

- Debridement/Wound Care
- Advanced Diagnostic Imaging
- CPAP/BIPAP
- Pain Management Injections
- EGDs

For commercial members, attended sleep studies may also be eligible for real-time approval when the clinical documentation entered through MCG meets medical necessity criteria.

In addition, we are in the process of adding additional services to this list so be on the lookout for more information soon.

5. Check Authorization Status Online

Instead of calling, you can monitor your requests electronically by:

- Viewing real-time authorization status updates.
- Accessing inpatient and outpatient authorization lists.
- Tracking submitted authorizations from start to finish.

Resources Available

We have step-by-step instructions for everything you can do electronically in the CareFirst Prior Authorization System available in the Learning and Engagement Center. Here are direct links as well for quick access to what you need:

- Utilizing the Prior Authorization Lookup (PAL) Tool
- Entering Inpatient Prior Authorizations
- Entering Outpatient Prior Authorizations
- Uploading Clinical Documentation
- Utilizing the MCG User Interface
- Checking Prior Authorization Status On-line
- Edit Dates of Service on Prior Authorization Requests

Thank you for partnering with CareFirst. We encourage you to take full advantage of these electronic self-service tools to streamline your prior authorization workflow and improve your overall experience.

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Get Answers Faster with CareFirst Interactive Voice Response Self-Service Tools

All lines of business

CareFirst offers interactive voice response (IVR) self-service options to help providers quickly access routine information without waiting to speak with a representative. These tools are designed to give you faster, more convenient access to commonly requested information so you can spend less time on the phone and more time supporting patients.

Why Use IVR Self-Service?

IVR self-service can help your practice obtain important member, claim and authorization information quickly and efficiently. For routine inquiries, using self-service first helps reduce wait times, supports faster administrative workflows and allows Provider Service representatives to focus on more complex or urgent issues that may require additional assistance.

Benefits for Your Practice

- **Faster access to routine information:** Retrieve commonly requested details in minutes, often without waiting on hold.
- **Greater convenience:** Available 24 hours a day, seven days a week.
- **Reliable information:** The IVR provides consistent responses and access to information available to CareFirst associates.
- **Flexible navigation:** Use your telephone keypad to move through prompts and obtain the information you need.

What is Available?

Commercial and FEP Members

CareFirst on Call is an automated Interactive Voice Response (IVR) system designed to give providers convenient, self-service access to important information anytime, day or night.

Using a telephone keypad, providers can quickly obtain:

- Member eligibility and benefits information
- Deductible and maximum benefit details
- Claim status updates
- Authorization status information

CareFirst on Call Reference Guides

The following reference guides are available to help providers navigate the IVR system and identify the appropriate key commands for their inquiries.

- CareFirst On Call Reference Card Professional
- CareFirst On Call Reference Card Institutional

Government Programs Members (Medicare Advantage PPO, DualPrime, CareFirst CHPMD and Healthy DC)

When you contact provider service, you can immediately utilize our IVR to check member eligibility. The system will prompt you step-by-step to quickly retrieve what you need.

To support quality service and assist with any questions regarding information received through the system, CareFirst maintains records of all IVR interactions for future reference. We encourage you to take advantage of the convenience and speed of CareFirst's IVR to access routine information quickly and help ensure the most efficient experience for your practice.

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New CareFirst APIs Coming Soon to Support Secure Health Information Sharing

CareFirst is preparing to introduce new and expanded Application Programming Interfaces (APIs) designed to support secure, standards-based health information sharing and help reduce administrative burden for providers. These updates are part of the CMS Interoperability and Prior Authorization final rule and related Blue Cross Blue Shield Association interoperability requirements.

Beginning in 2027, these APIs will make it easier for providers to request and receive certain patient information electronically, when permitted, and support more efficient prior authorization workflows.

What will the new APIs do?

- **Provider Access API:** Allows in-network providers with an established treatment relationship to electronically request certain patient data, including claims, encounter, clinical and prior authorization information, as applicable.
- **Prior Authorization APIs:** Supports electronic prior authorization functions, including checking whether authorization is required, identifying documentation needs, submitting authorization requests and receiving status updates.

Why this matters

These tools are intended to improve access to patient information, support care coordination, streamline prior authorization processes and help providers spend less time on administrative tasks and more time caring for patients.

