CareFirst

Family of health care plans

DENTAL

PROVIDER MANUAL

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Chapter 1: Welcome to CareFirst

Introduction to CareFirst

Mission

As CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) continues to transform, upholding our values and ethics in support of our mission remain crucial to our success. It is through our daily conduct that each of us can thrive and be our best on behalf of the people we serve; living our values and modeling the behaviors that form an ethical and supportive culture.

Online Resources and Contact Information

Provider Link List

Please refer to the Dental Provider Link List to help you navigate the provider website.

Provider Quick Reference Guide

Please refer to the Dental Provider Quick Reference Guide for additional information and resources to help you do business with CareFirst.

Introduction to the Manual

Video from Stacia Cohen

Please watch this short video for a message from Stacia Cohen, Executive Vice President of Health Services.

How to Use this Manual

This manual provides information for your patients who are CareFirst members. It is meant to be your primary reference guide to conducting business with CareFirst.

The information in the manual relates to all provider types. The information in this manual is organized by chapters and units within each chapter. Additionally, we have included links to helpful documents throughout the manual.

The entire manual can be downloaded as a searchable PDF document. Simply click on "View Entire Manual." Click on the magnifying glass, enter your keyword(s) in the search box to find the information you seek. Also, the table of contents has been hyperlinked, so you can easily navigate within the PDF.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. In the event that there is an inconsistency between your Participation Agreement and this Manual, your Participation Agreement controls.

If we make any procedural changes in our ongoing efforts to improve our service to you, we will update the information in this manual and notify you through email or BlueImpressions, our online dental provider newsletter. To be kept up-to-date with the most current information and alerted to changes, we strongly encourage you to sign up to receive our emails, which will let you know when the manual has been revised.

We welcome your feedback on the manual. If you have any comments or suggestions for additional improvements to the manual, please send them to providermanual@carefirst.com.

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

Read and print the Guidelines for Provider Self-Service.

New Providers/Office Staff Begin Here

We encourage all new providers/office staff to review our on-demand training modules that serve as foundational knowledge to doing business with CareFirst. You will also find additional helpful training modules. If you have questions after reviewing these training sessions, please email providered@carefirst.com.

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Chapter 2: Product Descriptions

Overview

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) offer a comprehensive portfolio of health insurance products and administrative services to 3.3 million individuals and groups in Maryland, Washington, D.C. and Northern Virginia. This section explains the various types of healthcare plans our members may have.

Dental Traditional (Indemnity)

The Participating Provider Network provides a benefit for covered services based on the CareFirst Traditional Allowed Benefit. This level of reimbursement applies to members covered under our Traditional Dental Plans.

Traditional Dental members may seek treatment from any participating provider in the network. Reimbursement is based on a percentage of the Traditional Allowed Benefit with applicable deductibles and co-insurance. Your contracted Traditional or Participating (PAR) fee schedule with CareFirst can be accessed on CareFirst Direct. Members seeking treatment from non-participating providers receive 100% of the Allowed Benefit for covered services, subject to deductibles, co-insurance and balance billing.

Dental Preferred Provider Organization

The Preferred Provider Network (PPO) provides a benefit for covered services based on the CareFirst Preferred Allowed Benefit. This level of reimbursement applies to members covered under our Preferred Dental Plans.

Preferred Dental members may seek treatment from any Preferred Dental provider in the network. Reimbursement is based at 100% of the Preferred Allowed Benefit with applicable deductibles and coinsurance. Members seeking treatment from a participating (not a preferred) provider may receive benefits at a reduced rate and are subject to billing up to the Traditional Allowed Benefit. Your contracted PPO fee schedule with CareFirst can be accessed on CareFirst Direct. Members seeking treatment from non-participating providers receive benefits at a reduced rate and are subject to deductibles, coinsurance and balance billing.

Dental Exclusive Provider Organization

Exclusive Provider Organization (EPO) works much like the PPO. However, the member does not have out-of-network benefits. Dental EPO plans operate as a PPO hybrid. CareFirst and BlueDental EPO members will share the cost for dental treatment – BlueDental EPO plans will have member copayments instead of coinsurance.

Reimbursement is determined by your contracted fee arrangement with CareFirst, less the member's copayments. All BlueDental EPO plans will have the same member copayments by procedure for services included in the plan benefits, but accumulations like annual maximums and deductibles may vary among our BlueDental EPO plans. Your office can access these EPO member copayment schedules via CareFirst Direct.

Dental Health Maintenance Organization

A Dental Health Maintenance Organization (DHMO) plan is a structured plan where dentists who participate receive a monthly, fixed fee (capitation), based on the number of members assigned to their practice. These plans have no waiting period, calendar year maximums, or deductibles. Most work that isn't preventative will be subject to copayments.

The plan's Copayment Schedule of Benefits is a document that defines all of the procedures covered by that plan, and the amount of money the member will owe to your office for each procedure. Members who enroll in the DHMO networks must assign a Primary General Dentist (PGD) to their plan. You can find and confirm the member's PGD assignment on CareFirst Direct, the member's identification card, and on a monthly eligibility report that gets mailed to your office. Your office can access these DHMO member copayment schedules via CareFirst Direct.

Referrals

Unless otherwise stated, all office services not rendered by a PGD require a written referral. A written referral is valid for a maximum of 120 days and limited to three visits except for standing referral situations.

Decisions to issue additional referrals rest solely with the PGD.

Federal Employees Health Benefit Plan/Federal Employee Program

All federal government employees and qualified retirees are entitled to health insurance benefits under the Federal Employees Health Benefits (FEHB) Program.

Federal employees are given a wide range of insurance options, from catastrophic coverage plans with high deductibles to HMOs. Some plans are offered nationwide while others offer coverage regionally.

The Federal Employee Program (FEP), also known as the Service Benefit Plan (SBP), has been part of the FEHB Program since its inception in 1960. For Maryland, Washington, D.C. and Northern Virginia, this fee-for-service plan is administered by CareFirst. More than 50 percent of all federal employees and retirees nationwide have chosen to receive their healthcare benefits through FEP. These members and their families receive health coverage through the local Blue Plan where they reside.

FEP Benefit Plan Options

The medical options with embedded dental benefits available to federal employees and retirees include:

- The Standard Option PPO which allows FEP members to seek covered services from both preferred/in-network and non-participating providers. When members use preferred PPO providers, their out-of-pocket expenses, such as coinsurance and copayment amounts, will be less.
- The Basic Option PPO has a lower premium than the Standard Option and no deductibles, but members must use participating preferred providers to receive benefits.

Learn more about the benefit plans at https://www.fepblue.org/benefit-plans.

SAMPLE: Standard Option ID card

Front of card:

Back of card:

SAMPLE: Basic Option ID card

Front of card:

Back of card:

SAMPLE: FEP Blue Focus ID card

Front of card:

Back of card:

How to Identify an FEP Policy

Members who are part of Blue Cross Blue Shield Association (BCBSA) FEP can be identified by the following:

- The letter "R" in front of their member ID number instead of a three-letter alpha prefix
- The BlueCross BlueShield (BCBS) FEP logo on their ID card.
- A thin blue border around the FEP Blue Focus ID card perimeter, which distinguishes it from the Standard Option card, which has a solid white border, and the Basic Option card, which has shaded blue font. Samples of each card are shown below.

Unlike the Standard and Basic FEHBP Options, there are no dental benefits included in the FEP BlueFocus plan.

BlueCross BlueShield FEP Dental

The BCBSA has partnered with the GRID Dental Corporation (GDC) to administer BCBS FEP Dental, formerly referred to as FEP BlueDental. BCBS FEP Dental is a supplemental dental plan offered to federal employees and utilizes the GRID+ (Traditional) network as an in-network provider source.

By participating with CareFirst, providers are considered in-network for BCBS FEP Dental members. The member's card will be identified with the BCBS FEP Dental logo, along with the claim's submission address and customer service number to verify benefits. Claims for members who enroll in both BCBS FEP Service

Benefit medical plan (FEHBP) and BCBS FEP Dental should always be sent to FEHBP first, for primary consideration, and are automatically routed to BCBS FEP Dental for secondary coverage consideration.

Coordination of Benefits (COB) with FEP

When BCBS FEP Dental members have the Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program® or FEP®) medical coverage, those claims should be submitted to their local Blue Cross Blue Shield (BCBS) company.

- To avoid duplicate claim submissions, do not submit dated claims to both the local BCBS company and BCBS FEP Dental.
  - Primary payment will be sent to you and then the Service Benefit Plan will forward the claim, along with the Primary payment amount, to BCBS FEP Dental.
  - BCBS FEP Dental will coordinate the benefits of the claim received from the medical carrier. Upon completion of COB, BCBS FEP Dental will send the Secondary payment to your office.
- When a member is covered by a Service Benefit Plan product with dental benefits and a separate BCBS FEP Dental plan, those two policies will coordinate to pay benefits on dental claims.
- It is recommended that the dentist not charge the patient for any copay or coinsurance associated with the medical plan benefits at the time of their dental office visit because, in most cases, these amounts will be addressed by the dental plan.

FEP BlueFocus

BCBS FEP Dental will be paid as the Primary dental benefit for those who are enrolled in FEP BlueFocus. FEP BlueFocus medical option does not have any dental embedded. All dental claims will be submitted directly to BCBS FEP Dental. FEP BlueFocus is printed on the FEHBP medical ID card.

Other Federal Employee Health Benefit Program (FEHBP) Medical Member

Submit claims to the other medical carrier. Primary payment will be sent to you. You then submit claims and Primary remittance to BCBS FEP Dental for Secondary COB payment. Please hold Secondary claim submission until you have received Primary payment and remittance from the other medical plan.

National Dental GRID

Introduction

The Dental GRID links dental provider networks, including the CareFirst Dental Provider Network and many of the nation's Blue plans.

Participating CareFirst dental providers are considered in-network for patients who are members of many Blue Cross and Blue Shield plans, and providers should check the patient's member identification card for the GRID or GRID+ indicator before considering the plan to be in network. Providers file claims directly to the Blue Cross and/or Blue Shield plan where the member's group benefits are located. Reimbursement is made to the participating provider, based on the current CareFirst provider agreement.

This section describes the advantages of the program and provides information to make filing claims easy. This section offers helpful information about:

- Identifying members
- Verifying eligibility
- Filing claims

What is the National Dental GRID?

Definition

CareFirst has partnered with other Blues plans nationally and the GDC to provide BlueCross and BlueShield card holding members with seamless access to in-network dental care, regardless of where they reside or travel within the United States. The National Dental GRID links the dental networks of BlueCross and BlueShield plans and utilizes two networks (GRID and GRID+).

Advantages to Providers

The National Dental GRID gives your practice national directory presence. Participating CareFirst Traditional or PPO Dental providers will be listed in the National Dental GRID and Dental GRID+ directory. The program offers providers access to more patients who hold the Cross and Shield insurance.

There is no disruption to your contracted compensation, as reimbursement for claims rendered under the National Dental GRID are calculated using your current contracted allowances with CareFirst. You can access your contracted allowances on CareFirst Direct.

Products included in the National Dental GRID

If you participate with our Traditional (Indemnity insurance), PPO, and EPO plans, your office is included in the national Dental GRID and GRID+ provider directory. A GRID+ indicator on your patient's ID card corresponds to your Traditional, or PAR reimbursement with CareFirst, and similarly, a GRID indicator on your patient's ID card corresponds to your Preferred, or PPO reimbursement with CareFirst. Participating providers verify members benefits and eligibility and submit claims directly to the member's plan. Providers will also be paid by the member's plan, according to the provider's current CareFirst reimbursement agreement.

Third Party Administrators (TPA)

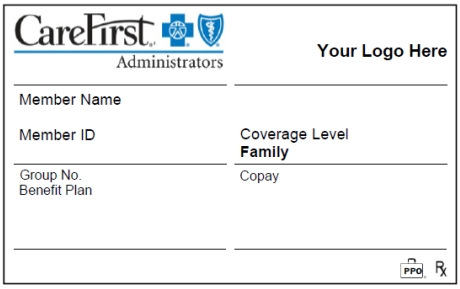
CareFirst jointly administers, with third-party administrators (TPAs), self-insured employers, and health and welfare funds, a TPA claims product. This product enables employers to utilize the CareFirst network of providers while still being able to design and administer their health benefits. CareFirst is actively involved and responsible for collecting and pricing claims, training and maintenance of the provider networks. The TPAs are responsible for issuing ID cards, handling claims adjudication, benefit and claims inquiries, correspondence, appeals, etc. Participating providers agree to accept the CareFirst allowance as payment in full for services rendered, less any deductibles and coinsurance amounts.

Member identification

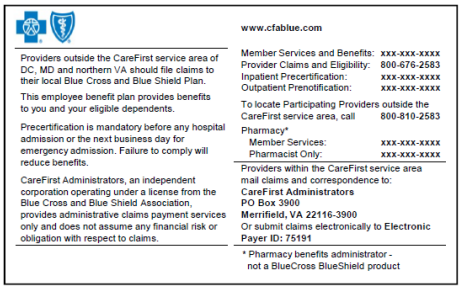
The member will have a unique ID card with the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund). The prefix on the ID card begins with an "A" followed by two numeric characters. Notice of Payments (NOPs), Explanation of Benefits (EOBs), checks and vouchers will

usually have the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund).

