CareFirst
Family of health care plans

5. Claims, Billing and Payments

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

Introduction to Claims Submission

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

Provider Self Service

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

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

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

CareFirst Direct

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

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

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

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

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

CareFirst on Call

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

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

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

Use of Third-Party Billing Companies

Many providers work with third-party billing companies to handle their administrative tasks. However, these billing companies often reach out to our Provider Services areas unnecessarily, requesting information that is readily available through our self-service tools. To streamline the process and reduce the need for these calls, providers should share this information and requirements for self-service with their third-party billing companies. Provider Services will redirect calls requesting routine information that can be readily obtained through our self-service tools back to those tools, CareFirst Direct and CareFirst on Call.

Common reasons third-party billers call:

- Member eligibility and benefits
- Claim information
- Remittance information

Alternatives to calling: Self-Service tools

Instead of calling Provider Services, third-party billers must obtain necessary information using our self-service tools. Refer to the above section, Provider Self Service for more information on our self-service capabilities and training resources.

Basic Claim Submission Requirements

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

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

This policy does not apply to:

- Crossover claims which are reimbursed by CareFirst as secondary to Medicare
- Claims for durable medical equipment (DME) supplies, orthotics/prosthetics or drugs for which there is no comparable CPT code

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

Reporting ICD-10 Diagnosis codes

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

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

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

CPT Category II Codes

Purpose

CPT Category II codes are supplemental tracking codes used to measure performance. The purpose of CPT II codes is to share valuable information about the care of your patient that is not obtainable through CPT codes. They help us fill gaps in care information by documenting clinical outcomes. Submission of these codes decreases the need for medical record requests and chart reviews. Additionally, they assist the provider in minimizing the administrative burden for a number of quality-based initiatives such as the Healthcare Effectiveness Data and Information Set (HEDIS).

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

Why use CPT Category II codes?

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

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

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

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

Where to locate CPT Category II codes

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

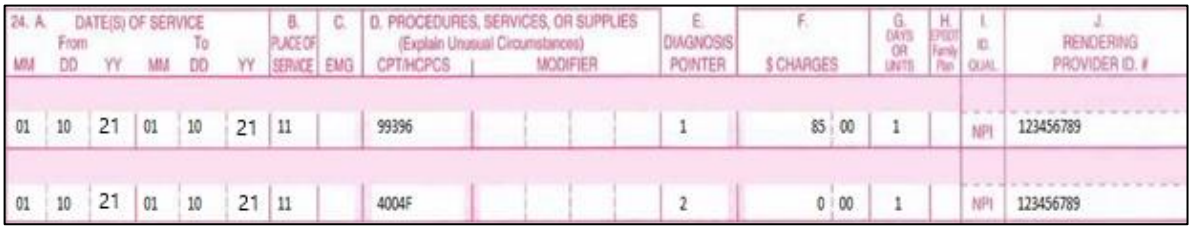
CPT Category II Codes	
Composite Measures: 0001F-0015F	Therapeutic, Preventive or Other Interventions: 4000F-4306F
Patient Management: 0500F-0575F	Follow-Up or Other Outcomes: 5005F-5100F
Patient History: 1000F-1220F	Patient Safety: 6005F-6045F
Physical Examination: 2000F-2050F	Structural Measures: 7010F-7025F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

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

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

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

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



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

Guidelines for Ancillary Claims Filing

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

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

Special Claims Submission Information for Facility Billing

Observation Services Guidelines

Observation services defined

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

Observation guidelines

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

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

Mother and Baby Claims Billing

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

Mother and Baby Diagnosis Related Grouper Payment

Routine delivery payment:

- Calculated using standard DRG payment methodology (i.e., DRG weight x base rate for type of coverage).
- The baby's payment for routine delivery is a per diem payment based on DRG 795 (NORMAL NEWBORN). Follow the formula listed in your facility's Data Sheet for a per diem substituting the number of nursery days paid on the claim for revenue code 170-179 for APPROVED DAYS in the calculation. Add the mother's DRG payment to the total of the per diem payment for the child to determine the total payment dur for the delivery.
- For the hospital to receive a separate payment for the baby based on a sick DRG:
    - The baby must have a separate, approved authorization.
    - The hospital must file a separate claim for the baby.

- The primary diagnosis for the claim for a sick baby cannot be ICD-10 codes Z38.00-Z38.8 (live born infant must be the sick diagnosis resulting in the extended stay).

