CareFirst
Family of health care plans

7. Care Management

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

Quality Improvement Program

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

QI Program

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

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

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

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

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

Goals and objectives

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

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

QI Committees

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

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

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

Clinical Guidelines

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

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

PrEP Medication and Related Ancillary Services

Preventive care at $0 cost-share

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

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

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

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

Population Assessments

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

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

- The U.S. Census Bureau American Community Survey (ACS)
- Association of American Colleges (AAMC) Race and Ethnicity Study
- CAHPS member satisfaction questions regarding age, sex, education, ethnicity and cultural and language needs
- CareFirst membership data

- Network provider characteristics including age, sex and languages spoken
- Member complaint data
- Pew Research Center Religious Landscape Study
- Use of language assistance/translator services, via the language line

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

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

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

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

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

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

The PCMH Program is based on several beliefs, assumptions and theories about what must be done to transform the healthcare system in the CareFirst region—and, by extension, the American healthcare system. The PCMH Program works with providers and members in their communities, and is supported by a clinical program model, offering programs designed to meet specific member needs such as transition from the acute care setting to skilled nursing facilities or home-based care services. At its core,

the goal is to help members achieve the highest level of recovery and stabilization possible and to support PCP panels to achieve their goals of improving quality and restraining the rise in healthcare spending.

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

National Committee of Quality Assurance

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

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

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

Complaint Process

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

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

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

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

- Physical accessibility
- Physical appearance
- Adequacy of waiting and exam room space

- Adequacy of medical/treatment record keeping

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

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

Language Assistance

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

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

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

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

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

Language Line Services

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

Disease Management Programs

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

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

- Asthma
- Diabetes
- Coronary Artery Disease (CAD)
- Chronic Low Back Pain
- Osteoarthritis
- Atrial Fibrillation

- COPD
- Heart Failure
- Irritable Bowel Syndrome
- Fibromyalgia

Members enrolled in the disease management program:

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

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

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

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

Clinical Programs

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

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

Clinical Programs Chart			
Program Name	Commercial	MA - Individual	MA - Group
Expert Consult	X		
24/7 Virtual Care Options	X		
Genetic Testing Prior Authorization	X		
Diabetes Virtual Care	X	X	X
Physiological Remote Monitoring	X		
Behavioral Health Digital Resource	X		
MAPD Palliative Care		X	X

Clinical Programs Chart			
24 Hour Nurse Advice Line	X	X	X
Medication Reconciliation Post-Discharge		X	X
Cardiology and Radiology Advanced Imaging	X (fully insured members on the Facets claim system only)		

Expert Consult

About the Program

The Expert Consult[8] program delivers a comprehensive virtual consult for the diagnosis and treatment of complex/orthopedic cases. This is useful when patient symptoms are not improving, have no diagnosis, are wanting a confirmation of diagnosis or whose treatment path may not be clear.

Fast Facts

- 75% of participating members rated the program as excellent[9]; and
- Reduces care costs by helping patients make informed treatment decisions

Who is Eligible?

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

Who is Not Eligible?

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

How Patients Can Engage

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

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

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

9 Based on clinical quality and addressing their concerns. CareFirst BOB 2023 Member Satisfaction response.

24/7 Virtual Care Options

CareFirst is committed to providing 24/7 virtual care to our members who continuously ask for these options. When regular providers are not available, CareFirst members can use CloseKnit® [10] or find other telehealth options offered by select value-based care provider partners. These options can be found on our website at carefirst.com/virtualcare. To be featured on this page, provider partners must meet the following criteria:

- 24/7 access and availability
- Appointment availability
- HIPAA compliant telehealth platform
- Active provider practice license in the CareFirst Service Area
- In-network provider for our largest CareFirst networks
- Primary care listed as the primary specialty
- Participation in a value-based care agreement
- Accepting new patients
- Maintains active status and usage of CareFirst's Provider Portal
- Commits to sharing notes back with the member's PCP

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

Note: FEP members must use Teladoc®.[11]

Genetic Testing Prior Authorization

About this Program

This program provides clinical appropriateness review services for genetic testing through Carelon Medical Benefits Management[12] using evidence-based clinical guidelines and real-time decision support.

Fast Facts

- Cost savings of $ 0.71[13] per member per month;
- More than 26,000[14] annual authorizations completed;
- 93%[15] provider satisfaction rate; and
- 91%[16] program intake rate.