Front



Back



CFA, LLC dba CareFirst Administrators and NCAS

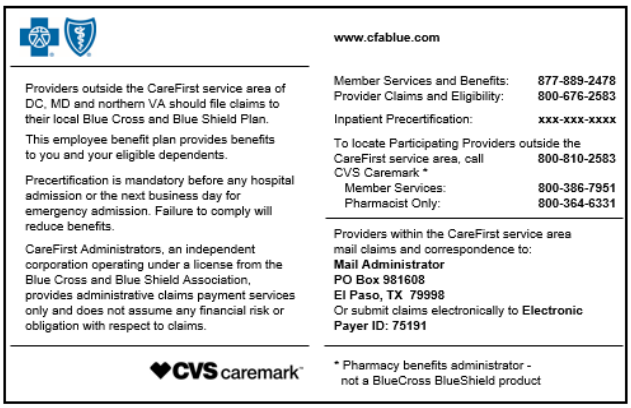
CFA, LLC dba CareFirst Administrators

CFA, LLC dba CareFirst Administrators is a wholly owned subsidiary of CareFirst, Inc. CareFirst Administrators (CFA) is Blue-Branded and operates under an independent license from the BCBSA. CFA provides administrative services to self-funded employer groups whose plans are governed by the Employee Retirement Income Security Act of 1974. This allows members to take advantage of local plan networks for out-of-area services. Products are customized using the BCBS national network of providers.

CFA provides administrative services only and does not assume any financial risk or obligation with respect to healthcare benefit claims for the self-insured portion of the plan. Though CFA offers access to the CareFirst provider network, specific requirements of member's health benefits vary and may differ than the procedures outlined in this manual.

Though CFA membership information is not available through the CareFirst Direct portal, CFA does have an interactive voice response system (IVR), 877-889-2478 that providers can access for patient benefits, eligibility and claims information.

CFA members' identification cards carry the CFA logo. Contact information for claims and correspondence is listed on the back of the card.



Claims should be submitted electronically using payer code 75191. Correspondence and paper claims should be submitted to:

CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998

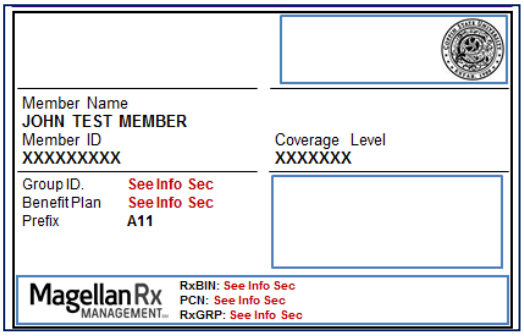
For more information, refer to www.cfablue.com.

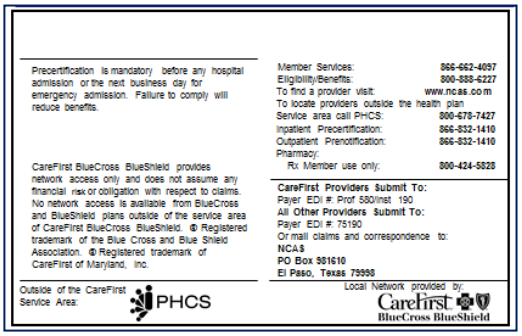
NCAS

CFA, LLC dba NCAS (NCAS) is a non-blue branded national TPA for companies headquartered throughout the United States. Members in the CareFirst service area have access to the CareFirst provider network. Members outside of the CareFirst service area are provided access to provider networks through agreements with NCAS. NCAS shares administrative duties with the employer groups or TPA.

NCAS is responsible for benefits eligibility and claims processing. NCAS has an IVR, 877-889-2479, that providers can access for patient benefits, eligibility and claims information. NCAS membership information is not available through the CareFirst Direct portal.

NCAS members' ID cards will have a dual logo and may have a CareFirst network logo if the group is located in the CareFirst service area. Otherwise, the logo of the applicable provider network will appear on the ID Card that shows both CareFirst and the TPA. Contact information and mailing addresses are listed on the back of the card.





Claims for NCAS should be submitted electronically using payer code 00580 for dental claims. Correspondence and paper claims should be mailed to:

NCAS
P.O. Box 981610
El Paso, TX 79998

For more information, visit www.NCAS.com.

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Chapter 3: Provider Network Requirements

Administrative Functions

Credentialing

Dental

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

Eligible dental providers

- General Dentists
- Endodontists
- Oral Surgeons (Medical)
- Oral Surgeons (Dental)
- Orthodontists
- Pediatric Dentists
- Periodontists
- Prosthodontists

Dental provider credentialing

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

How to apply

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

Once you have completed your application (CAQH will email you notification that your application is complete), and you have authorized CareFirst to access your data, access and complete our CAQH Data Sheet and send to dentalcontracting@carefirst.com. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

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

- Valid, current, unrestricted licensure
- Valid, current, Drug Enforcement Agency and Controlled Dangerous Substance registration, if and as applicable, for each state where the practitioner practices
- Appropriate education and training in a relevant field
- Board certification, if applicable
- Review of work history
- Active, unrestricted, admitting privileges at a participating network hospital, if applicable

- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
- Attestation to ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use
- Current malpractice insurance coverage certification which must include the limits of coverage of $1M/$3M, the expiration date and the name of the provider covered under the policy

If all credentialing criteria are met, the CareFirst Dental Director refers the practitioner to the Dental Advisory Committee (DAC) for a recommendation to approve the application.

If the credentialing criteria is not met, the Dental Director may deny the application or defer to the DAC for their recommendation. The Dental Director may request additional information from the practitioner. Practitioners will be notified in writing upon approval or denial. If the application is denied, the practitioner is afforded the opportunity to submit a written appeal within 30 days. The decision based on the appeal is final.

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

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

To ensure that CareFirst has obtained correct information to support credentialing applications and made fair credentialing decisions, providers have the right, upon request, to review this information, to correct inaccurate information and obtain the status of the credentialing process. Requests can be made by calling 443-921-0676.

Locum Tenens

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

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

Recredentialing

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

Ongoing Monitoring of Sanctions

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

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

Adding a New Practitioner to Your Existing Group Practice

Practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website. If the CAQH ProView application is already complete, make sure it includes the new practice affiliation information. Once complete, go to www.provider.carefirst.com, hover

over *Join Our Networks*, and under *Dental*, click on *How to Apply.* Access, complete and fax the CAQH Dental Provider Datasheet and a completed Billing Authorization Form to CareFirst at 410-720-5080 or email it to dentalcontracting@carefirst.com. CareFirst will add you to our CAQH ProView roster.

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

Access and Availability

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

Appointment Wait Times – Network Accessibility Standards

Members should be able to schedule an appointment for the care they need within the specified time frames.

Network accessibility standards	
Appointment type	**Time frame**
Urgent Dental Care	72 hours
Non-urgent Dental Care	14 calendar days
Preventive dental care	60 calendar days

Provider Data Accuracy

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

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

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

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

Role of the PGD – BlueChoice and The Dental Network DHMO

General Dentists are recognized as primary care providers (PCPs), also known as Primary General Dentists (PGDs).

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

Each CareFirst BlueChoice/The Dental Network (TDN) member selects a PGD upon enrollment and receives an individual member ID card with the name of the PGD on the card.

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

Requests received after the first of the month will be effective on the first day of the next month following the request.

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

Referring to a Dental Specialist

Primary General Dentist Responsibilities (DHMO)

- When the clinical examination reveals that a DHMO member has treatment needs that require a specialist, select an in-network specialist from the Find a Doctor specialist list located on carefirst.com. If a participating specialist is not available in the area, the PGD must contact the DHMO Provider Service Department to obtain authorization to refer to a non-participating specialist. An authorization will only be provided if the member does not have access to an appropriate participating specialist within a 50-mile radius.
- Verify that the procedure is a covered benefit according to the member's plan. Non-covered procedures may be referred to a specialist; however, the member will be responsible for all fees incurred.
- A written referral with a preliminary clinical diagnosis and appropriate radiographs should be sent to the specialist.
- The PGD is responsible for instructing and preparing the member for the appointment with the specialist, including taking the referral and radiographs to the specialist.

Specialist Responsibilities (DHMO)

- Provide treatment for the member as indicated on the referral form
- Collect applicable copayment and submit claim(s) to the payor ID listed on the Dental Claims and Service Reference Guide
- If the specialist has questions concerning the benefit coverage for a non-routine case or treatment, please contact the DHMO Provider Service Department.

Availability

If a PGD needs to be absent from the office for more than 10 days, they are required to contact us to obtain approval of providing acceptable coverage for our members. The dentist will be responsible for the cost of care rendered to their assigned members during his/her absence.

A PGD is required to have a system in place to accommodate emergency appointments and after hour emergencies. Emergency appointments should be granted within 24 hours during normal workdays for members assigned to the practice. If the assigned member is refused or unable to contact the dentist, covering dentist, or office staff member, and must be seen elsewhere, the PGD office will be held accountable for out-of-network fees up to $75.

Specialty Referral Criteria (DHMO)

To be considered for specialty care coverage, the following criteria must be met:

- The member must be eligible in the PGD office when services are rendered
- The referral must be made by the PGD to the appropriate participating specialist after examining the patient
- A participating network specialist must provide the treatment.

Back-up Coverage

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

After Hours Care

All PGDs or their covering dentists must provide telephone access 24 hours a day, seven days a week so you can appropriately respond to members and other providers concerning after hours care. The use of recorded phone messages instructing members to proceed to the emergency room during off-hours is not an acceptable level of care for CareFirst BlueChoice/TDN members and should not be used by CareFirst BlueChoice/TDN participating providers.

Open/Closed Panel

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

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

Requests for opening and closing a panel can be faxed on your letterhead to 410-720-5080 or emailed to dentalcontracting@carefirst.com. Written notifications should be mailed to:

CareFirst BlueCross BlueShield
Attn: Dental Networks Management
Mailstop: RRS-130
10455 Mill Run Cir.
Owings Mills, MD 21117

Changes in Provider Information

Providers who need to change their file information may submit a Dental Change in Provider Information Form, found in the Resources section of www.carefirst.com/providerforms > Dental. This form is also available on CareFirst Direct, our online provider portal, post-login. Any change to a provider's file must be received in writing.

Requests for termination are made effective 90 days from the date of receipt of the written request. Providers are expected to continue to provide services for eligible members until the effective date of the termination. Written notification should be mailed to:

CareFirst BlueCross BlueShield
Dental Provider Networks and Credentialing
Mailstop RRS-130
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-720-5080
Email: dentalcontracting@carefirst.com

Provider files remain active until we are notified of termination, retirement, loss of licensure or death.

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

Reduction, Suspension or Termination of Privileges

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

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

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

To make final determinations, the dental director seeks advice from the DAC and may appoint other practitioners as ad hoc members to the DAC to offer specialized expertise in the dental specialty that is the subject of the case or issue presented. As part of its investigation, the committee may use information that may include chart review of patient care, complaint summaries, peer/staff complaints and/or interviews with the practitioner.

The dental director or credentialing manager notifies the practitioner in writing of the reason(s) for the termination and/or sanction, their right to appeal the determination and the appeal process. The

practitioner may appeal the decision by submitting a written notice with relevant materials they consider pertinent to the decision within 30 days of being notified of the decision. The practitioner forfeits their right to appeal if they fail to file an appeal within 30 days of receiving notification of the decision.

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

Quality of Care Termination

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

All Other Sanctions or Terminations

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

Member to be Held Harmless

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

Reimbursement

Participating providers agree to accept a plan allowance (also called allowed benefit or allowed amount) as payment in full for their services. Participating providers may not bill the member for amounts that

exceed the allowed amount for covered services. Members may be liable for non-covered services, deductibles, copayments and coinsurance.

CareFirst's fee schedule is a list of plan allowances that are reviewed regularly. When adjustments to the fee schedule are made, providers will be notified if they will be impacted. They will receive a list of the impacted codes and fees. Fee schedules for additional codes can also be obtained via CareFirst Direct.

American Dental Association Codes

CareFirst will add codes and plan allowances to your standard fee schedule following their release from the American Dental Association (ADA). Fee schedules for these changes can be obtained upon request from the provider or via CareFirst Direct.

Notice of Payment (NOP)

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. An NOP accompanies each check and enables providers to identify members and the claims processed for services rendered to those members. Your office can also elect to receive NOP and payments electronically through ERA and EFT enrollment with your clearinghouse. These can be accessed post-login on CareFirst Direct. Participating providers are reimbursed according to the CareFirst Allowed Benefit as listed on the Dental Fee Schedules.

Capitation (DHMO)

Capitation is paid to participating DHMO general dentists for each member who has selected his/her office as their primary dental site. The Capitation Report is mailed with the capitation check between the 15th and 20th of each month. Capitation may also be deposited electronically in your office's bank account through EFT connectivity with your clearinghouse. Capitation rates for each plan are listed on each Member Copayment Schedule.

