CareFirst
Family of health care plans

3: Provider Network Requirements

Administrative Functions

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

Ancillary Institutional Professional

Credentialing

Professional Providers

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

Eligible professional providers

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

Professional provider credentialing

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

Eligible professional providers with supervision

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

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

Behavioral Health Supervisory Credentialing

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

How to apply

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

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

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

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

Malpractice Insurance Coverage

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

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

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

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

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

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

Institutional and Ancillary Providers

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

Eligible institutional and ancillary providers

- Medical
  - Birthing Center
  - Freestanding Ambulatory Surgery Center (ASC)
  - Freestanding Dialysis

- Home Health
- Hospice
- Hospital
- Rehab Hospital
- Skilled Nursing Facility
- Lithotripsy

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

Locum Tenens 

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

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

Recredentialing

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

Ongoing Monitoring of Sanctions

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

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

Adding a New Practitioner to Your Existing Group Practice

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

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

Access and Availability

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

Appointment Wait Times—Network Accessibility Standards 

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

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

Network accessibility standards—DC (Commercial plans)	
Appointment type	**Time frame**
First appointment with a new or replacement PCP	Within 7 business days

Network accessibility standards—DC (Commercial plans)	
First appointment with a new or replacement provider for Behavioral Health treatment, including Substance Use treatment	Within 7 business days
First appointment with a new or replacement provider for Prenatal Care treatment	Within 15 business days
First appointment with a new or replacement provider for Specialty Care treatment	Within 15 business days

Provider Data Accuracy

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

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

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

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

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

Institutional and Ancillary Provider Credentialing

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

How to apply

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

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

Fax: 410-505-2765

Email: Institutional.Credentialing@CareFirst.com.

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

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

Practice Transformation

What is Practice Transformation?

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

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

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

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

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

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

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

Practice and Payment Transformation at CareFirst

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

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

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

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

Primary care

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

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

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

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

Specialty care

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

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

Examples of transformation strategies for specialty care practices:

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

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

Health systems

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

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

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

Examples of transformation strategies for health systems:

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

Preparing for value-based care

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

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

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

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

Provider Scores

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.

Provider Profile Score

The Profile Score is calculated at the practice level and is used for developing the BlueEssentials network. The Profile Score includes quality and member experience, cost efficiency, and relationship health. To learn more about the measures and methodology, please email profilescore@carefirst.com.

Top Specialist Designation

To support transparency for members, CareFirst may also designate certain individual providers as "Top Specialist" in the Provider Directory based on cost efficiency and quality / appropriateness criteria. CareFirst cost data is used alongside quality and appropriateness measures and methodology from BlueCross BlueShield Association Axis Provider Insights. The following specialties are currently eligible for the designation:

- Cardiothoracic Surgery
- Cardiology
- Endocrinology
- Gastroenterology
- Nephrology
- Neurology
- Obstetrics & Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pulmonology
- General Surgery
- Rheumatology
- Urology

To learn more about the measures and methodology, please refer to the CareFirst Top Specialist Designation Methodology found at provider.carefirst.com or email Provider_Designations@carefirst.com.

Providers without this designation may not have enough data for evaluation or may practice a specialty not yet included. Providers with any practice location in Maryland may not be eligible for designation at this time due to state regulations. This designation will be visible to certain Commercial members based on their health plan enrollment after members log in to the Provider Directory.

Role of the PCP—BlueChoice Only

Providers in the following medical specialties are recognized as PCPs:

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

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

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

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

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

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

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

OB/GYNs as PCPs

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

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

Back-up Coverage

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

After Hours Care

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week so you can appropriately respond to members and other providers concerning after hours care. The use of recorded phone messages instructing members to proceed to the emergency room during off-hours is not an acceptable level of care for CareFirst BlueChoice members and should not be used by CareFirst BlueChoice participating physicians. Refer to Payment Policy PP CO 200.01 After Hours Office Visits – Professional.

Open/Closed Panel

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

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

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

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

Written notifications should be mailed to:

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

Reduction, Suspension or Termination of Privileges

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

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

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

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

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

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

Quality of Care Termination

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

All Other Sanctions or Terminations

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

Member to be Held Harmless

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

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

Health Insurance Portability and Accountability Act (HIPAA) Compliant Codes

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

Reimbursement

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

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

Payment Policy Reference Manual

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

The policies in this Payment Policy Reference Manual are for informational use only. These policies are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or

a contract. Member/subscriber coverage will vary from contract to contract and by line of business. Benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts.