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[10] CloseKnit is a registered Trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit does not provide Blue Cross Blue Shield products or services and is providing in person and telehealth services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members. Atlas Health, LLC is a corporate affiliate within the CareFirst, Inc. corporate umbrella of companies.
[11] Teladoc is an independent company provider telehealth services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.
12 Carelon Medical Benefits Management is an independent company that provides clinical solutions for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members. Carelon does not provide Blue Cross and Blue Shield products or services.
13 Based on avoidance of unnecessary testing for calendar year 2022.
14 Based on volume for calendar year 2022.
15 Based on vendor conducted provider survey for calendar year 2022.
16 Based on percent of reviewed tests requested on their web utilization for calendar year 2022.

Who is Eligible?

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

Who is Not Eligible?

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

How Patients Can Engage

To access this program:

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

Diabetes Virtual Care

Program Overview

The Diabetes Virtual Care program provides support for members who need help stabilizing their type 2 diabetes. In collaboration with Onduo[17], a leading virtual care management company, this program offers personalized support, easy-to-use tools and access to certified diabetes educators through a mobile app. The program provides members with the care and support they may need in between their doctor visits, such as testing supplies and connected devices, virtual coaching, insights about their glucose levels, A1c trends and more.

Fast Facts

- Personalized support access to diabetes educators and easy-to-use tools through a mobile app
- Since 2020, more than 6,300 CareFirst members with type 2 diabetes have enrolled and stayed active18
- Enrolled members with A1C of 8% or greater, showed an overall average A1C decrease of 1.2%19

Who is Eligible?

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

Who is Not Eligible?

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

- Pregnancy
- History of or diagnosed with cirrhosis or liver failure
- History of or diagnosed with severe end-stage kidney disease

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

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

19Results are based on members who are engaging with their care lead and program materials and have provided an initial and at least one follow-up A1c value since program inception. Individual results may vary.

- Organ transplant or bone marrow transplant
- Cystic fibrosis
- Any other condition or situation that, in Onduo's discretion, is deemed not the best fit

How Do Members Enroll?

Members are referred into the program by a CareFirst case manager, CareFirst care coordinator or by self-enrolling after receiving a personalized communication (phone call, letter, email) from CareFirst and Onduo. Members must be 18 years of age or older, been diagnosed with type 2 diabetes, own a smartphone, and have medical benefits through CareFirst.

Members can register for the program at onduo.com/carefirst, or call 833-HiOnduo (833-446-6386) with questions.

Physiological Remote Monitoring

Remote Patient Monitoring (RPM) enables patients to better manage their chronic health conditions and actively participate in coordinating healthcare decisions with their designated provider. RPM facilitates the capture and transmission of patient generated physiological data from electronic devices that measure blood pressure, heartrate, pulse oximetry, body temperature and weight in a timely and accurate manner.

RPM requires a prescription from either the discharging inpatient/emergency department provider or patient's personal primary care or specialty care provider. CareFirst covers remote monitoring for the following diagnoses for members who have had an ED visit or inpatient discharge in the previous 60 days.

Remote Patient Monitoring	
Condition	**Activity Monitored**
Congestive Heart Failure (CHF)	Weight, Blood Pressure, Pulse OX, Daily Heart Rate
Chronic Obstructive Pulmonary Disease (COPD)	Weight, Blood Pressure, Pulse OX, Daily Heart Rate
Chronic Kidney Disease (CKD)	Weight, Blood Pressure, Pulse OX, Daily Heart Rate
High Blood Pressure – Hypertension (HBP)	Blood Pressure
Coronavirus Disease (COVID-19)	COVID-19 Symptom Monitoring

Coverage for remote monitoring may continue for 120 days from the date of ED service or inpatient discharge. Devices must be Bluetooth enabled and should be supplied by the provider. Personal devices such as an Apple Watch® or Fitbit® are not approved for RPM. Eligible remote monitoring devices must:

- Meet the FDA definition of a "medical device," and
- Be able to transmit the patient's physiological data through a secure connection established by the prescribing provider.

CPT code 99453 may be used for the device setup and patient education. Monitoring and interactive communications may be billed every 30 days for codes 99454, 99457, and 99458.