Member Copayments (DHMO)

Member copayments are collected by the office at the time of service based on the copayment listed on the Member Copayment Schedule. Some procedures on the schedule list two copayment amounts. The amount on the left is due when the service is rendered by the PGD. The amount on the right is due when the service is rendered by a specialist to whom the member was referred. Copayment schedules are available on CareFirst Direct and can be accessed from the member's benefits and eligibility page.

GRID and GRID+

Participating CareFirst Traditional or PPO Dental providers will be listed in the National Dental GRID and Dental GRID+ directory. The program offers providers access to more patients who hold the Cross and Shield insurance. Participating providers submit claims directly to the member's plan. Providers will also be paid by the member's plan, according to the provider's current CareFirst reimbursement agreement.

Note: A GRID+ indicator means that the member has Traditional coverage benefits available for dental services received from a participating dentist inside the U.S., from a Blues plan. Likewise, a GRID indicator means that the member has PPO coverage benefits available for dental services received from a participating dentist inside the U.S., from a Blues plan. Your reimbursement amounts contracted with CareFirst remain unchanged when you provide dental services for Blues members who have GRID or GRID+ coverage. You will still receive support from your Provider Relations Specialists and from the dedicated customer service teams available to you.

Confidentiality

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

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

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

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

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

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

General Policy

- All records and other member communications that have confidential medical and insurance information must be handled and discarded in a way that ensures the privacy and security of the records.
- All clinical information that identifies a member is confidential and protected by law from unauthorized disclosure and access.
- The release or re-release of confidential information to unauthorized persons is strictly prohibited.
- CareFirst limits access to a member's personal information to persons who need to know, such as our claims and clinical management staff.
- The disposal of member information must be done in a way that protects the information from unauthorized disclosure.
- CareFirst releases minimum necessary PHI in accordance with the Privacy Rule as outlined in HIPAA and our notice of privacy practices (NPP).

Member Access to Clinical Records

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

Provider Service HIPAA Validation

When calling into Provider Service, all providers will need to validate patient information. Please provide the patient's full name (first and last), along with **three** other pieces of information. This information includes:

- Patient's date of birth
- Patient's address
- Patient zip code
- Patient identification number
- Patient phone number

Treatment Setting

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

Information Security Policy

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

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

Quality Improvement Measurement

Data for quality improvement measures is collected from administrative sources, such as claims and member clinical records.

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

Notice of Privacy Practices

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

Administrative Services Policy

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

malpractice coverage increases. Additional examples of such services may also include but not be limited to:

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

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

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

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

Treatment of Family Members

Treatment of family members or self is not a covered benefit. Providers should not bill CareFirst for services rendered to family members or themselves.

The American Dental Association Principles of Ethics and Code of Professional Conduct (ADA Code) includes a similar standard of practice, indicating that "dentists should avoid interpersonal relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient."

Family members include spouses, parents, children, and siblings of a provider, and may also include other family members, in accordance with the applicable benefit contract.

Member Complaints

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

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

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

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

Please include the following information when submitting a complaint:

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

Requests for Charts

Affordable Care Act Risk Adjustment

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

Background

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

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

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

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

Clinical outreach

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

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

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

Medical record retrieval

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

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

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

Best practices in medical record documentation

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

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

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

Make sure to avoid common errors:

- Incomplete medical record documentation
  - Lack of condition specificity where required
  - Key condition statuses (e.g., transplant, amputation)
- Missing provider signature and/or credentials
  - Missing provider signature on clinical records
  - Missing provider credentials on clinical records
- Short-hand documentation of medical record
  - Use of symbols or other medical terminology that cannot be translated into diagnosis codes
  - Lack of condition specificity where possible

- Other common errors
  - Name on medical record does not match other documents
  - Pages from the medical record are missing

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

HHS Risk Adjustment Data Validation

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

Background

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

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

Provider outreach

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

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

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. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), 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 DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., 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.
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CareFirst
Family of health care plans

Chapter 4: Claims, Billing and Payments

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, benefits 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 address your inquiry more quickly. 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 time 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/provider 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 to CareFirst Direct. 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/portaluserguides.

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/providerguides.

Basic Claim Submission Requirements

Reporting Current Dental Terminology (CDT®)

Use the most current edition of the CDT, published by the American Dental Association® (ADA), to report services for treatment. The CDT manual can be purchased directly from the ADA by calling 800-947-4746 or visiting www.ada.org.

Note: The existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract.

Timely Filing of Claims

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

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:

- 837D – Dental Claims
- 835 – Electronic Remittance Advice
- 277CA – Payer Acceptance Report
- 270 – Eligibility Inquiry
- 276 – Claim Status

Electronic Claims (837D)

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
- Pre-Treatment Estimates (PTEs)

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. You can review remittance details on CareFirst Direct, as well as within your practice management system through 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)

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)

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.

Claim Status (276)

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, contact your trading partner.

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 ADA claim forms. For dental services that are eligible for benefits under the patient's medical policy, please complete all required field below on a CMS-1500 claim form and submit to CareFirst. Claims missing or containing invalid information in any of the fields below will be returned.

Field name	Version 2019 ADA Claim Form Box	CMS-1500 box (Medical Only)
Insured ID Number	15	1a
Patient Name	12	2
Patient Date of Birth	13	3
CDT Code	29	n/a
ICD-10 Diagnosis	n/a	21
Dates of Service	24	24a
Place of Service, Facility Code	38	24b

Procedure Code/Revenue Code	29	24d
Charge	31	24f
Days of Units	41-42 (for orthodontia)	24g
Rendering National Provider Identifier	54	24j
Federal Tax ID	51	25
Signature of provider	53	31
Billing NPI	49	33a

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 the most current 2019 © American Dental Association claim form. Instructions are available at www.ada.org. All information must fit properly in the blocks provided.
- Using the most current edition of the CDT, published by the ADA, to report services for treatment. **Note:** the existence of a procedure code does not guarantee coverage; the benefit is determined based on the member's contract.
- Using a membership ID number only. Social Security numbers will not be accepted in place of a membership ID number. Claims will be returned if the Social Security number is used as a membership ID number
- With your office's actual charges by procedure.

Pre-Treatment Estimate Submission Process

Dental providers and/or members who wish to obtain clinical review for dental treatment prior to services being rendered may request a Pre-Treatment Estimate (PTE). CareFirst strongly encourages providers to submit PTEs and required attachments electronically through your clearinghouse and NEA. PTEs submitted by hard copy should be submitted on a completed ADA claim form. Check the box for "Dentist's pre-treatment estimate" and leave the date of service blank. Include the following:

- ADA CDT procedure code(s)

- Appropriate supporting documentation for the service(s) to be rendered (see Reference Guide for Required Attachments). Providers with electronic capabilities are encouraged to submit attachments via one of our preferred trading partners.

This PTE process is an optional service limited to procedures which are subject to Utilization Review and listed in the Reference Guide for Required Attachments. The PTE provides a clinical review of a proposed treatment plan and is not a guarantee of payment or a prior authorization.

In the PTE process, benefits will be considered based on current eligibility and clinical guidelines. Providers will be notified on the Estimate of Eligible Benefits (EEB) form indicating approval or denial. Upon completion of treatment, the EEB form should be used to request reimbursement by completing the date of service, signing, and submitting the EEB to the appropriate claim submission address indicated on the form. Resubmission of supporting documentation is not necessary when submitting for reimbursement. Payment will be considered based on the following conditions:

- PTE was issued less than 270 days prior to the date service was completed.
- Member was eligible on the date service was completed.
- Frequency and annual maximums have not been exceeded.
- Service must be a covered benefit at the time service was rendered.
- Services rendered are consistent with those indicated on the PTE.

Note: If pre-treatment approval was granted on the EEB form, submit the EEB for completed services. Claims submitted on an ADA claim form for services that have been approved via the EEB process will automatically generate a request for supporting documentation.

Providers and/or members who choose not to request a PTE must continue to submit claims with the required attachments (radiographs, periodontal charting, etc.) for services requiring clinical documentation. You can check CareFirst Direct or CareFirst on Call to verify if the claim has been received by CareFirst.

Dental Reference Guide for Required Attachments

As part of our Utilization Management Program, you are required to submit supporting documentation for select dental procedures. The Dental Reference Guide for Required Attachments is updated on an annual basis, and lists by category of service, the procedure codes and the specific documentation required for submission with the claim.

Note: The requirements for attachments and documentation apply to all procedure codes within the range noted.

Notice of Payment

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. An 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 or if money has been recouped by CareFirst because of an adjudication.

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 contact Provider Services or submit a claim inquiry on CareFirst Direct to initiate an adjudication. The claim(s) will be reprocessed, and a new check will be issued.

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 "Submit a Claim Inquiry" function.

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. Dental providers should submit corrected claims in the HIPAA transaction 837D and indicate "corrected claim" in the Remarks section of the submission.

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

If submitting a paper 2019 © ADA Claim Form, "Corrected Claim" must be written at the Remarks section of the claim form.

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. Mail these claims to the correspondence address.

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, accumulation calculations, rejections or automatic denial determinations, or clinical records, procedure/code errors. Before sending an inquiry, consider submitting a corrected claim.

The preferred method for submitting an inquiry is electronically through CareFirst Direct using the "Submit a Claims Inquiry" function. When you cannot use CareFirst Direct, contact the appropriate provider services area to file a claims inquiry.

What is an Appeal?

An appeal is a formal written request to CareFirst for reconsideration of a medical or contractual adverse decision. When CareFirst processes a claim and rejects it due to medical necessity or an adverse decision, providers may appeal the rejection in writing within 180 days from the Explanation of Benefits (EOB) or adverse decision. Appeals must be submitted in a letter on the provider's office letterhead.

Providers may appeal an adverse benefit determination based on medical necessity, appropriateness, or a decision to deny experimental/investigational or cosmetic procedures. The appeal letter must describe the reason(s) for the appeal and the clinical justification/rationale for the request.

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 clinical records including lab reports, X-rays, treatment plans, progress notes, etc.

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

All appeal decisions are answered in writing. The appeal will be reviewed by a dentist or an appropriate practitioner who was not involved in the initial denial. Please allow 30 days for a response to an appeal.

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.

Visit carefirst.com/inquiriesandappeals for more information.

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.

CareFirst uses the Standard method of processing COB for all plans, which states that we will coordinate claims up to the highest allowed benefits of the two coverages. The liability of CareFirst as the secondary carrier will never exceed the highest allowed benefit between the two coordinating coverages, and CareFirst's payment as secondary carrier will never exceed what we would have paid as primary. The standard provision in a member's contract considers the amount paid by the primary carrier and our Allowed Benefit (AB). If the amount of the primary carrier's payment exceeds or equals the AB, we pay nothing.

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.)

The participating provider cannot balance bill the member if the primary carrier and our reimbursement does not equal the total billed charges. The participating provider can only bill for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance. If the primary carrier appropriately denies benefits for rendered services, we automatically become the primary carrier for covered services.

Note: Providers may submit primary COBs electronically or via hard copy to our claims mailing address.

Coordination of benefits with Affordable Care Act (ACA) pediatric dental coverage

When a CareFirst member has a medical plan, is eligible for embedded pediatric dental coverage, and is also covered under a CareFirst Employer Group dental plan, the embedded pediatric coverage will always be primary for the member.

Coordination of benefits with DHMO policies

When coordinating between an indemnity and a capitation dental plan, the following rules apply:

- When the capitation plan is primary, the capitation copayments to the treating dentist remain the capitation plan's usual care. The indemnity plan should pay benefits for the patient's copayment up to the indemnity plan's allowable benefit.
- When the indemnity plan is primary, and treatment is received from a participating capitation provider, the indemnity plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation plan's allowable amount.

Note: DHMO providers may only bill the secondary carrier the member's copayments

When coordinating benefits between two capitation plans, the following rules apply:

- **Primary General Dentist (PGD):** For a case in which the PGD participates with both capitation plans, the patient should be charged in accordance with the lesser of the two copayment schedules. This rule applies regardless of whether the two capitation plans are administered by the same managed care company or by two different managed care companies. If the PGD only participates with one of the capitation plans, the PGD has no choice but to charge in accordance with the capitation plan in which he/she participates.
- **Specialist:** For a case in which the specialist participates with both of the capitation plans and both of the capitation plans are administered by the same managed care company, the patient should be charged in accordance with the lesser of the two copayment schedules and the specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the capitation plan.

  For a case in which the specialist participates with both of the capitation plans and the capitation plans are NOT administered by the same managed care company, the patient should be charged in accordance with the plan that has been determined as the primary plan. The specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the primary plan. When the specialist submits a claim for additional payment (if applicable) to the secondary plan, the claim must include an EOB from the primary plan. If the secondary plan is a CareFirst DHMO plan, there will not be any additional payment to the specialist if the combined payment from the patient and the primary plan to the specialist is equal to or greater than the amount guaranteed to the specialist by the DHMO.

Orthodontia

CareFirst does not coordinate coverage for orthodontia. When members have dual dental CareFirst coverage whereby both plans include orthodontic benefits, CareFirst will process orthodontic claims under both plans simultaneously; there is no primary or secondary carrier in cases of orthodontia under CareFirst policies.