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

Payment Policy References		
ID Number	Policy Name	Manual Topic
PP CO 010.01	Place of Service Codes for Evaluation & Management Services - Professional	Evaluation and Management (E/M) Services
PP CO 013.01	Anesthesia	Anesthesia by Operating Surgeon
PP CO 014.01	Evaluation and Management Services	Transitional Care Management Services
PP CO 015.01	Visual Acuity Screening	Visual Acuity Testing
PP CO 016.01	Critical Care	Critical Care Services
PP CO 020.01	Limited License Providers	Limited Licensed Providers, Physician Assistants, Anesthesia Assistants, Assistant Behavior Analysts and Registered Behavior Technicians; Ambulatory Surgery Centers
PP CO 050.01	Bilateral Services	Bilateral Procedures; Policy Guidelines for Reporting Bilateral Procedures
PP CO 070.01	Co-Surgeon/Team Surgery	Co-surgeon and Team Surgery
PP CO 070.02	Surgical Assistants	Assistant Surgeon; Assistant-at-Surgery
PP CO 070.03	Global Surgical Period	Global Period; Same Day Visit; Global Surgical, Anesthesia and Maternity Reimbursement Guidelines; E/M Services During the Global Period; Emergency Medicine

Payment Policy References		
PP CO 080.01	Global Obstetrical Policy	Obstetrics and Gynecology; Obstetrics Package; Maternity Services
PP CO 090.01	NCCI Editing – Professional, DME Supplier and Facility	Add-on Codes Without Base; Add-on Procedures
PP CO 100.01	List of Eligible Services – DME Supplier	Durable Medical Equipment; Guidelines for Ancillary Claims Filing
PP CO 100.02	DME Percent of Change (POC)	Guidelines for Ancillary Claims Filing
PP CO 100.03	DME Owned in History/Rent to Own	Guidelines for Ancillary Claims Filing
PP CO 100.04	Supplies and Equipment	Supplies and Equipment
PP CO 200.01	After Hours Office Visits – Professional	After Hours Care
PP CO 200.02	Telehealth Services	Telemedicine; Online/Internet and Telephone Services
PP CO 400.01	Multiple Procedure Payment Reduction (MPPR) – Pay Percent – Therapy Services – Professional	Pay Percent Professional Therapy
PP CO 400.02	MPPR – Pay Percent – Diagnostic Imaging Services – Professional	Pay Percent Multiple Radiology
PP CO 400.03	MPPR – Pay Percent – Cardiovascular Services – Professional	Pay Percent Multiple Cardiology
PP CO 400.04	MPPR – Pay Percent – Ophthalmology Services - Professional	Pay Percent Multiple Ophthalmology
PP CO 600.04	Professional, Technical and Global Services	Modifier Reimbursement Guidelines; Supervision, Interpretation and/or Guidance for Diagnostic Tests
PP CO 600.05	Modifier Policy	Payment/Non-Payment Modifiers; Modifier Reimbursement Guidelines; Global Surgical, Anesthesia and

Payment Policy References		
		Maternity Reimbursement Guidelines; CPT Modifer-25; CPT Modifier-57
PP CO 800.01	Dialysis - Facility	Dialysis Facilities
PP CO 900.01	Home Health Agency - Facility	Home Health
PP CO 900.02	Hospice - Facility	Hospice
PP CO 900.03	Skilled Nursing Facility	Skilled Nursing Facility
PP CO 900.04	Ambulatory Surgery Centers (ASC)	Free-Standing Ambulatory Surgery Center Payment Methodology; Air Ambulance

The Health Services Cost Review Commission

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

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

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

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

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

Diagnosis Related Group Inpatient Payment Methodology

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

Reimbursement should be calculated using:

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

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

Diagnosis Related Group Reimbursement Cases

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

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

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

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

Methods of Reimbursement for Facilities

CareFirst provides several other methods of hospital reimbursement:

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

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

Office-Based Drug Reimbursement Methodology

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

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

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

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

For commercial members, providers may obtain injectable medications from a source of their choice. CareFirst has a contract with CVS Caremark®[2]. CVS Caremark can ship single doses of most injectable medications, on an individual patient (prescription) basis, directly to the provider office for administering. This option is available for most office injectables, eliminating the upfront cost of stocking expensive specialty injectables. CVS Caremark will obtain eligibility and benefits, then bill CareFirst directly. Your practice should continue to bill CareFirst for the administration by following current procedural terminology (CPT®) guidelines and using the appropriate CPT codes.

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

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

Reimbursement methodology

If you obtain office injectable drugs, the following reimbursement methodology applies. Injectable drugs are reimbursed at 6% above the average sales price (ASP). Injectable drugs without an ASP may be reimbursed at 20% off the lowest average wholesale price (AWP). The ASP is calculated by the Centers for Medicare and Medicaid Services (CMS) and is available at CMS.gov. The AWP is sourced from a third party and is reflective of data comprised from multiple nationally recognized pricing services, including pharmaceutical manufacturers.

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

Exemptions to pricing methodology include:

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

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

Medical Injectables

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

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

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

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

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

Outpatient Hospital Methodology

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

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

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

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

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

Free-Standing Ambulatory Surgery Center Payment Methodology

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

Concierge Services Policy

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

To verify member benefits, use CareFirst Direct.