Behavioral Health Digital Resource

CareFirst, along with 7 Cups[20], a global behavioral health company, offers an innovative approach to helping patients across the entire mental health/mental illness spectrum—from those who want to maintain their mental well-being to those needing help getting through a difficult time.

The **Behavioral Health Digital Resource** is available to CareFirst patients 13 years and older, with medical benefits—anonymously, confidentially and at no cost. At this time, it's not available to patients enrolled in Medicare Advantage, Medicaid or CareFirst Administrator plans.

7 Cups uses a robust technology platform to provide access to a variety of options through a smartphone, computer or tablet:

- **Talk with someone who understands:** 7 Cups maintains a network of more than 430,000 trained active listeners who provide real-time one-on-one emotional support in more than 140 languages. All listeners go through the Active Listener Training Course. This course consists of content, videos, and interactive exercises, including chatbot simulations. After completing the courses, listeners are enrolled in a continuing education program, engaging in additional trainings and gaining more experience assisting people in need.
- **Learn new coping skills:** Aimed at helping patients better understand conditions, treatment and self-management options. Includes 35 treatment plans consisting of educational and therapeutic exercises.
- **Support forums:** Online discussion boards, moderated chat rooms and scheduled topic-specific group chats allow for real-time support, available in multiple languages.
- **Connect with a licensed therapist:** Patients can connect with a CareFirst behavioral healthcare manager who can help them make an appointment with a provider. Standard medical benefits apply.

Patient's accessing 7 Cups can connect with behavioral health providers in the CareFirst provider network.

You patient's may start by visiting carefirst.com/myaccount and selecting the Behavioral Health tile, or by downloading the 7 Cups app from the iOS or Android stores.

MAPD Palliative Care Program

About This Program

The CareFirst BlueCross BlueShield Palliative Care Program[1] provides support services for advanced and end-stage disease for Medicare Advantage members with illnesses such as cancer (stage IV and certain stage III cancers) , advanced heart failure (Class III-IV), advanced chronic obstructive pulmonary disease (COPD, Stage III-IV), advanced end-stage renal disease (ESRD), end-stage liver disease, advanced neurologic disease, and advanced dementia.

The service begins with an initial visit in the home or virtually. In this first meeting, the provider will learn about the member's illness, their goals, symptoms and challenges, and the level of support available from family, friends, and other caregivers. Based on this information, the vendor works with the member and you to develop a care plan that is focused on the member's needs and goals.

[20] 7 Cups is an independent company that provides mental health services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

Fast Facts

- 42 patients served;
- 194 in-home visits completed;
- 68% reduction in hospital readmissions for program participants[21]

Who is Eligible?

Medicare Advantage members who have been identified as having advanced illness, either through an identification process or provider referral.

How Patients Can Engage

Members are contacted by our vendor, based on clinical need, to enroll in the program.

24-Hour Nurse Advice Line

About this Program

When members have questions about their health, they may not be sure where to go. Instead of waiting and worrying, they can call the Nurse Advice Line staffed by registered nurses 24 hours a day, seven days a week, 365 days a year. The nurse will ask a few questions and give information to help members decide what to do next. The Nurse Advice Line provides support and guidance for any non-emergency situations, such as fever, cuts, burns, sore throat, coughing, sinus pain, or any health-related issues. The service is personal, confidential and available at no cost.

Fast Facts

The Nurse Advice Line service is personal, confidential and available at no cost and can help members:

- Decide when to visit their doctor or go to a convenience clinic, urgent care center or the emergency room;
- Understand their medications;
- Find network doctors and prepare for an appointment;
- Learn about preventive care.

For foreign language calls, Nurse Advice Line utilizes a global telephone interpretation service that has linguists available 24/7 to assist with more than 200 languages and dialects.

Who is Eligible?

The Nurse Advice Line is available to all CareFirst members with medical benefits under commercial, Medicare Advantage, DSNP and Medicaid.

How Patients Can Engage

To access this program, members can dial the toll-free number on the back of their CareFirst medical insurance card reach a nurse for general questions about health issues or where to go to for care.

- Commercial members call 800-535-9700
- Medicare Advantage members call 833-968-1773
- DSNP members call 800-229-8201
- Medicaid members call 800-231-0211

[21] Data provided by Aspire Health based on CareFirst BOB since program inception in January 2021. Results may vary.