What providers should do now

- Watch for additional communications from CareFirst with launch timing, technical documentation and onboarding information.
- Review upcoming educational materials as they become available.
- Ensure the appropriate teams in your organization, including clinical, administrative, prior authorization and technical/EHR teams, are aware of these upcoming changes.

No immediate action is required. CareFirst will share more information as implementation activities progress and provider resources become available.

Thank you for your continued partnership as we work to improve health information sharing and support more efficient care delivery.

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Reminder: Use Modifier GY for Services Not Covered by Medicare

To help ensure accurate claims processing, providers should append **modifier GY** when billing services that are **statutorily excluded from Medicare coverage or otherwise not covered by Medicare**.

Medicare Crossover Claims Submission

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

- Wait 30 days from the Medicare Explanation of Benefits (EOB) date before submitting your secondary claim.
- If you are submitting a secondary claim electronically, you must include the Medicare EOB or remittance advice date.
- Out-of-area member claims for covered services will be rejected by the member's home plan. When you receive a rejection notification, you must resubmit these claims to CareFirst for processing through BlueCard®.
- Medicare claims billed using a "GY" modifier can be submitted directly to CareFirst without prior submission to Medicare. These claims are not impacted by the 30-day requirement and do not require the inclusion of a Medicare EOB.

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

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Are you In- or Out-of-Network? How to Verify your Network Participation

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

CareFirst offers multiple provider networks to meet the needs of our customers, members and the communities we serve. It's important to understand which networks you participate in, as this helps ensure members receive appropriate care, aren't turned away from receiving care, and have clear expectations about potential out-of-pocket costs.

Access the Provider Updates and Attestation tool within the CareFirst Provider Portal (CareFirst Direct) to verify your network participation. Refer to this step-by-step resource for assistance.

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CareFirst CHPMD Monthly and Quarterly Formulary Updates: Pharmacy Benefits

CareFirst CHPMD

CareFirst CHPMD posts monthly and quarterly formulary updates in its website's *Drug List* section, CareFirst Community Health Plan Maryland - Drug List (Formulary) Updates | CareFirst BlueCross BlueShield.

Major formulary changes effective **September 1, 2026**:

- **Added to the formulary:**
  - Buprenorphine transdermal system
  - Indomethacin Capsule
  - Hydromorphone ER Tablet
  - Opill Tablet
  - Saxagliptin Tablet
- **Removed from the formulary:**
  - Etodolac capsule, tablet and ER tablet
  - Oxaprozin tablet
- **Now processed under the Medical Benefit:**
  - Decnupaz injection
  - Evdi injection

Major formulary changes effective **October 1, 2026**:

- **Added to the formulary:**
  - Umeclidinium/Vilanterol inhaler
- **Removed from the formulary:**
  - Humulin R U-500 injection
  - Prenatal 19 chew tablet
  - Tolvaptan tablet (Jynarque)
  - Trinate tablet
  - Tybost tablet
- **Now processed under the Medical Benefit:**
  - Favlyxa injection
  - Gemcitabine injection
  - Lumvoa injection
  - Sarclisa injection
  - Nufymco injection
  - Tevimbra injection
  - Yesafili injection

To reduce costs for your patients, please recommend formulary agents first.

For a non-formulary drug, providers can submit prior authorization to CVS Caremark and provide supporting notes for why the member is unable to use the formulary agent(s). Documentation is required for approval, including the name of medication(s) tried and reason for treatment failure, inadequate treatment response, intolerance, contraindication, and/or adverse effect, whichever are applicable. Prior authorizations can be submitted electronically via CoverMyMeds, by fax or by phone.

If the provider would like to do a Peer-to-Peer review, they can call the CVS Caremark Prior Authorization line for specialty drugs at 1-866-814-5506 or non-specialty drugs at 1-877-418-4133. A Peer-to-Peer review is only allowed PRIOR to an appeal being requested. Appeals are processed by CVS Caremark; guidance is included in the Adverse Determination (Denial) letter.

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Weight Management as a Sole Indication is Excluded from Coverage Under Maryland Medicaid Benefits

CareFirst CHPMD

Requests submitted only for weight loss, obesity, or weight management cannot be approved, even when the medication has an FDA-approved weight-loss indication.

Prior authorization of these drug classes requires clinical documentation. **A provider statement or attestation is not sufficient.** Requests submitted without medical records supporting the coverage criteria may be denied.