Dental Benefits Covered Under Medical Policies

Most of the time CareFirst processes dental-related services under a patient's dental plan. However, there are a few cases where the patient's benefit is processed under their medical plan. There are three major service types that fall under this category:

- **Complex Oral Surgery**, defined by CareFirst as medically necessary procedures intended but not limited to:
  - Attain functional capacity;
  - Correct a congenital anomaly;
  - Reduce a dislocation;
  - Repair a fracture;
  - Excise tumors, non-odontogenic cysts or exostoses; or
  - Drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts and jaws.
- **Accidental Injury**, defined by CareFirst as dental services needed as a result of accidental bodily injury (except for accidents caused by biting or chewing), occurring on or after the patient's effective date of coverage, to the mouth, jaws, cheeks, lips, tongue, roof and floor of the mouth.
- **Temporomandibular Joint Disfunction**, when the patient's benefits allow and after the case is reviewed.

In these cases, claims must be:

- Reported using the CMS-1500 claim form, version 02/12, and the applicable AMA Current Procedural Terminology (CPT®) and ICD-10 diagnosis code.
- Submitted to the appropriate medical claims processing area for Prior Authorization when required.
- Submitted with a narrative and itemization of the CDT codes rendered.
- Processed under the patient's medical coverage instead of their dental coverage.

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Chapter 5: Fraud, Waste and Abuse

Special Investigations Unit

The Special Investigations Unit (SIU) of CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst), and its affiliates and subsidiaries, is the in-house, dedicated unit responsible for coordinating the detection, investigation, referral and prevention of suspected fraud, waste and abuse (FWA). The resolution of these issues is consistent with CareFirst's mission: to provide affordable and accessible healthcare to its members.

The SIU strives to protect CareFirst members, providers, vendors, and assets from FWA-caused harm. To accomplish its goals, the SIU may pursue a wide array of strategies, which may range from educational activities to financial recovery of improperly paid Company funds to termination of network providers. In certain instances, the SIU may engage, work with, and support local or federal law enforcement.

The SIU's anti-fraud activities are both proactive and reactive. Cases are derived from a variety of internal and external sources, such as tips, calls to the anonymous anti-fraud hotline, referrals from internal departments or external agencies, and leads generated from profile analysis of data stored in internal operating and claims processing systems. Case resolution results in education opportunities, changes in internal policies, processes, practices, or procedures, recovered savings, referrals to law enforcement for criminal investigations and/or civil recovery of assets, termination of providers from CareFirst networks, and/or administrative referrals to applicable professional boards.

Fraud, Waste and Abuse

Our members and providers play an important role in helping us identify and combat fraud, waste and abuse. CareFirst's definitions of fraud, waste and abuse include:

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain, by means of false or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

Waste

The expenditure, consumption, mismanagement, use of resources, practice of inefficient or ineffective procedures, systems and/or controls to the detriment or potential detriment of entities. Waste is generally not considered to be caused by deliberate misconduct but rather by the misuse of resources.

Abuse

Actions that may, directly or indirectly, result in unnecessary costs, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary, without knowingly and/or intentionally misrepresenting facts to obtain payment. Deliberate ignorance or reckless disregard of rules and procedures may be considered fraud.

If you suspect fraud, waste and/or abuse, call our hotline at 800-336-4522. You may also email us at SIU@carefirst.com.

Claims Reviews

CareFirst's SIU is comprised of experienced healthcare professionals with expertise in clinical, financial, revenue cycle, health information management and coding specializations, and the unit works with various other functions within CareFirst to coordinate a comprehensive approach to the claims review process.

- **Flagged claims review:** CareFirst may review claims flagged as at risk for fraud, waste and abuse prior to payment. We look for easily identifiable errors and services claimed for payment that are not covered in a customer's benefit package.
- **Pre-payment review:** As a result of a post-payment audit or investigation, a provider may be required to submit all or selected claims with supporting clinical records for review before claims are paid. This review is to determine appropriateness of services billed and/or the medical necessity of the services reported.
- **Post-payment review:** The SIU may perform a review after claims are paid to determine appropriateness of claim coding, services billed and medical necessity.

During the review process, CareFirst examines clinical records to ensure they appropriately support the services billed on the claim. Documentation and services must meet contractual and individual provider licensing requirements, as well as be medically necessary, appropriate and covered by the member's benefit plan. This includes, but is not limited to, compliance with the Medical Record Documentation Standards Policy and compliance with national coding and billing standards (CPT®, HCPCS, CDT, ICD-10). Records that contain cloned documentation, conflicting information or other such irregularities may be disallowed for reimbursement.

Post-Payment Investigations and Audits

When a potential fraud, waste and abuse problem is identified or reported, CareFirst's SIU performs an investigation which may include obtaining clinical records for review against provider claim submissions, performing an onsite visit at the provider's office, a facility or other locations where clinical records are stored, and interviews of members, providers and their staff. Once complete, CareFirst notifies the provider of the findings. The provider may then be asked to perform a self-audit of clinical records and claims not previously subject to review.

Additionally, CareFirst's SIU educates the provider on proper coding and billing practices and expects the provider to adhere to such practices on any future billings. CareFirst may also require the provider to comply with pre-payment claims review until appropriate billing practices are demonstrated.

If potential fraud is detected, CareFirst's SIU refers the issue to the appropriate law enforcement and/or regulatory agency. If necessary, the SIU will work with CareFirst's Provider Contracting department to terminate providers from the CareFirst networks.

Retroactive Denials and Overpayment Recovery

CareFirst's SIU will, to the extent allowed by law and the provider contract, deny claims and collect overpayments through a future offset of payments when appropriate. Situations giving rise to such denials, recoveries and/or offsets may include a provider's failure to supply requested records, identification of improperly coded or billed claims or other identified fraud, waste and abuse. Providers will be notified in advance of the SIU's intent to conduct such recovery and will be provided an opportunity to provide supplemental information regarding the underlying claims related to the SIUs decision.

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Chapter 6: Care Management

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. CareFirst assesses member care and services using quantitative and qualitative relevant data, to identify barriers or causes for less-than-optimal performance and 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:

- Clinical/treatment records
- Claims
- Pharmacy data
- Health risk appraisals
- Utilization Management (UM) information
- Member/provider surveys
- Current literature

As our partner in case management, 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 American Dental Association'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 network of providers to meet the needs and preferences of our members by maintaining a systematic monitoring and evaluation process.
- Implement methods, tracking, monitoring, and oversight processes for all dental and dental-medical care provided to CareFirst members to ensure safe and accessible, affordable oral health care.
- Establish collaborative partnerships with our network dentists and local dental organizations.
- Deliver data and support to clinicians to promote evidence-based clinical practices 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 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.
- 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.
- 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. 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 provide input and feedback on QI program activities through participation in the following committees:

QI program committees	
Committee	**Purpose**
Quality Improvement Council (QIC)	Evaluates the quality and safety of clinical and behavioral healthcare and the quality of services provided to members
Dental Credentialing Committee	Reviews the credentials of providers and potential providers applying for initial or continued participation in the plan

Clinical Guidelines

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

- Introduction
- Diagnostic
- Restorative
- Endodontics
- Periodontics
- Prosthodontics (removable)
- Implants and related services
- Fixed Prosthodontics
- Oral Surgery
- Orthodontics
- Adjunctive general services

The Dental Clinical Criteria are reviewed annually by the Dental Advisory and the Oral Maxillofacial Surgery Advisory Committees and are modified/updated as needed to reflect current scientific research and literature as well as updates adopted by medical societies and professional organizations.

Performance Data

CareFirst must meet the performance and evaluation goals of the QI program. CareFirst retains the right, at their discretion, to use all provider data including provider performance data for QU activities including, but not limited to, activities to increase the quality and efficiency of services to members (or employer groups), public reporting to consumers and member cost-sharing.

Population Assessments

CareFirst continuously analyzes the cultural, ethnic, racial and linguistic characteristics of its members and released an updated Cultural, Ethnic, Racial and Linguistic (CERL) report as of April 2023. The assessment includes specific characteristics of the geographic populations we serve correlated to CareFirst membership. Various data sources were 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
- CareFirst membership data
- Network provider characteristics including age, sex and languages spoken
- Member complaint data

- Use of language assistance/translator services, via the language line

Maintaining the Access, Availability and Quality of Our Network Providers

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	Applies to Medicare Advantage when a provider is on the Preclusions list
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 dentist through its paper and web-based directory. The information includes, but is not limited to the provider's name, gender, specialty, group affiliations 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 dentists in its networks.
Maintain and update office contact information	■ Maintain information on accessibility of services for members	CareFirst assists members with the ability to find a provider when they need them, and it uses the information in its database

Network Maintenance		
	■ Monitor network adequacy (provider type, ratio and geography)	to identify who is accepting patients. 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 dentists in its networks.
CareFirst reports adverse events to the appropriate licensing boards and to the National Provider Data Bank.	■ Alert CareFirst to potential adverse events and complaints	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 and Social Determinants of Health

CareFirst serves three primary geographic regions: Maryland, D.C. and Northern Virginia. Within those three regions are smaller sub-regions. Annually, CareFirst analyzes social determinants of health in those geographic areas and identifies those most likely to directly impact the health and well-being of our members. Additionally, an assessment of these findings helps drive the CareFirst primary areas of focus for care coordination and the clinical programs that support our members' health.

A recent analysis identified the social determinants of health expected to have the greatest negative impact on our members and areas most in need of prevention and treatment efforts. Within our geographic regions and corresponding populations, poverty, crime, air quality, alcohol consumption and access to medical services presented some of the most significant social challenges impacting the health of CareFirst members. Each year, population and member experience data are assessed so that, as a health plan, we can determine needs and prioritize services. This data helps CareFirst focus healthcare resources and/or services to help improve member health.

Social determinants of health cause many challenges for members and may vary widely based on the area in which they live. This contributes to variations in health by region and in each of the areas we

serve, with different geographic areas presenting different challenges. Chronic issues such as lack of access to healthy food, poverty, poor housing and lack of access to medical care all contribute to reduced health outcomes.

As a health plan, CareFirst is committed to offering programs and services designed to create the maximum positive impact and health outcomes for our members.

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:

- Adverse clinical decisions
- Adverse coverage decisions
- 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 needed 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.

Clinical Programs

Data-Driven and Evidence-Based Decision Making

CareFirst evaluates quality of dental services against proven and established national references such as the Dental Quality Alliance, the American Dental Association's Evidence-Based Care Guidelines and the Clinical Review Guidelines emanating from the American Association of Dental Consultants and National Association of Dental Plans.

CareFirst leverages its robust dental claims database to identify outliers in practice patterns based on claims submitted for payment. Chart audits are conducted proactively when patterns of behavior are identified through overviews of provider groupings such as, geography and specialty, or when a compliant or board/malpractice action identifies a gap or deviation in standard care. These gaps are investigated further to determine the extent of the issue, any nuanced and reasonable rationale for these gaps or deviations, and to coach and counsel a provider to return to a more standard practice pattern.

For example, if a provider was found to be 2.5 standard deviations from the norm for his/her geographic region and specialty for a higher ratios of surgical extractions to simple extractions, clinical charts for patients who received surgical extractions would be requested from the provider's office. The patient charts are reviewed to identify patterns and reasons for deviation of care. CareFirst and the provider work together to return care standards back to the norm.

In addition to patient chart audits, CareFirst may also perform site visits. Site visit reviews of the clinical operations and facilities of the dental providers are performed when there is a recorded member complaint or board/malpractice action related to a facility or asepsis issue noted. The site visit review guidelines were developed using current CDC and OSHA infection control standards and scoring is weighted based on significance of any items reviewed.

CareFirst also performs utilization review to evaluate the appropriateness, clinical necessity and efficiency of dental procedures. Clinical guidelines for benefit coverage are developed using the same national references listed above, keeping with dental industry and professional standards. Utilization review includes flexibility on a case-by-case basis, with input from the rendering dental providers, as well. Members are free to choose treatment plans based on discussions with their providers and may elect to pay for and have noncovered procedures performed as out of pocket expenses.

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 Dental Clinical Criteria.

Inpatient Hospitalization Services

Pre-Admission Certification Process for Dental Admissions

- All dental inpatient hospital admissions must be authorized, such as orthognathic or TMJ surgeries. 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.
- You can request prior authorization:
  - Online: Log in at carefirst.com/provider and click the Prior Authorization/Notifications tab to begin your request
    Note: The prior authorization must be done no more than three days after the date of service and can be entered 31 days before the outpatient date of service. Submit the authorization request to the care management 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. For on-demand training and resources, visit carefirst.com/learning.
  - 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.
- Authorization decisions are made within two working days of obtaining necessary clinical information. 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

- All emergency inpatient hospital admissions must be authorized within 48 hours of the admission of next business day. The hospital must request authorization.
- Unauthorized hospital stays result in a retrospective review of the admission.