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

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

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

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

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

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

Confidentiality

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

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

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

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

In 2013, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights issued a final rule that implemented a number of provisions of the HITECH Act to strengthen the privacy and security protections for health information established under HIPAA. HIPAA requires CareFirst to develop procedures to protect the confidentiality, integrity, and availability of electronically protected health information. CareFirst has implemented all HIPAA-required security controls, including the ARRA-added requirements that became final with the publication of the HIPAA final rule, and has remained in compliance with these regulation since their original effective date.

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

General Policy

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

- CareFirst releases minimum necessary protected health information in accordance with the Privacy Rule as outlined in HIPAA and our notice of privacy practices (NPP).

Member Access to Medical Records

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

Provider Service HIPAA Validation

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

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

Treatment Setting

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

Information Security Policy

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

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

Quality Improvement Measurement

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

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

Notice of Privacy Practices

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

Administrative Services Policy

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

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

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

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

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

Treatment of Family Members or Self

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

Member Complaints

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

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

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

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

Please include the following information when submitting a complaint:

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

Requests for Charts

Affordable Care Act Risk Adjustment

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

Background

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

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

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

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

Clinical outreach

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

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

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

Medical record retrieval

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

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

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

Best practices in medical record documentation

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

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

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

Make sure to avoid these common errors:

- Incomplete medical record documentation
  - Lack of condition specificity where required
  - Key condition statuses (e.g., transplant, amputation)
- Missing provider signature and/or credentials

- Missing provider signature on medical records
- Missing provider credentials on medical records

- Short-hand documentation of medical record
  - Use of symbols or other medical terminology that cannot be translated into diagnosis codes
  - Lack of condition specificity where possible
- Other common errors
  - Name on medical record does not match other documents.
  - Pages from the medical record are missing.

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

HHS Risk Adjustment Data Validation

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

Background

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

The purpose of this audit is to provide CMS with a better understanding of the data that they receive regarding disease prevalence, coding interpretation and variances across the country. This audit is not specific to you or your practice and is not designed to monitor your practice, or your billing or coding patterns.

Provider outreach

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

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

Evio Patient Outcome Program

Beginning in 2024, CareFirst is implementing a new outcomes-based drug efficacy tracking program, called Gene+ Outcomes. CareFirst has partnered with a clinical data collection vendor, Evio® [3], and will utilize their Engage platform to administer all outcomes-based patient monitoring.

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

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

- Evio will outreach to you when your patients meet the criteria for monitoring.

[3] Evio Pharmacy Solutions LLC is an independent company that provides administrative services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.

- Providers will be requested to submit patient-specific attestations, as well as provide clinical data and/or upload medical documentation to support tracking the drug efficacy.
- Evio will use this data to track efficacy of certain drugs.

HEDIS

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

"The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public, policy makers and payers have the information they need to compare performance."[4]

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

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

Medical record retrieval process

CareFirst is contracted with a medical record retrieval (MRR) and review vendor, to help coordinate the medical record retrieval process for the HEDIS and RA Programs. This medical record retrieval process is time sensitive and lasts only for three months (from the first week of February until the first week of May). Requested medical records need to be provided to our vendor within 5 business days of the received request.

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

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

[4] HEDIS® 2020 Volume 1, The National Committee for Quality Assurance, Washington, DC, 2019

- Mail
  - You can mail your records directly to our vendor, who will also provide prepaid postage labels.

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

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

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

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

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

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

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

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

Documentation standards

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

Claim filing tips

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

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

Maternity Care	
Code Number	Code Definition
0500F	Initial prenatal care visit (refer to AMA CPT standard for details)

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

PCP, Nephrology, Ophthalmology and Endocrinology	
Code Number	Code Definition
3044F	Most recent HbA1c level less than 7%
3045F	Most recent HbA1c level 7-9%
3046F	Most recent HbA1c level greater than 9%
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
3066F	Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, renal insufficiency, any visit to a nephrologist)
3060F	Positive microalbuminuria test result documented and reviewed

PCP, Nephrology, Ophthalmology and Endocrinology	
3074F	Most recent systolic blood pressure less than 130 mm of Hg
3075F	Most recent systolic blood pressure 130-139 mm of Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm of Hg
3078F	Most recent diastolic blood pressure less than 80mm of Hg
3079F	Most recent diastolic blood pressure 80-89 mm of Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm of Hg

High Blood Pressure	
Code Number	Code Definition
3074F	Most recent systolic blood pressure less than 130 mm of Hg
3075F	Most recent systolic blood pressure 130-139 mm of Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm of Hg
3078F	Most recent diastolic blood pressure less than 80mm of Hg
3079F	Most recent diastolic blood pressure 80-89 mm of Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm of Hg

FIGmd

In 2019, CareFirst launched a clinical data integration initiative with our partner, FIGmd.[5] FIGmd is a cloud-based, interoperable, clinical data and quality management platform. FIGmd's core competency is to securely extract and store medical records.

[5] FIGmd is an independent company providing administrative services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.

Why did CareFirst partner with FIGmd?

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

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

Advance Directives

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

PCP offices may be asked to do the following:

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

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

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