Frequent causes of denial include requests submitted for:

- Wegovy or Zepbound for members with Type 2 Diabetes: coverage should be requested for diabetes-indicated formulary alternatives such as Ozempic injection or tablet products, Mounjaro or liraglutide.
- Wegovy for cardiovascular risk reduction when the member has cardiovascular risk factors only and does not have established atherosclerotic cardiovascular disease as defined by applicable Maryland Department of Health clinical criteria.
- Requests submitted without clinical documentation, such as recent chart notes supporting the diagnosis, BMI, treatment plan, or applicable clinical findings.

To promote timely review and reduce preventable denials, please include:

- Diagnosis code and requested indication, including confirmation of Type 2 diabetes, when applicable.
- Recent chart notes supporting the diagnosis, BMI and treatment plan.
- Documentation of diet and exercise program participation.
- For Wegovy cardiovascular risk reduction requests: documentation of established atherosclerotic cardiovascular disease, not only cardiovascular risk factors.

- For Wegovy Metabolic Dysfunction-Associated Steatohepatitis (MASH) requests: documentation supporting noncirrhotic metabolic dysfunction-associated steatohepatitis with moderate to advanced liver fibrosis.
- For Zepbound obstructive sleep apnea requests: chart notes and sleep study documentation supporting moderate to severe obstructive sleep apnea.

Coverage criteria may be requested through the prior authorization process or by contacting the CVS Caremark Pharmacy Prior Authorization Department at 877-418-4133. If faxing a request, include the medication name, diagnosis code, requested indication, and supporting chart documentation. Fax the completed Formulary Exception/Prior Authorization Request Form with clinical information to CVS Caremark at 855-762-5205.

If a request is denied missing criteria or documentation, please address the missing information before resubmitting. Complete submissions help reduce administrative burden and support timely access when therapy is medically appropriate.

GLP-1 and GLP-1/GIP Quick Reference

The table below is a high-level guide and does not replace applicable prior authorization criteria as of June 2026.

Drug	Type 2 DM	ASCVD / CV	MASH	OSA	Weight loss
Foundayo tablet	🚫	🚫	🚫	🚫	**EXCLUDED**
Liraglutide injection	Eligible	🚫	🚫	🚫	**EXCLUDED**
Mounjaro injection	Eligible	🚫	🚫	🚫	**EXCLUDED**
Ozempic oral or injection	Eligible	🚫	🚫	🚫	**EXCLUDED**
Wegovy injection	🚫	Eligible	Eligible	🚫	**EXCLUDED**
Wegovy tablet	🚫	Eligible	🚫	🚫	**EXCLUDED**
Zepbound injection	🚫	🚫	🚫	Eligible	**EXCLUDED**

Reminder: "Eligible" does not guarantee approval. Approval requires the requested indication, diagnosis, and supporting clinical documentation to meet applicable prior authorization criteria.

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Medical Records Retention & Accessibility Reminder

Maintaining complete and accessible medical records is important to supporting continuity of care, quality improvement, risk adjustment and other health plan activities. CareFirst reminds participating providers to retain medical records in accordance with applicable contractual, regulatory and legal requirements and to ensure records remain retrievable and accessible when requested. When transitioning electronic health record (EHR) systems, changing vendors, archiving records, relocating or undergoing other operational changes, practices should ensure continued access to historical patient records. This includes establishing a process to retrieve records maintained in a previous EHR system or through a third party storage or archive vendor.

Resources

- Maryland Department of Health Medical Record Retention and Fees FAQs
- Maryland Department of Health Medicare Records Page

Thank you for your continued partnership in supporting accurate and timely medical record retrieval.

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Medical Policy Updates

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

Our Healthcare Policy department regularly reviews medical policies and procedures based on new evidence and technological advances. You can review Healthcare Policy Updates on our Medical Policy webpage.

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Payment Policy Updates

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

In consideration of current industry standards and to align with CareFirst's mission to provide affordable healthcare, CareFirst has made an update to the following Payment Policies in the online Payment Policy Reference Manual:

The following will impact commercial lines of business effective December 6, 2026:

- **PP CO 050.01 Bilateral Services –** this policy was updated to more clearly outline how the logic in the Coding Guidelines section is applied to Professional versus Facility claims. In addition, if the description of the procedure code specifies unilateral but there is another code that specifies bilateral in nature for the same service, CareFirst will deny the claim line. Always report the most comprehensive code for the services performed

- **PP CO 003.01 New Patient –** this policy was created to clearly outline how CareFirst applies New Patient logic. Some of the information in this policy was previously found in the Provider Manuals. With the publication of this policy, that information is now removed from the Provider Manual.