Prospective and Concurrent review processes

- 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 Dental Claims and Services 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 dental director.
- The CRN or CCR nurse will notify the attending provider and the facility of our dental 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 clinical 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:

- 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 the 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 dentist reviewers available to discuss UM decisions. Providers may call 410-605-2457 or email CantonDentalAdverseDeterminations@carefirst.com to speak with a dentist reviewer or to obtain a copy of any of the above-mentioned criteria. All cases are reviewed on an individual basis.

Important note: CareFirst affirms that all UM decision-making is based only on appropriateness of care and service. Practitioners and/or other individuals are not rewarded for conducting Utilization Review (UR) for denials of coverage or service.

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. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), 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 DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., 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.
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CareFirst
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Chapter 7: Policies and Procedures

Medical Policy and Technology Assessment

Medical Policies and Medical Policy Operating Procedures

The CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) evidence-based medical policies and medical policy operating procedures can be found in the Medical Policy Reference Manual. This manual is an informational database, which, along with other documentation, is used to assist CareFirst in reaching decisions on matters of medical policy and related member coverage. These policies and procedures are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract. Medical policies are applicable to services covered under the patient's medical plan; several may apply to oral health care and are available for reference.

Member coverage will vary by contract and line of business. Benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts. In some instances, a patient's oral health care treatment may be covered under the medical policy. It is important to review the treatment considered, to determine whether the service provided may be covered under the medical benefit plan or the dental benefit plan.

Medical policies and medical policy operating procedures are not intended to replace or substitute for the independent clinical judgment of a practitioner or other health professional for the treatment of an individual. Medical technology is constantly changing, and CareFirst reserves the right to review and update its medical policy periodically and as necessary.

For specific reporting codes and instructions, refer to the appropriate and current coding manual, such as:

- The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS Level II codes)
- The International Classification of Diseases (ICD)
- The American Medical Association's (AMA) Current Procedural Terminology (CPT®) (HCPCS Level I codes).
- The American Dental Association's® (ADA) Current Dental Terminology (CDT®)

The Medical Policy Reference Manual is organized according to specialty, and in some cases, subspecialty. There are search functions available online to help you identify any alignment of your treatment plan and the patient's presentation to an existing medical policy. Commonly reviewed medical policies by dental practitioners are:

- 1.03.001 – Orthotic Devices and Orthopedic Appliances
- 2.01.018 – Sleep Disorders
- 2.01.021 – Temporomandibular Joint (TMJ) Dysfunction
- 2.03.012 – Adjunctive Diagnostic Aids for Oral Cancer Screening
- 7.01.136 – Oral-Facial Trauma/Accidental Injury
- 7.01.137 – Oral-Facial Pathology
- 9.01.007A – General Anesthesia for Dental Care (Maryland and Virginia Mandates)

The introduction to the Medical Policy Reference Manual should be referenced prior to reviewing the medical policies and procedures. This section describes the medical policy process, format of documents, and definitions and interpretive guidelines of key terms such as medical necessity, cosmetic and experimental/investigational.

The medical policies and procedures located in the Medical Policy Reference Manual provide guidelines for most local lines of business. Many national accounts, processed through the National Account Service Company (NASCO) system, and members with Federal Employee Program (FEP) benefits, may defer to policies developed by the Blue Cross and Blue Shield Association (BCBSA). Therefore, there may be differences in medical policy and technology assessment determinations depending on the member contract. Benefits and coverage determinations should be verified prior to providing services.

Technology Assessments

A technology assessment is a process in which current or new/emerging technologies are thoroughly researched, evaluated and formulated, as appropriate, into evidence-based CareFirst medical policy. Technologies include drugs, devices, procedures and techniques. CareFirst has adopted the criteria of the BlueCross and BlueShield Association Technology Evaluation Center (TEC) for use in determining a technology's appropriateness for coverage. These criteria, along with an explanation of how they are applied, can be found in the introduction of the Medical Policy Reference Manual under Definitions and Interpretive Guidelines.

Technology assessments are presented with supportive data to the CareFirst technology assessment committee (TAC) on a regular basis. TAC is comprised of members of the healthcare policy department, CareFirst medical and dental directors and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether the technology is experimental/investigational) are made by consensus of the TAC. TAC determinations are effective on the first day of the month following the meeting.

Dental Clinical Criteria

To process claims accurately and consistently, CareFirst and CareFirst BlueChoice developed Dental Clinical and Policy Guidelines based on current community standards of dental care and are derived through consultation with the American Dental Association Dental Practice Parameters, dental practices, academic communities and current scientific literature. The dental policy guidelines are supported by a system designed to adjudicate claims efficiently and accurately based on the member's contract. These edits use the most cost-effective, clinically appropriate claim reimbursement, based on clinical standards and contractual limitations.

Dental Claims Adjudication Edits

Overview

Claim adjudication policies and associated edits are based on thorough reviews of a variety of sources including, but not limited to:

- CareFirst dental clinical guidelines
- ADA guidelines
- CMS policies

- Professional specialty organizations (e.g., American Association of Pediatric Dentists (AAPD), American Academy of Oral Maxillofacial Surgeons (AAOMS), American Association of Dental Consultants (AADC), etc.)
- State and/or federal mandates
- Member benefit contracts
- Provider contracts
- Current healthcare trends
- Clinical and technological advances
- Specialty expert consultants

Requests for Clinical Information

In order to accurately adjudicate claims and administer member benefits, it is sometimes necessary to request clinical records. The following is a list of some of the claims categories from which CareFirst may routinely require submission of clinical information, either before a service has been rendered, or before or after adjudication of a claim. Some of these specific modifiers are discussed in more detail throughout this manual. CareFirst maintains a dynamic list of required supporting documentation that must accompany a dental claim, and also may require information for the following categories:

- Procedures or services that require prior authorization.
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies.
- Procedures or services that are or may be considered experimental/investigational.
- Claims involving review of clinical records.
- Procedures or services reported with unlisted, not otherwise classified or miscellaneous codes.
- Claims involving coordination of benefits.
- Claims being appealed.
- Claims being investigated for fraud and abuse or potential inappropriate billing practices.
- Claims that are being investigated for fraud or potential misinformation provided by a member during the application process.

This list is not intended to limit the ability of CareFirst to request clinical records. There may be additional individual circumstances when these records may be requested. By contract, these records are to be provided without charge.

Basic Claim Adjudication Policy Concepts

The following represent key coding methodologies, claims adjudication policies and reimbursement guidelines.

Note: These claim adjudication and associated reimbursement policies are applicable to local CareFirst lines of business. Adjudication edits/policies may differ for claims processed on the national processing system (NASCO) depending on the account's home plan and FEP.

Unbundled Procedures

Procedure unbundling occurs when two or more procedure codes are used to report a service when a single, more comprehensive procedure code exists that more accurately represents the service provided. Unbundled services are not separately reimbursed. If the more comprehensive code is not included on the claim, the unbundled services will be re-bundled into the comprehensive code; if it is a covered benefit, the more comprehensive service will be eligible for reimbursement. Always report the most comprehensive code(s) available to describe the services provided.

Incidental Procedures

An incidental procedure is carried out at the same time as a more complex primary procedure and/or is clinically integral to the successful outcome of the primary procedure. When procedures that are considered incidental are reported with related primary procedure(s) on the same date of service, they are not eligible for reimbursement.

Integral/Inclusive to Procedures

These are procedures that are considered integral to or included in the primary service. Integral or included in procedures are not eligible for reimbursement.

Duplicate Services and Multiple Reviews

Paying more than one provider for the same procedure or service represents duplicate procedure reimbursement.

CareFirst will reimburse only once for a service or procedure. Duplicate procedures, services and reviews, whether reported on the same or different claims, are not eligible for reimbursement.

Submissions of claims containing a miscellaneous code (DX999) are reviewed by our dental consultants. A reimbursement allowance is established based on this review using a variety of factors including, but not limited to, evaluating comparable procedures with an established fee. To be considered for reimbursement, a miscellaneous CDT code must be submitted with a complete description of the service or procedure provided. Any applicable records or reports must be submitted with the claim.

All applicable reimbursement policies will apply (i.e., incidental procedures, multiple procedures, etc.) in relation to claims submitted with miscellaneous codes.

General and Specialty Related Claim Adjudication Policies and Reimbursement Guidelines

New Patient Visit Frequency

According to CDT guidelines, a new patient is one who has not had services from the same practitioner or group in the same specialty in the past three years. An established patient periodic oral evaluation visit must be reported if the patient is seen, for any reason, by the same practitioner or member of the group with the same specialty, within the three-year timeframe. This also applies to dentists who are on-call for or covering for another dentist.

If a new patient comprehensive exam code is reported more than once by the same provider/group within the three-year timeframe, the code will automatically be denied and allowed an alternate benefit for a periodic examination.

Preventive Services

Preventive services, also known as health maintenance exams, include preventive oral examinations, related X-ray or imaging, laboratory or other diagnostic tests. Most CareFirst member contracts include a benefit for these preventive examinations, many of which are limited to twice per benefit year/annually.

For additional information, refer to the Dental Clinical Criteria, and always verify patient eligibility and benefits.

Common Limitations and Exclusions

Member contracts include limitations and exclusions, which may vary, based on regulatory requirements and/or the level of coverage purchased by the employer group. This is for information purposes only.

Below are the most common limitations used in the administration of dental care and may be combined with other policies and guidelines to ensure cost effectiveness and acceptable community standards of care. Use one of our self-service options to verify specific benefit coverage.

General Criteria

Procedures should be performed based on dental necessity and as appropriate in the diagnosis, treatment and care of the member's condition. Treatment rendered for cosmetic reasons, member convenience or services that do not meet standards of care are not eligible for benefits. General criteria for members with Indemnity contracts are as follows:

- If there is an alternative dental procedure(s) that meets generally accepted standards of professional dental care for a covered member's condition, the benefit will be provided based upon the lowest cost alternative.
- CareFirst will provide benefits for covered services for a course of treatment up to 90 days after the date a member's coverage terminates, if the treatment:
  - Begins before the termination date of the member's coverage.
  - Requires two or more visits to the dentist's office on separate days (this provision does not apply to orthodontic services).

Diagnostic/Preventive Services

The following benefits are generally limited to twice per benefit plan year:

- Oral exams (comprehensive oral evaluations are limited to one in a three-year period per provider)
- Routine prophylaxis
- Bitewing radiographs (up to two bitewing procedures/benefit plan year)
- Topical fluoride (age limits may apply)

The following benefits are generally limited to once per 36 months:

- One set of full mouth radiographs, or one panoramic film and one set of bitewing radiographs, in addition to those mentioned above
- One cephalometric radiograph
- Sealants on permanent molars, one per tooth (age limits may apply)

The following benefits are limited to once per five years:

- Space maintainers for prematurely lost cuspid to posterior deciduous teeth

LabCorp for Dental Biopsies

LabCorp is the only national laboratory that CareFirst BlueChoice members can use when they require biopsies of the oral cavity or surrounding tissue. If pathology reports are reviewed by a lab other than LabCorp for these members, they will have unnecessary out-of-pocket expenses.

All dental laboratory work for members who have BlueChoice medical plans must be performed by LabCorp.

Teledentistry

Telemedicine services refers to the use of a combination of interactive audio, video or other electronic media used by a licensed healthcare provider for the purpose of diagnosis, consultation or treatment consistent with the provider's scope of practice. Use of e-mail, online questionnaires or fax is not considered a telemedicine service.

The ADA and CareFirst have defined synchronous teledentistry (D9995) as a real time encounter, interactive, with both audio and visual components. The use of asynchronous teledentistry (D9996) will not be a covered encounter when used without subsequent real time audio and visual encounters for encounters for emergencies and urgent dental care during this public health crisis.

The ADA has compiled information on how to perform these services and has provided additional guidance on how to bill for teledentistry services. We will not provide a benefit for photographs, streamed or recorded video or any other costs of the actual telemedicine technology. We consider this technology as equivalent to your in-office fixed costs.

CareFirst's coverage for audio-visual teledental visits will be limited to the problem-focused exam (D0140) and follow up (D0170), with D9995 considered inclusive to the telehealth service. If you and your patient determine that an office visit with you is necessary to resolve the problem, the in-person evaluation at your office on the same date of service will be considered inclusive to the telemedicine evaluation completed earlier in the day.

One evaluation will be covered per patient per date of service. For problem-focused telemedicine evaluations, please submit the appropriate code, D0140 or D0170, and your usual fee. Add D9995 to identify the synchronous telemedicine encounter and include a brief description of the patient's emergency problem in the remarks section. CareFirst will pay based on the contracted fees and the patient's plan design.

Note: D9995 is a non-reimbursable line item on the claim but allows you, your patient and CareFirst to distinguish that the examination/evaluation was performed using synchronous teledentistry means.

If your practice has its own telemedicine capability (audio/video), proceed with visits and bill CareFirst as normal with a place of service "02" and follow normal billing guidelines for both hard copy and electronic claim submissions. The Office for Civil Rights (OCR) at the HHS has stated that providers may use commercially available and third-party video chat services to provide telemedicine without risk that OCR might seek to impose a penalty for noncompliance with the Health Insurance Portability and Accountability Act (HIPAA) Rules. Guidance and frequently asked questions can be found on the OCR website.