Medication Reconciliation Post-Discharge

Medication reconciliation is a critical part of post-discharge care coordination for all members. As such, CareFirst will support this initiative by reaching out to certain members who have been recently discharged from the hospital and review their medications. We may send you documents detailing our discussions with members and may ask for certain changes to the medication regimen we discuss.

Prior Authorization Requirements for Cardiology and Radiology Advanced Imaging

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively, "CareFirst") is continually working with healthcare delivery partners to optimize care management strategies while ensuring members receive affordable, quality care.

CareFirst and EviCore are collaborating to provide services for CareFirst members enrolled in our fully insured commercial plans for Cardiology and Radiology Advanced Imaging. EviCore leverages clinical expertise, evidence-based guidelines, and innovative technologies to deliver best-in-class medical benefit management solutions that inform more effective, affordable treatment and site of care decisions for each patient's needs.

Ordering providers need to submit a prior authorization for outpatient services to EviCore for these fully insured members on the Facets platform.

Services performed without authorization may not be reimbursed for healthcare services, and CareFirst participating providers may not seek reimbursement from members. Additional information on the specific services that will require authorization are available on our provider website under **Programs/Services > Pre-Cert/Pre-Auth (In Network)**. Here is a direct link to that page: Pre-Cert/Pre-Auth (In-Network) (carefirst.com)

Note: FEHBP members are not included in these requirements.

How to request prior authorization?

- From our provider website, log into the CareFirst Provider Portal (CareFirst Direct).
- Select the **Prior Auth/Notification** tab.
- Select **Start Now** within the Advanced Imaging for Cardiology and Radiology box to be transferred to EviCore's Prior Authorization Portal (CareCore National Portal).

Please access the EviCore Health Resource Page for CareFirst for more information on services requiring authorization, clinical guidelines, FAQs, and training opportunities.

Clinical Resources

Clinical resources are developed under our QI program and support our providers in treating chronic disease and conditions and providing preventive care. These resources include the clinical practice guidelines and the preventive service guidelines.

Outpatient Pre-Treatment Authorization Plan

The Outpatient Pre-Treatment Authorization Plan is a pre-treatment program that applies to outpatient physical, speech and occupational therapy. Providers should use CareFirst Direct to determine member benefits and if an authorization is required. If so, then use CareFirst Direct to submit the authorization.

Coordinated Home Care and Home Hospice Care

The Coordinated Home Care and Home Hospice Care programs allow recovering and terminally ill patients to stay at home and receive care in the most comfortable and cost-effective setting. To qualify for program benefits, the patient's physician, hospital or home care coordinator must submit a treatment plan to CareFirst. Authorization requests should be submitted via CareFirst Direct. A licensed home health agency or approved hospice facility must render eligible services. Once approved, the home health agency or hospice is responsible for coordinating all services.

Inpatient Management

The Inpatient Management nurses are responsible for managing timely and smooth transitions from inpatient to home or other levels of care for members admitted to a facility across the nation.

The nurse uses experience and skills in utilization management, including proficiency leveraging Milliman Care Guidelines, to determine medical necessity and appropriate level of care. They also use their case management experience and interventions to engage members/enrollees, their families and other support systems in discharge planning. Whether onsite or telephonic, the Inpatient Management nurse collaborates with hospital care team including case managers, social workers and discharge planners to ensure CareFirst members/enrollees for all lines of business receive the appropriate level of care and partner to address any potential barriers to discharge. The RNs will refer to appropriate wrap around services and/or Case Management to meet the member's ongoing care coordination needs.

Comprehensive Medication Review Program

The Comprehensive Medication Review program seeks to review and mitigate the potential for medication-related issues in high-risk and high-cost members. The program engages a specialized pharmacist to review a member's medication profile and identify medication recommendations. The pharmacist will evaluate for drug compatibility and interactions to ensure each drug is as effective as possible. Any medication recommendations and the reasons for the changes are communicated to the prescribing physicians.

Behavioral Health and Substance Use Disorder Program

CareFirst's Behavioral Health and Substance Use Disorder (BSD) program is designed with a patient-advocacy focus. Our licensed behavioral health professionals provide behavioral health and substance use disorder care coordination to members in need. Services under this program include:

- BSD care coordination
- Transition of care services
- Needs assessment
- Assistance with locating providers and setting initial appointments

For more information visit carefirst.com/pcmhguidelines.