The following will impact commercial lines of business effective January 1, 2027:

- **PP CO 080.00 Maternity Care Services –** This new policy outlines the guidelines related to Maternity Care services because of the new 2027 American Medical Association (AMA) coding structure. Providers will continue to bill using the current global structure through 2026. Any changes to billing should not occur until January 2027.
  - **PP CO 080.01 Global OB Services** policy will be retired as of 12/31/2026.

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Focus on Quality

Antibiotic Stewardship & Avoidance for Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

All lines of business

Antibiotic stewardship plays an important role in improving patient safety, reducing unnecessary antibiotic exposure and slowing the spread of antibiotic resistance. This is especially important in outpatient care, where CDC data indicates that at least 28% of antibiotic prescriptions are not needed and recent guidance suggests that roughly 30% of outpatient antibiotic prescribing may not align with clinical guidelines.

Unnecessary or repeated antibiotic use can increase the risk of adverse drug events, contribute to resistant infections that are harder and more costly to treat and reduce the long-term effectiveness of these therapies. These risks apply across all age groups but are especially important for infants, as unnecessary antibiotic exposure may cause side effects such as diarrhea, allergic reactions and disruption to healthy gut bacteria.

For respiratory conditions such as acute bronchitis and bronchiolitis, where most cases are nonbacterial, stewardship supports evidence-based prescribing and reinforces the importance of reserving antibiotics for cases where they are truly indicated.

Building on this stewardship approach, the NCQA measure of Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) helps evaluate whether antibiotics are being used appropriately for respiratory conditions that are typically viral. The measure tracks the percentage of episodes among members ages three months and older with a diagnosis of acute bronchitis or bronchiolitis who were not dispensed an antibiotic within three days of diagnosis.

AAB is also a valuable quality metric because it reinforces the importance of accurate prescribing and complete documentation, including the need to code comorbid conditions or competing diagnoses when antibiotic treatment is clinically justified.

To support appropriate performance on the AAB measure and promote responsible antibiotic use, antibiotics should be avoided unless there is clear clinical evidence of a bacterial infection. Because many upper respiratory conditions are viral, antibiotic treatment often provides no clinical benefit and may expose patients to unnecessary risk.

Complete and accurate documentation is equally important when antibiotics are clinically appropriate. In those cases, providers should document and code all relevant comorbid conditions and competing diagnoses, such as pharyngitis, on the same claim to clearly support the clinical rationale for treatment and ensure the encounter is captured as specifically and completely as possible.

References:

Antibiotic Use (Centers for Disease Control and Prevention)

CareFirst Quality Toolkit MY2026

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Continuing Education Unit (CEU)-Eligible Population Health Courses Available Now

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

The Risk Adjustment and Coding team has collaborated with the American Academy of Professional Coders (AAPC) to offer new online courses in Quality Improvement and Risk Adjustment.

Read the full article.

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Register Today: Risk Adjustment Office Hours

Medicare Advantage, DualPrime

CareFirst BlueCross BlueShield (CareFirst) is committed to supporting our network providers with ongoing education and other resources. Our Risk Adjustment Coding live office hours webinars—tailored for all Medicare Advantage plans including Group, Individual and DualPrime—help providers stay abreast of the latest documentation and coding for HCC and feature best practices, updates and reminders from CareFirst.

To register, click on the date of the session that works best for you and complete the registration

form.

- Thursday, October 22, 12-1p.m.
- Thursday, November 19, 12-1p.m.

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In Case You Missed It

Update and Attest your Provider Data Using the Provider Directory Updates and Attestation Tool

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

We're excited to share the availability of the Provider Directory Updates and Attestation self-service tool within the CareFirst BlueCross BlueShield Provider Portal (CareFirst Direct). All providers can now take advantage of the new enhancements, allowing you to easily attest and update provider directory information. Access this step-by-step resource for assistance.

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CareFirst Administrators: Administrative Platform Transition Reminders

Commercial

CareFirst Administrators (CFA) enrollment, claims and billing is upgrading to a new platform. This transition began on November 1, 2025, with a small number of members and will continue monthly until the process is complete. Read the full article in the December 2025 issue of BlueLink.