The Maryland Preserve Telehealth Access Act

Effective July 1, 2021, the Maryland Preserve Telehealth Access Act expands the telehealth definition to include audio-only calls, which result in the appropriated delivery of a billable, covered healthcare service. All professional provider types are included in this mandate, but not all procedures. If a provider offers audio-only calls, they will be paid at the same rate as an in-person office screening visit (D0190), where applicable. This mandate expires June 30, 2025, and is applicable to patients enrolled in a fully insured Maryland benefit plan.

Dental providers should use D0190 with D9995 for audio-only dental telehealth visits. Audio-only teledentistry visits are covered when the patient is unable to participate in an audio-visual, synchronous visit in lieu of presenting in person to the office.

Restorative Services

The following benefits are generally limited to once per 12 months:

- Silver amalgam and composite restorations, one restoration per surface.

The following benefits are limited to once per five years:

- Dentures, full and/or partials.
- Fixed bridges, including crowns, inlays and onlays used as abutments for or as a unit of the bridge.
- Crowns, inlays, onlays.
- Stainless steel crowns (age limits may apply).

The benefit for regular denture adjustment and relining is limited to once per 36 months, but not within six months of the date of initial placement. **Please note** the following benefit limitations for immediate denture adjustment and relining:

- Initial adjustment/relining, three months after placement.
- Second adjustment/relining, within the first year.
- Third adjustment/relining, three years thereafter.

The following benefits are limited to once per 12 months:

- Recementation of crowns, inlays and/or bridges.
- Repair of prosthetic appliances per specific area of the appliance.

The following services are contract exclusions:

- Replacement of a denture, bridge or crown as a result of loss or theft.
- Replacement of an existing denture, bridge or crown that is satisfactory or that could be repaired.
- Replacement of dentures, a bridge or a crown which were paid partially or fully under the terms of the policy and five years have not lapsed from the date of placement/replacement.

Endodontic Services

The following contractual limitations generally apply:

- Pulpotomy is limited to deciduous teeth.

- Root canal therapy is limited to permanent teeth.
- Retreatment of a root canal is limited to one per tooth per lifetime.

Periodontal Services

The following benefits are generally limited to a full mouth treatment once per 24 months:

- Periodontal scaling and root planing
- Gingival curettage

The following benefits are limited to once per five years:

- Osseous surgery, including flap entry and closure; one full mouth treatment.
- Gingivectomy; one full mouth treatment.
- Limited or complete occlusal adjustments in connection with periodontal treatment.
- Mucogingival surgery limited to grafts and plastic procedures, one treatment per site.

Oral Surgical Services

Some oral surgical procedures may have a benefit under a member's medical policy, including:

- Services related to the treatment of temporomandibular disorder (TMD)
- Treatment of fractures, simple or compound
- Orthognathic surgery
- Accidental injury
- TMJ

The following benefits are available based on the dental policies outlined below:

- Both the extraction of a tooth and surgical removal of a cyst, only if the cyst is > 1.25cm. If the cyst measures < 0.5cm, a benefit is provided for the extraction only; the cyst is considered inclusive.
- Alveoplasty, only if three or more teeth in a quadrant were extracted
- Frenulectomy and soft tissue graft performed on the same day.
  Note: the benefit is provided for the graft only and the frenulectomy is considered inclusive. Services rendered to members for the treatment of TMD, including radiographs and/or tomographic surveys, are not covered under the dental policy.

The following services are subject to professional review and the benefit is available based on individual consideration:

- Oroantral fistula closure
- Tooth reimplantation and/or stabilization of accidental evulsed or displaced tooth and/or alveolus
- Tooth transplantation
- Surgical repositioning of teeth
- Vestibuloplasty, covered under ACA plans only

Anesthesia Services

A benefit for general anesthesia and intravenous sedation is provided if:

- Required for oral surgery and,
- Administered by a dentist who has a permit to administer conscious sedation or general anesthesia.

The following oral surgical services are eligible for general anesthesia and/or intravenous sedation if the oral surgery is covered under a member's policy:

- Apicoectomy
- Surgical extractions (two or more) and soft tissue, partial/completely bony
- Root resection
- Hemisection
- Surgical removal of residual tooth roots (cutting procedures)
- Osseous surgery
- Oroantral fistula closure
- Bone replacement graft
- Tooth reimplantation
- Pedicle soft tissue graft
- Free soft tissue graft
- Surgical exposure of impacted or unerupted tooth
- Alveoloplasty
- Vestibuloplasty
- Removal of odontogenic/nonodontogenic cyst or tumor
- Removal of exostosis
- Incision and drainage of abscess – intraoral/extraoral soft tissue
- Excision of hyperplastic tissue

Benefits for local anesthesia are considered inclusive to the primary procedure(s) performed and a separate benefit is not provided.

Orthodontic Services

A benefit for orthodontic treatment is provided to members and will continue to be paid as long as the following criteria is met:

- Orthodontic coverage is provided in the member's contract.
- The member remains eligible to receive orthodontic benefit.
- The orthodontic treatment is to reduce or eliminate an existing malocclusion.

Diagnostic Records

Pre-treatment records are important tools for orthodontists to make an accurate diagnosis and develop the treatment plan. The records include study models, diagnostic photographs, cephalometric and panoramic films. Use CDT Procedure Codes:

- Panoramic Radiograph – D0330
- Cephalometric Radiograph – D0340
- Diagnostic Casts – D0470
- Oral/Facial Images – D0350/D0351

Active Comprehensive Orthodontic Treatment

Active orthodontic treatment begins with the insertion of the appliance. The comprehensive treatment procedure codes include the placement of the appliance, adjustments/follow-up (monthly visits), the removal of the appliance, construction of the retainer and any other follow-up treatment to maintain the achieved anatomical, functional and aesthetic results and/or stabilize the dentition after removal of the appliance. The dentist should select the comprehensive CDT Procedure Code that is most appropriate to the patient's current stage of dentofacial development:

- D8070 – Comprehensive orthodontic treatment of the transitional dentition
- D8080 – Comprehensive orthodontic treatment of the adolescent dentition
- D8090 – Comprehensive orthodontic treatment of the adult dentition

Standard Dental Billing Guidelines

For members covered under standard dental plans, the benefit for the orthodontic treatment is provided in quarterly or monthly installments, based on the employer group's specifications and determined on the anticipated length of treatment. When submitting the initial claim for orthodontic treatment, include the following information:

- Banding Date
- Length of treatment (in months)
- Total charge for the treatment

Dentists will submit one claim for the entire orthodontic course of treatment. An initial payment for comprehensive treatment is made upon banding and consists of the lesser of 25 percent of the Allowed Benefit or 25 percent of the member's orthodontic lifetime maximum.

Payments of the remaining allowance will be spread throughout the remaining months of treatment. We will automatically make quarterly or monthly payments based on the existing treatment plan. The benefit will continue to be paid until treatment is completed if the following conditions exist:

- The policy remains active
- The member remains covered under the policy
- The member has not reached the age of ineligibility as defined in the contract
- The member's lifetime maximum has not been exhausted
- The member continues to be under active treatment

Billing Guidelines for Individual Select Preferred

For members covered under the Individual Select Preferred (ISP) plan, claims for the initial consultation and diagnostic records should be submitted to CareFirst for reimbursement. Claims should not be submitted for the comprehensive treatment. These services can be billed directly to the member at the time of banding.

Billing Guidelines for DHMO

For members covered under the Dental HMO (DHMO), providers should charge the member the appropriate copayment for services based on the appropriate Member Copayment Schedule, available on CareFirst Direct. Specialists should submit one claim for the entire orthodontic course of treatment and one payment will be made for the difference between the member's copayment and the provider's Orthodontic Guarantee. One payment will be made for the difference between the member's copayment on each service, and the provider's orthodontic pricing guarantee.

Billing Guidelines for CareFirst Administrators

For members who hold dental insurance through CareFirst Administrators (CFA), our third-party administrator, CFA processes orthodontic claims by paying out 25% of the entire benefit at banding. Dentists are then required to submit a monthly claim (using comprehensive codes, not D8670) for the remainder of the treatment. This is an affiliate company of CareFirst, and an independent licensee of the Blue Cross and Blue Shield Association.

Billing Guidelines for BCBS FEP Dental

BCBS FEP Dental recommends a pre-treatment estimate (PTE) be submitted prior to treatment for orthodontic services. A PTE is not a guarantee of benefits. PTEs can be sent directly to BCBS FEP Dental and do not need to be sent to the primary medical carrier first.

Dental Services Under the ACA

Health Insurance Exchanges in Maryland, the District of Columbia, and Virginia established under the Affordable Care Act (ACA) enroll individuals and families who purchase health insurance plans offered by CareFirst and other carriers. CareFirst's medical plans offered in the individual and small group markets (both on and off of the Exchange) have the mandated 10 Essential Health Benefits (EHB), which include a pediatric dental benefit. They do not include an adult dental EHB; dental coverage for adults age 20 and older must be purchased through a separate dental plan.

As part of the ACA, certain dental services for children must be included as covered benefits for the member when using in-network providers.

ACA Pediatric Orthodontia

The pediatric dental orthodontic benefit requires prior authorization for medical necessity before any treatment begins. Diagnostic records and the examination do not require a PTE. If the treatment does commence before authorization is received from CareFirst, no benefit will be allowed.

Orthodontic benefit provisions are slightly different in the ACA dental contracts for Maryland, the District of Columbia, and Virginia.

- Maryland and the District of Columbia use the Handicapping Labiolingual Index (HLD) with a threshold value of 15 to qualify for benefits
- Virginia requires the Salzmann Deviation Index with a threshold value of 25 to qualify for benefits

The pediatric dental orthodontic benefit requires prior authorization for medical necessity before any treatment begins. However, providers may assess the patient prior to submitting a PTE. If the provider's assessment of the case results in a low score, there is no requirement to submit the case for review.

Primary Carrier ACA Embedded Pediatric Dental

In cases where dual orthodontic coverage exists between a standalone dental benefit option and a medical plan which includes pediatric dental (ACA embedded pediatric dental), the provider should determine if the patient's orthodontia is medically necessary based on the requirements for the ACA embedded pediatric dental plan (HLD or Salzmann indices).

If the provider's assessment of an orthodontic case results in a low score, there is no requirement that the case must be submitted for review. In these cases, providers should expect to receive two Notices of Payment (NOPs): one reflecting a denial under the patient's pediatric dental plan, and a second NOP showing that the treatment has been processed under the standalone dental plan.

Orthodontic Maximum

Orthodontic benefits are based on the member's contract. The orthodontic maximum amount(s) varies by account. Use one of our self-service options to verify specific benefit coverage. Members seeking treatment from a participating orthodontist are responsible for the coinsurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst Allowed Benefit.

Orthodontic Treatment In Progress

Members enrolled after the placement of the appliance may be eligible to receive orthodontic benefits for the treatment in progress. Use one of our self-service options to verify specific benefit coverage. Providers should submit the total charge, total length of treatment and original banding date. CareFirst will prorate the treatment plan and consider a benefit based on the cost of the remaining treatment. All expenses incurred prior to the effective date of the contract are not eligible for reimbursement and are considered to be the member's responsibility.

Members Transferring from Another Orthodontist

New orthodontists must submit a claim indicating the anticipated number of months in the treatment plan and include the charge for the treatment and banding date, if appropriate. A payment schedule will follow the monthly or quarterly installments; however, the initial allowance of 25 percent will not apply, and the benefit will be limited to the remaining lifetime maximum amount.

Dental Guidelines for Dental Implants

The dental implant policy applies only to members covered under the Standard Traditional and Preferred dental products. Some contracts may vary and, therefore, exclude dental implants or may limit coverage of dental implants to the replacement of one missing tooth as an Alternate Benefit in lieu of a three-unit bridge.

Clinical Guidelines

- All dental implants and related services are subject to review by the dental director.
- A benefit is subject to medical necessity. The treatment must meet the criteria and be clinically appropriate based on accepted standards of dental care.
- Dental Implants are not recommended nor will a benefit be provided for young patients who have potential for future growth and development of their oral structures.

- A benefit applies only to the replacement of natural missing teeth.
- An implant must be necessary to restore the dental arch to form and function.
- A benefit may be considered only for teeth #2–#15 and #18–#31.
- An alternate benefit may be considered if there is a more conservative, less expensive treatment available that meets the standard of care.
- A benefit will not be provided to replace a supernumerary tooth.
- A benefit will not be provided to replace a tooth or teeth in space(s) not created by a missing natural tooth or teeth or created by a supernumerary tooth.
- A benefit may be considered only when the implant permits replacement of a functional tooth.

Implant Quality Assurance

Note: Specific requirements of a member's dental benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels.

Provider Guidelines

CareFirst strongly encourages providers to submit PTEs and required attachments electronically or submit using the current 2012© American Dental Association claim form. Check the box for "Dentist's pre-treatment estimate" and leave the date of service blank

The appropriate supporting documentation must be submitted with the pre-treatment estimate or claim. Radiographs must be of diagnostic quality and properly labeled with the patient's name, dentist's name and address. Providers may also electronically transmit the supporting documentation via National Electronic Attachment, Inc. (NEA). Please include the NEA document number in the Remarks section on the ADA claim form if you submit by mail. For more information, contact NEA at 800-782-5150 and select option #2.