Gender Services

CareFirst is committed to supporting LGBTQ+ individuals, their families and their employers, and we understand that lesbian, gay, bisexual, transgender and gender diverse people face unique health disparities. Our dedicated Gender Services specialist can help members:

- Understand what treatment choices are available;
- Navigate benefits and what an individual's plan covers; and
- Provide support and guidance.

Additionally, our Gender Services Specialists provide educational support and guidance to providers.

For more information, send an email to gender.services@carefirst.com.

Inpatient Hospitalization Services

Prior Authorization Process for Elective Admissions

All elective inpatient hospital admissions must be authorized. The participating hospital must request authorization through CareFirst Direct. For CareFirst BlueChoice members, all services must be approved by the PCP, who must concur that the proposed treatment plan is clinically appropriate. CareFirst requires all Facilities to provide notification of an inpatient admission or observation stay

within 24 hours of admission or commencement of observation, or by the next business day for weekend and holiday admissions. For more information please refer to the Inpatient and Observation Care Notification Requirements Policy .

You can request prior authorization:

- Online: Log in at carefirst.com/provider and click the Prior Authorization/Notifications tab to begin your request
  Note: Pre-Authorizations should be requested prior to the date of service. Submit the authorization request to the Pre-Authorization department at least 15 business days prior to all elective admissions, except when it is not medically feasible due to the member's medical condition. Request review timelines vary, and are based on applicable NCQA, state and federal requirements. Necessary clinical information must be submitted to conduct a review of the request. For on-demand training and resources, visit:
  - How to Add Level of Care to Inpatient Requests
  - How to Enter an Observation Notification
- By fax: Visit carefirst.com/providerforms to download the appropriate prior authorization form.
- By phone: Call 866-PRE-AUTH (773-2884).

- Unauthorized hospital stays will result in a retrospective review of the admission.
- Written authorization denials are issued within one business day of making the decision. Expedited or standard appeal information is included with the denial information.
- If the admission dates for an elective admission change, notify the care management department as soon as possible, and no later than one business day prior to the admission.

Emergency admission certification process

- Hospitals must complete a notification of an emergency inpatient hospital admission within 24 hours of the admission or the next business day. The hospital must request authorization.
- Unauthorized hospital stays result in a retrospective review of the admission.

Prospective and Concurrent review process

- Prospective review is performed when the inpatient authorization is requested prior to admission or within 48 hours of the admission to the inpatient facility.
- The hospital's utilization review (UR) department must provide clinical information to the assigned CareFirst Clinical Review Nurse (CRN) (for prospective reviews), Concurrent Clinical Review (CCR) nurse, or call the number listed next to pre-auth/pre-cert on the Provider Quick Reference Guide).
- CareFirst's CCR nurse will contact the attending provider or follow agreed hospital protocol if further clarification of the member's status is necessary.
- CRN and CCR nurses use approved medical criteria to determine medical necessity for acute hospital care.
- If the clinical information meets CareFirst's medical criteria, the days/services will be approved.
- If the clinical information does not meet the approved medical criteria, the case will be referred to our medical director.
- The CRN or CCR nurse will notify the attending provider and the facility of our Medical Director's decision.
- The attending provider may request an appeal of an adverse decision.

Retrospective review process

The UR nurse will notify the appropriate hospital department and request medical records when a retrospective review of the clinical record is necessary.

Discharge Planning Process

The hospital or attending provider must initiate a discharge plan as a component of the member's treatment plan. The hospital, under the direction of the attending provider, should coordinate and discuss an effective and safe discharge plan with both CareFirst and the patient immediately following admission. Discharge needs should be assessed, and a discharge plan developed prior to admission, when possible. Referrals to hospital social workers, long-term care planners, discharge planners or hospital case managers should be made promptly after admission and coordinated with CareFirst.

An appropriate discharge plan should include:

- Full assessment of the member's clinical condition and psychosocial status
- Level, frequency and type of skilled service care needs
- Verification of member's contractual healthcare benefits
- Referral to a CareFirst BlueChoice participating provider, if needed
- Alternative financial or support arrangements, if benefits are not available

Outpatient Hospital Services

CareFirst BlueChoice requires authorization for all outpatient services, including laboratory and radiology, performed in a hospital setting.