Medicare Supplemental Products Billing

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

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

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

Federal Employee Program® coordination of benefits

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

Denial Notices Issued by Hospital

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

Non-DRG reimbursement cases (MD only)

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

- The facility, the attending provider and CareFirst agree and document that it is not medically necessary for the member to remain in the facility.
- An appropriate discharge plan has been developed.
- The member or family member refuses discharge. However, the hospital is strongly encouraged to discuss the case with the attending provider and the member and/or a family member, to ensure that the patient and/or family member understands their financial responsibility before the written

denial is issued. It is recommended that the hospital have the member sign a document indicating their understanding that they remainder of the stay could be member liability.

Timely Filing of Claims

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

Institutional claims must be submitted within 365 days after:

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

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

Reconsideration

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

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

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

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

Electronic Capabilities

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

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

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

Electronic Claims (837P and 837I)

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

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

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

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

Electronic Remittance Advice (ERA – 835)

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

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

Electronic Fund Transfer

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

Payer Acceptance Report (277CA)

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

Eligibility Inquiry (270)

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

Claim Status (276)

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

Questions?

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

Paper Claims Submission Process

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

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

Claim Fields		
Field name	CMS-1500 box	UB-04 locator
Insured ID Number	1a	FL60
Patient Name	2	FL08b
Patient Date of Birth	3	FL10
ICD-10 Diagnosis	21	FL67
Dates of Service	24a	FL06
Place of Service, Facility Code	24b	FL04
Procedure Code/Revenue Code	24d	FL42
Charge	24f	FL47
Days of Units	24g	FL46
Rendering National Provider Identifier	24j	N/A
Federal Tax ID	25	FL05
Signature of provider	31	N/A
Billing NPI	33a	FL56

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

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

Medicare Crossover Claims Submission

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

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

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

How to Submit Claims with Denied Charges

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

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

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

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

Notice of Payment

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

Claims Overpayments

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

Collection of Retroactively Denied Claims

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

Effective Follow-Up on Claims

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

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

Step-by-Step Instructions for Effective Follow-Up

Claim status

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

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

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

Large volume of unpaid claims

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

Corrected Claims, Inquiries and Appeals

What is a Corrected Claim?

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

How do I Submit a Corrected Claim?

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

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

Professional and Institutional Provider claims should include:

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

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

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

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

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

What is an Inquiry?

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

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

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

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

Correspondence address:

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

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

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

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

For all other MD FEP inquiries:

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

Helpful tips when completing a PIRF

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

What is an Appeal?

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

Please include the following information on the letter:

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

Professional Providers

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

Institutional Providers

Clinical Appeals and Analysis Unit (CAU) Mail Administrator
CareFirst BlueCross BlueShield
P.O. Box 17636
Baltimore, MD 21298-9375

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

Expedited or emergency appeals process

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

- The member's psychological state; or

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

Note:

- Retrospective or post service denials are not eligible for expedited review.
- We will answer an expedited review or emergency appeal within 24 hours from the date the appeal is received.
- Expedited appeals can be faxed to 410-528-7053 and will be responded to within 24 hours.
- Certain plan types may define expedited and/or emergency procedures differently based on Member contracts.

Appeal resolution

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

- The specific reason for the appeal decision.
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based.
- A statement regarding the availability of all documents, records or other information relevant to the appeal decision is available free of charge, including copies of the benefit provision, guideline, protocol or other documents on which the decision was based.
- Notification that the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning will be provided free of charge upon request.
- Contact information regarding a state consumer assistance program.
- Information regarding the next level of appeal as appropriate.

Visit carefirst.com/inquiriesandappeals for more information.

Clinical Appeals and Analysis Unit

Peer-to-peer conversation

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

Overview

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

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

of a denial determination, the provider is informed of the right to appeal and the process for initiating an appeal.

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

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

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

Applicable Products

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

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

Instructions for submitting an appeal

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

Expedited appeals process

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

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

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

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

Standard appeals

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

- A letter of medical necessity written on the provider's professional letterhead, which explains the clinical justification or rationale for the denied service

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

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

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

Appeal resolution

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

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

Coordination with Other Payers/Other Party Liability

Subrogation

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

Personal Injury Protection – No Fault Automobile Insurance

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

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

Workers' Compensation

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

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

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

Coordination of Benefits

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

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

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

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

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