Member Contractual Limitations and Exclusions for Standard Traditional and Preferred Dental Members

All existing contractual provisions, limitations and exclusions apply. Specifically:

- Major restorative—services limited to once per 60 months (five years) or as stated in the member's contract.
- Replacement of an existing denture or bridge that is determined by CareFirst to be satisfactory or repairable.
- Implant services performed for elective and/or cosmetic reasons will not be covered.
- Benefit is subject to member's annual contract maximums.

Financial Responsibility

CareFirst member contracts state that CareFirst has the right to allow the least costly alternative treatment to treat the presenting condition, if a professionally acceptable alternate exists. This limitation does not preclude the doctor or patient from a more expensive treatment plan; however, the doctor and patient must agree in advance how they are going to handle the additional cost and the member must be

informed of and agree to the member liability. Providers may request a PTE along with supporting required documents for clinical review prior to starting the treatment.

Billing for Services Rendered to Patients

Licensed providers may only report and submit claims for services rendered to patients that the practitioner individually and personally provides. CareFirst contracts with participating providers to perform services for an agreed upon fee. It is that provider, and only that provider, who can submit a claim and receive reimbursement.

As outlined in the CareFirst medical record documentation standards policy, 10.01.013A, in the Medical Policy Reference Manual, participating providers must accurately and completely document the medically necessary services they perform in the appropriate medical record and sign the document(s) attesting that they performed the service. Guidelines to create and maintain clinical and financial patient records are outlined by the ADA as well as notated in state regulations.

Special Services

Services rendered during off-hours, on weekends, on holidays, on an emergency basis when the office is typically closed and must be opened to treat the patient may be billed with a narrative using CDT code D9440. This service may not be covered under a patient's plan and would be the financial responsibility of the patient.

Sleep Disorders

CareFirst provides benefits for the diagnosis and management of sleep disorders, including oral appliances. Most sleep disorder services can be provided in the home setting. Refer to medical policy 2.01.018, Sleep Disorders in the Medical Policy Reference Manual for details and authorization requirements.

The D.C. Minor Consent for Vaccinations Amendment Act of 2020

CareFirst has implemented the D.C. Minor Consent for Vaccinations Amendment Act of 2020 (the Act). This legislation allows minors, 11 years of age or older, to receive a vaccine, if the minor is capable of meeting the informed consent standard and the vaccination is recommended by the United States Advisory Committee on Immunization Practices (ACIP) and provided in accordance with the United States Advisory Committee on Immunization Practices' recommended vaccinations schedule.

The Act applies to all age-appropriate vaccines including COVID-19. Vaccine(s) given under the Act must be administered in Washington, D.C.

Providers are not required to administer vaccines to minors without parental consent. However, should the elect to do so, the Act requires that providers notify CareFirst as well as seek reimbursement directly from the insurer for vaccinations given without parental consent, pursuant to the Act.

To support the Act, CareFirst developed the following process so we can suppress the EOB statement normally sent to the parent/guardian.

To ensure proper reimbursement and suppression of the corresponding EOB for vaccines administered under this Act, providers must complete both the D.C. Minor Consent Notification Form and the appropriate paper claim form.

Note: Claims for vaccines administered under this Act should not be sent electronically and must be sent on one of the paper forms below:

- Professional claims – please use the current version of the CMS-1500 form (version 02/12) on original red-ink-on-white-paper.
- Institutional claims – please use the current version of the UB-04 form on original red-in-on-white-paper.

Providers must submit both the completed notification form and correct paper claim form by mail to the following address:

CareFirst BlueCross BlueShield
Privacy Office
P.O. Box 14858
Lexington, KY 40512

Please note: Providers must follow this process exactly as outlined or CareFirst will not be able to suppress the EOB.

Refer to the Frequently Asked Questions and instructions for the paper claim form process for more information.

Radiology/Imaging

Dental X-rays (standard)

Dental x-rays are standard of care to visualize various parts of the dental complex that cannot be seen with the naked eye during an examination. While CareFirst has criteria for frequency and type of radiographs, it is imperative that the practitioner exposes the patient as little as clinically necessary to be able to diagnose and treat the patient. The ADA describes the need to take the individual patient, their clinical history, etc. into consideration when prescribing x-ray exposure. In general, if a procedure is being performed and radiographic verification of size, fit, etc. is necessary, subsequent radiographs of the same tooth/area will be considered inclusive, (e.g., during endodontic treatment, or crown seating with a test for marginal integrity).

Dental Cone Beam Computed Tomography (CBCT) imaging is currently not a covered procedure for dental benefit-covered services.

Intra and extraoral photography is considered inclusive to the primary service(s) performed and fees for those cannot be charged to the patient, except as part of the orthodontic case workup. Use of these photographs is helpful when submitting a claim on behalf of a patient if it most clearly demonstrates the clinical need for the primary procedure.

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. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), 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 DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., 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.

All other trademarks are property of their respective owners.

CareFirst
Family of health care plans

Chapter 8: Medicare Advantage

Provider Network Overview

CareFirst Advantage, Inc. is the entity that provides the network and products servicing our Medicare Advantage (MA) Members and integrated Medicare Advantage Prescription Drug (MA-PD) plans.

CareFirst BlueCross BlueShield Medicare Advantage participating providers play an integral role in managing and transforming care for our enrollees. Together, we can provide an integrated system of coordinated, efficient and quality care.

The provider networks for CareFirst's Medicare Advantage plans are different than our commercial dental networks. You must sign a separate agreement to be included in the MA dental networks.

Participating Provider Responsibilities

Providers participating in CareFirst must comply with the following responsibilities:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers, and maintaining a medical record that meets CareFirst standards.
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members.
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special healthcare needs.
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members.
- Provide hearing interpreter services on request to members who are deaf or hard of hearing.
- Participate in and cooperate with CareFirst in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by CareFirst.
- Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 11 years.
- Support, cooperate and comply with CareFirst Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- Treat all members with respect and dignity, provide appropriate privacy and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons.
- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered.

- Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary.
- When clinically indicated, contact members as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local policy, social services agencies and poison control centers to provide high-quality patient care.
- Document in a prominent place in medical record if individual has executed advance directives.

Provider Network Participation

Enrollment and Participation in the Medicare Advantage Networks

CareFirst Advantage, Inc. offers eligible providers an opportunity to participate in the CareFirst MA dental networks, which is utilized for the CareFirst BlueCross BlueShield Medicare Advantage products. Network providers provide care to CareFirst BlueCross BlueShield Medicare Advantage members, and CareFirst reimburses for covered services at the agreed upon payment rate.

Providers who have opted out of or have been excluded or precluded from the Medicare program are not eligible.

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

For questions regarding credentialing or participation, please contact CareFirst's Dental Credentialing Department at (443) 921-0676. For more information on credentialing, please refer to Chapter 3: Network Requirements.

Marketing of Medicare Advantage

Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V, and the CMS Managed Care Manual, Chapter 3, Medicare Communications and Marketing Guidelines (MCMGs), including, without limitation, materials governing "Provider Initiated Activities" in Section 60.1.

CMS holds plan sponsors, such as CareFirst, responsible for any marketing materials developed and distributed on their behalf by their contracting Providers. Providers are not authorized to engage in any marketing activity on behalf of CareFirst without the prior express written consent of an authorized CareFirst representative, and then only in strict accordance with such consent.

Product Information

Medicare Advantage, also known as Medicare Part C, is a health plan approved by Medicare and offered by private insurance companies like CareFirst. MA plans bundle Medicare Part A (hospital/facility costs) and Medicare Part B (doctor/labs/other costs) with added benefits and services, including dental.

CareFirst currently offers individual and group Medicare Advantage plans—that is, Medicare Advantage plans which individuals can purchase, as well as Medicare Advantage plans which employer groups can purchase for their retiree populations.

Individual Medicare Advantage (HMO)

Plan Designs

Both individual Medicare Advantage plans include embedded dental coverage. The CareFirst BlueCross BlueShield Advantage Core medical plan includes embedded basic preventive dental care and treatment.

CareFirst offers two HMO options for individual Medicare Advantage enrollees:

- CareFirst BlueCross BlueShield Advantage Core
- CareFirst BlueCross BlueShield Advantage Enhanced

The CareFirst BlueCross BlueShield Advantage Core plan includes preventive care and treatment only.

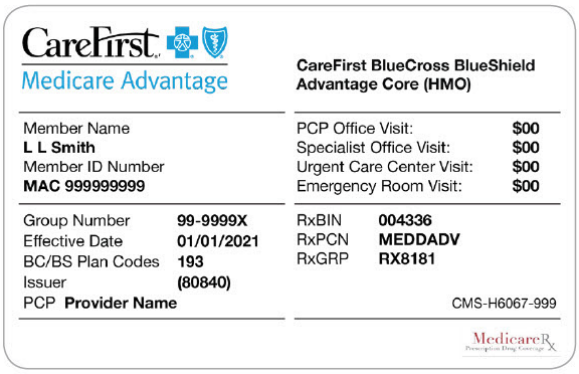
The CareFirst BlueCross BlueShield Advantage Enhanced medical plan includes preventive dental care and treatment, plus some benefits for minor palliative, minor restorative, periodontic and simple extraction services.

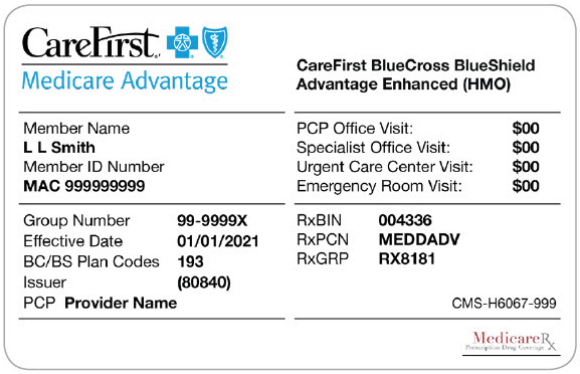
Members who choose the Enhanced plan hold a more comprehensive dental benefit package which includes major restorative and major oral, endodontic, major periodontic, prosthodontic, and non-routine dental care.

Member Identification

The prefix for the CareFirst BlueCross BlueShield Individual MA plan is 'MAC'.

Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. CareFirst On Call is not available for MA inquiries.


CareFirst Medicare Advantage
CareFirst BlueCross BlueShield Advantage Core (HMO)
Member Name
L L Smith
Member ID Number
MAC 999999999
PCP Office Visit: $00
Specialist Office Visit: $00
Urgent Care Center Visit: $00
Emergency Room Visit: $00
Group Number 99-9999X
Effective Date 01/01/2021
BC/BS Plan Codes 193
Issuer (80840)
PCP Provider Name
RxBIN 004336
RxPCN MEDDADV
RxGRP RX8181
CMS-H6067-999
MedicareRx


CareFirst Medicare Advantage
CareFirst BlueCross BlueShield Advantage Enhanced (HMO)
Member Name
L L Smith
Member ID Number
MAC 999999999
PCP Office Visit: $00
Specialist Office Visit: $00
Urgent Care Center Visit: $00
Emergency Room Visit: $00
Group Number 99-9999X
Effective Date 01/01/2021
BC/BS Plan Codes 193
Issuer (80840)
PCP Provider Name
RxBIN 004336
RxPCN MEDDADV
RxGRP RX8181
CMS-H6067-999
MedicareRx

The membership ID cards that individual MA members will bring to the office will not contain any typical dental indicators, although all individual MA members' plans include dental coverage. We encourage dental providers to verify eligibility and benefits on CareFirst Direct as you do today for other CareFirst products.

Group Medicare Advantage

Introduction

The Centers for Medicare and Medicaid Services (CMS) allows private insurance carriers, such as CareFirst to develop Employer Group Waiver Plans (EGWP) Medicare Advantage plans. CareFirst customizes the plans for employer groups who offer these plans to their retirees. These plans are known as Group

Medicare Advantage plans and offer all the same coverage as Original Medicare, plus additional benefits such as dental, vision, hearing, fitness, and more.

Employer groups can choose if they want to cover additional dental services such as preventive and comprehensive benefits through the Group Medicare Advantage plan.

Dental providers who participate in our Medicare Advantage PPO Dental Provider Network are considered in network for Medicare Advantage PPO members enrolled in any of CareFirst's Medicare Advantage PPO plan offerings.

Plan Designs

CareFirst offers Group Medicare Advantage or Medicare Advantage Prescription Drug plans based directly to Employer Groups for their retirees, spouses, or dependents that are eligible for Medicare (Part A and Part B).