- The hospital is responsible for initiating all requests for authorization for outpatient services through CareFirst Direct.
- If authorization criteria are met, authorization will be issued. In addition, the caller will be instructed whether the member is accessing an in- or out-of-network benefit. There will be instances in which

the member will be directed to a more appropriate network provider for certain services (i.e., laboratory, radiological services).

- If the admission date for an outpatient elective procedure changes, care management must be notified by the hospital as soon as possible, but no later than one business day prior to the procedure. Lack of notification may result in a denial of the claim.

Note: All pre-operative services must be performed by or arranged by the member's PCP/specialist.

Utilization Management

Decisions are based on the following criteria:

- Milliman Care Guidelines
- MCG Health Behavioral Health Care Guidelines
- American Society of Addiction Medicine (ASAM) is for all substance use disorders medical decisions. ASAM criteria is an evidence-based template to determine the appropriate level of substance use disorder intervention for an individual.
- CareFirst Medical Policy Reference Manual
- CareFirst's Dental Clinical Criteria have been developed, revised, and updated periodically. They are reviewed and approved by the CareFirst Dental Advisory Committee (DAC) and/or the Oral and Maxillofacial Surgery Advisory Committee (OMSFAC). The criteria are derived from reviews of the current dental literature, subject textbooks, other insurance companies, and
  - Practice Parameters, American Association of Periodontology
  - Parameters of Care, American Association of Oral and Maxillofacial Surgery
  - Oral Health Policies and Clinical Guidelines, American Academy of Pediatric Dentistry
  - Position Statements, American Association of Dental Consultants
  - Dental Practice Parameters, American Dental Association

CareFirst makes physician reviewers available to discuss UM decisions. Providers may call 410-528-7041 or 800-367-3387, ext. 7041 to speak with a physician reviewer or to obtain a copy of any of the above-mentioned criteria. All cases are reviewed on an individual basis.

Important note: CareFirst affirms that all UM decision-making is based only on appropriateness of care and service. Practitioners and/or other individuals are not rewarded for conducting UR for denials of coverage or service. Additionally, financial incentives for UM decision makers do not encourage underutilization of coverage or service.

Prior Authorizations and Notifications

Prior Authorizations and notifications should be requested according to the timeframes below. Refer to training here:

- How to Add Level of Care to Inpatient Requests
- How to Enter an Observation Notification

Prior Authorizations and Notifications Timeframes			
Type of admission/service	**Submission requirement**	Response timeframe	Notes
Inpatient (routine)	15 days in advance of admission	Within 15 days of request for non-risk accounts. Within two days of request for risk accounts.	Notification is late if request is not received prior to the date of admission. Penalties may apply.
Emergency admissions	Notification is required within 24 hours or the next business day.	Auto approvals via the authorization system for emergency admissions	Notification is late if not submitted within seven days after the emergency admission. Penalties may apply.
Outpatient hospital	15 days in advance of the procedure	Within 15 days of request for non-risk accounts. Within two days of request for risk accounts.	
PT/OT/ST	15 days in advance of the treatment	With 15 days of request for non-risk accounts. Within two days of request for risk accounts.	Notification is late if request is not received prior to the beginning of care. Penalties may apply.
Observation	Notification is required within 24 hours or the next business day		BlueChoice HMO members require authorization not notification. See the BlueChoice Chapter.

Complex Case Management

CareFirst has designed a program to help its members with acute, multiple or complex conditions to obtain access to care, services and resources. A team of registered nurse case managers work closely with the member and their family. The case managers will take an interdisciplinary approach to provide short term or comprehensive interventions as needed. Additionally, case managers create a plan of care specific to the member's needs that produces positive clinical results and promotes independence in managing their healthcare. Interventions and services may include, but are not limited to:

- A physical and psychosocial assessment
- Social drivers of health
- Care coordination
- Referrals to community resources
- Referrals to other clinical programs with both internal and external partners

Case managers provide specialized care for:

- High-risk pregnancy

- Acute and complex medical needs
- Trauma
- Special needs pediatrics
- Adult and pediatric oncology
- Hospice, palliative and end-of-life care

Case Management Referral Process

Healthcare providers, patients, family members, employers or anyone familiar with the case may refer candidates for CCM by calling 888-264-8648 or 866-773-2884.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., CareFirst BlueCross BlueShield Community Health Plan District of Columbia, CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.