As part of this transition, we have engaged PNC Healthcare, powered by ECHO Health, to provide electronic payment methods via their Claims Payment and Remittance service for newly transitioned members.

Please review this important information to ensure your payment and remittance preferences are up to date.

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Important Guidance for Providers Using Third-Party Billing Companies

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

We realize many of our participating providers contract with third-party billing companies to support their administrative needs. These companies reach out to Provider Service, often for information or answers that are readily available through one of our self-service tools.

The link below includes important information you can discuss with third-party billing companies to ensure they can obtain what they need through our self-service options.

Read the full article.

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Reminder: Medical Records Requests in Progress

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

Each year, CareFirst retrieves medical records from our network providers to fulfill various regulatory requirements and audits. We recognize large medical requests can be time-intensive and labor-intensive to your practices, so we hope this reminder is helpful in allowing you to coordinate requests across initiatives and vendors. As always, thank you for your partnership.

View the Record Retrieval Calendar: Click here to access the calendar and note the various vendors that may reach out on behalf of CareFirst. Very few practices will be impacted by all retrieval efforts.

Read the full article.

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Attention Maryland Medicaid Providers: HIV Reporting Form

CareFirst CHPMD

Providers participating in Maryland Medicaid must notify the Maryland Department of Health—using the link below—of patients with an HIV diagnosis. This will ensure beneficiaries receive appropriate resources to help manage their care. Access the Maryland Confidential Morbidity Report (DHMH 1140) - HIV Only form for instructions and points of contact for any questions.

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Important Reminder for Providers: CMS Registration Requirement

Medicare Advantage

As a reminder, providers must be registered with the Centers for Medicare & Medicaid Services (CMS) to be paid for services rendered to Medicare patients.

The Provider Enrollment, Chain, and Ownership System (PECOS) is a web-based platform managed by CMS that facilitates the enrollment process for Medicare providers and suppliers. PECOS streamlines provider enrollment, allowing providers and credentialing staff to efficiently manage and submit Medicare enrollment information electronically.

Review the PECOS Fact Sheet.

The PECOS database can be found here.

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Complete the 2026 Mandatory Model of Care Training Attestation Today!

DualPrime

All providers who see CareFirst BlueCross BlueShield Advantage DualPrime (HMO-SNP) members **must** complete their mandatory Model of Care training upon enrollment in our network, and then annually each year after. Attestation for the annual training may be done at the practice level and takes less than 10 minutes.

Read the full article.

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Are You Up to Date on Best Practices and Quality Standards?

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

From recommending preventive care options for your patients to managing day-to-day office operations, the clinical resources on our provider website offer valuable time-saving tools. Use these resources to help support your treatment plan for patients with chronic diseases and those in need of preventive services.

CareFirst's Quality Improvement Council reviews our clinical resources annually and adopts nationally recognized guidelines and best practices to make sure you are updated when information changes.

Access the Quality Standards and Best Practices resource for more information.

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Atlas Systems Outreach to Providers Underway

Commercial, Medicare Advantage, CareFirst CHPMD, DualPrime

As a reminder, CareFirst BlueCross BlueShield has a contract with a third-party vendor, Atlas Systems, to assist in assessing the accuracy and completeness of our online provider directory. Your office may receive a call as we conduct this important outreach.

Important Note: These calls are legitimate and not a scam.

Read the full article.

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Events

Registration Available for 2026 Provider Live Webinars

We will have several live webinars available for you to attend in 2026. Please visit the Learning and Engagement Center Webinar page to register for those that apply to you.

Additional Live Webinar Opportunity:

- **Recovering from Chronic Pain: Addressing 90% of What We Don't See**
  Presented by Gregory Hobelmann, MD, MPH, Ashley Addiction Treatment
  - Thursday, October 29 at 5:30 p.m.

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CareFirst Holiday Closings in 2026

- Veterans Day: Wednesday, November 11
- Thanksgiving Day: Thursday, November 26
- Day after Thanksgiving: Friday, November 27
- Christmas Day: Friday, December 25

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Stay Connected with the Latest Information from CareFirst

Are you and your staff receiving CareFirst Provider News and our BlueLink Newsletter via email? If not, take a minute and sign up here.

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