Some groups will have dental coverage and the plan names can be either:

- CareFirst BlueCross BlueShield Group Advantage (PPO)
- CareFirst BlueCross BlueShield Group Advantage without Drugs (PPO)

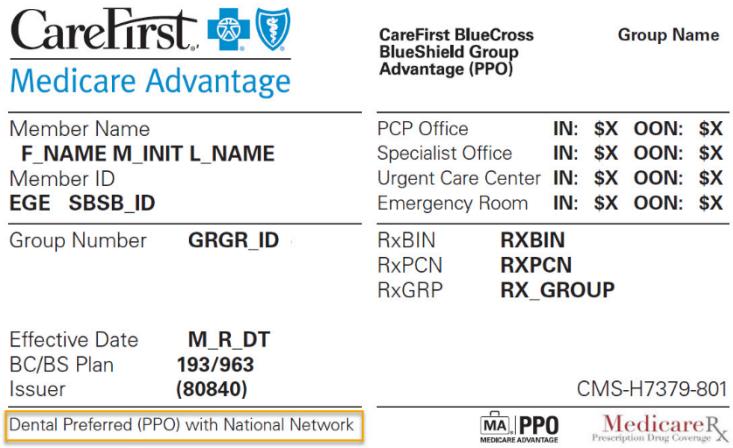
The dental design for the employer groups that have coverage through their Group Medicare Advantage plan is mirrored from their current commercial/retiree benefits with some adjustments. It is key to review the dental benefits for the employer groups that have chosen to obtain coverage with us using CareFirst Direct.

Importantly: Group MA dental benefits are displayed on CareFirst Direct in the same way it is for commercial dental plans.

Member Identification

The prefix for CareFirst BlueCross BlueShield Group Medicare Advantage is 'EGE.'

Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. CareFirst on Call is not available for MA inquiries.


CareFirst
Medicare Advantage

CareFirst BlueCross BlueShield Group Advantage (PPO)

Group Name

Member Name
F_NAME M_INIT L_NAME
Member ID
EGE SBSB_ID

PCP Office	IN:	$X	OON:	$X
Specialist Office	IN:	$X	OON:	$X
Urgent Care Center	IN:	$X	OON:	$X
Emergency Room	IN:	$X	OON:	$X

Group Number GRGR_ID

RxBIN RXBIN
RxPCN RXPCN
RxGRP RX_GROUP

Effective Date M_R_DT
BC/BS Plan 193/963
Issuer (80840)

CMS-H7379-801

Dental Preferred (PPO) with National Network

MA PPO MEDICARE ADVANTAGE

MedicareRx Prescription Drug Coverage

Reminder: Always check your Group MA patient's member identification card. The **'Dental Preferred (PPO) with National Network'** indicator will be your source of truth regarding whether your patient's MA coverage includes dental benefits.

For more complex inquiries regarding your Individual or Group Medicare Advantage patients, you can contact our dedicated Medicare Advantage Provider Services unit at 833-493-0535.

Claims Submission

We encourage providers to submit claims electronically as you do today for other CareFirst products. We will also accept paper claims which can be submitted to the address found in the Dental Claims and Service Reference Guide.

Appeals and Grievances

Introduction

CareFirst BlueCross BlueShield Medicare Advantage encourages our members to let us know if they have questions, concerns, or problems related to covered services or the care that they receive. Members are encouraged to first contact Member Services at 855-290-5744 for assistance. For information about the rules for making complaints in different situations, please review the information in this section.

Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complain, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

What are Appeals and Grievances?

Members have a right to request a coverage determination. If the plan denies coverage for the requested item or service, they have the right to appeal and ask us to reconsider the decision. They also have a right to file a grievance (also called a complaint) about the health plan.

Appeal

An appeal can be filed by a member to ask the plan to review a decision made on healthcare services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage. For example, a member may file an appeal if:

- We refuse to cover or pay for services a member thinks we should cover.
- We or one of our plan providers refuses to render a service that a member believes should be covered.
- We or one of our plan providers reduces or cuts back on services or benefits that a member has been receiving, or
- The member believes that we are stopping coverage of a service or benefit too soon.

Grievances

A grievance is any complaint or dispute expressing dissatisfaction with any aspect of our operations, including dissatisfaction with our Medicare plans, Member Services, a provider, or treatment facility that does not involve a coverage determination.

As an example, grievances may be filed if a member is experiencing a problem regarding:

- The quality of care by a plan provider
- Waiting times for appointments or in the waiting room
- Provider behavior or the behavior of the provider's office staff
- Not being able to reach someone by phone to get the information needed, or
- The cleanliness or condition of a provider's facilities

Members can file a grievance within 60 calendar days of the date of the circumstance giving rise to the grievance.

The grievance will be sent to our Appeals and Grievance Department for handling. The plan's response may take 30 days or up to 44 days if more information is needed and an extension is granted.

Submitting a Grievance

Concerns about the plan are important to us. For immediate attention and assistance in resolving their concerns, members can call Member Services to submit a grievance verbally.

Call: 855-290-5744

Members can also fax or mail their grievance in writing to us at:

Fax: 443-753-2298

Mail:
CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

Provider Payment Disputes

Member Appeals vs. Provider Payment Disputes

Contracted providers do not have appeal rights on the provider's behalf. If there is a member liability or for any pre-service denials, a provider can file an appeal on a member's behalf. In these instances, the provider should follow the member appeal process above.

Providers can dispute a payment they believe was paid incorrectly or not paid at all. If a provider receives a service that is denied in part or in whole, with no member liability, and the provider disagrees with the decision then the provider can dispute that payment.

CareFirst BlueCross BlueShield Medicare Advantage has a two-level payment dispute process.

First Level Contracted Provider Disputes

When a provider disagrees with a payment amount or with a payment denial with no member liability, the provider may call CareFirst MA provider service for a review of the payment. The provider must give a reason for the payment dispute. Our provider service team will research the issue and follow up with the provider.

- If the response satisfies the provider, the verbal dispute/service case is considered closed.
- If the provider continues to disagree with the payment, they may file a second level provider dispute.

Second Level Provider Disputes

- To submit a provider dispute, contracted providers must make a written request which must be received by the plan within:
  - 180 calendar days of the date of their denial notice denying a post-service claim. When an authorization has been denied, provider must adhere to the 60-day time frame, the 180 days once the claim has denied does not apply.
- When submitting a written request for a payment dispute, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member's medical records containing all pertinent information regarding the services rendered by the provider.
- All post service payment provider appeal reviews will be completed within 60 days of the date the written request was received.
- The provider will be informed of the decision in writing by mailing notification within 60 days from receipt. If the appeal is approved, payment will be issued within 60 calendar days of notification.

Acting as an Authorized Representative

CareFirst BlueCross BlueShield Medicare Advantage will accept appeals made by the member and/or his/her authorized representative or the prescribing/treating physician or other prescriber or a nonparticipating provider involved in the member's care. CareFirst BlueCross BlueShield Medicare Advantage will accept grievances made by the member and/or his/her authorized representative. The member may appoint:

- A family member
- A friend
- A lawyer
- An unrelated party such as an advocate
- Physician or provider
- Dentist
- Court appointed guardian
- Durable Power of Attorney
- Healthcare Proxy

To appoint a representative, members and their representative must complete the CMS Appointment of Representative (AOR) form and send it to:

Fax: 443-753-2298

Mail:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

CareFirst BlueCross BlueShield Medicare Advantage will not require information beyond what is included in the AOR form of the requirements outlined below for an equivalent written notice. An equivalent written notice includes the following:

- Name, address, and telephone number of the member;
- Name, address, and telephone number of the appointed individual;
- Member's Medicare Beneficiary Identifier, or Plan ID number;
- The appointed Representative's professional status or relationship to the party;
- A written explanation of the purpose and scope of the representation;
- A statement that the member is authorizing the Representative to act on his or her behalf for the claim(s) at issue;
- A statement authorizing disclosure of individually identifying information to the Representative;
- A statement by the individual being appointed that he or she accepts the appointment; and
- Notice is signed and dated by both the Enrollee and the individual being appointed.

CareFirst BlueCross BlueShield Medicare Advantage will accept the AOR form with electronic signatures if the form is submitted through a secure portal or other secure electronic means provided applicable regulatory and CMS website/electronic communication requirements are met. AOR forms contain a Member's Medicare Beneficiary Identifier (MBI) or Plan ID number and will be treated as protected information by CareFirst BlueCross BlueShield Medicare Advantage.

CareFirst BlueCross BlueShield Medicare Advantage will file and make accessible for use a copy of the signed AOR form, or equivalent written notice, for future grievances, coverage requests, or appeals submitted within the complaint timeframe. CareFirst BlueCross BlueShield Medicare Advantage will include a copy of the AOR form, or equivalent written notice, when sending a case file to an Independent Review Entity (IRE), or any other entity other than CareFirst BlueCross BlueShield Medicare Advantage.

The Representative form is valid for one year from the date it has signatures for both the Enrollee and the appointee, unless sooner revoked. If the Enrollee would like the same individual to continue serving as an appointed Representative after one year, the Enrollee must reappoint that person by submitting a new AOR form to CareFirst BlueCross BlueShield Medicare Advantage.

We will keep the form as valid for the life of a grievance, coverage request, or appeal if the grievance, coverage request, or appeal was received within one year of the date a Representative form is signed by both the Enrollee and appointee.

It is important to note that the appeals process will not commence until CareFirst BlueCross BlueShield Medicare Advantage receives a properly executed AOR or for payment appeals from non-participating providers, a properly executed Waiver of Liability statement.

Member Appeals for Coverage or Payment of Other Medical Services

After CareFirst BlueCross BlueShield Medicare Advantage has made a coverage determination to not approve or pay for services a member believes should be covered or provided, the members or their authorized representative may file an appeal.

This would be a standard appeal for benefits (pre-service appeal) or payment of a claim (payment appeal).

Payment Appeals

A payment appeal is an appeal for a service that has already been received and the initial decision denied payment for the item or service. Members can file a standard payment appeal within 60 calendar days of the date of the notice of our initial determination. That timeframe may be extended if good cause exists.

All standard claims payment appeals must be submitted in writing to:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

Standard Pre-Service Appeals

For more information, refer to our Medical Provider Manual.

Standard Appeal Timeframes

If a standard appeal is filed, we will send a decision within:

- 30 days if the appeal is regarding a pre-service request for coverage of a benefit or service that a member wants to receive.
- 60 days for an appeal for payment for a service that was already received.

Decisions on Appeals

A payment appeal must be decided within 60 days. If the payment is approved upon appeal the payment must be issued within the 60 days. If the payment denial is upheld in full or in part, the case must be forwarded to the IRE for review.

For a standard pre-service review, when care has not yet been provided, CareFirst BlueCross BlueShield Medicare Advantage must finalize the appeal within 30 days or sooner if the member's health condition warrants. If the request is for a Medicare Part B prescription drug not yet received, CareFirst BlueCross BlueShield Medicare Advantage must finalize appeal within 7 calendar days of receipt of an appeal. If additional information is needed to complete the appeal review the timeframe for completion can extend up to 44 calendar days.

For expedited pre-service appeals regarding medical care, CareFirst BlueCross BlueShield Medicare Advantage has up to 72 hours to make a decision, but will make it sooner if the member's life, health, or ability to regain maximum function requires it. All adverse reconsideration decisions are automatically forwarded to the IRE for review. Also, if we do not issue a decision within the standard or expedited timeframes as outlined above, the appeal will be automatically forwarded to the IRE for review. The IRE has a contract with CMS and is not part of CareFirst BlueCross BlueShield Medicare Advantage. The timeframe for a Part C expedited preservice review appeal can be extended up to 17 calendar days if additional information is needed to complete the appeal.

When the appeal is for services that have not been received, if the member requests an extension, or if we find that some information is needed that would be beneficial to the member in this review, an extension of up to 14 calendar days may be granted. The 14-day extension is also an option with an expedited appeal. If we do not issue a decision by the end of the extended time period, the appeal is automatically forwarded to the IRE for review. CareFirst BlueCross BlueShield Medicare Advantage cannot take extra time when the appeal is for a Part B prescription drug.

Upon completion of the reconsideration, all parties to the appeal will be notified of the outcome. If the decision is a denial, the member or authorized representative will be verbally notified that their appeal has been forwarded to the IRE.

Appeals for Coverage of Part D Drugs

CareFirst BlueCross BlueShield Medicare Advantage encourages its members to contact us through Part D Member Services with any questions concerns or problems related to prescription drug coverage. As with medical services, CareFirst BlueCross BlueShield Medicare Advantage also has processes in place to address various types of complaints that members may have regarding their prescription drug benefits.

Prescribing physicians or other prescribers who feels that an enrollee's life or health is in serious jeopardy may have immediate access to the Part D appeal process by calling 1-888-970-0917. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

For more information, refer to our Medical Provider Manual.

Member Grievances

For more information, refer to our Medical Provider Manual.

Medicare Pharmacy Management

Pharmacy Network

CareFirst BlueCross BlueShield Medicare Advantage has a nationwide network of 60,000+ pharmacies that includes major chains, independents, supermarkets and more. Members are encouraged to use pharmacies that are part of our network. The Pharmacy Directory is available at carefirst.com/Medicare.

Formulary

A formulary is a list of drugs that we cover. CareFirst BlueCross BlueShield Medicare Advantage will have one formulary option for both the Core and Enhanced plans. Members who chose the Enhanced plan will have additional coverage for generic drugs in Tier 1 during the coverage gap. This is denoted by the symbol GC in both the printable and searchable versions of the formulary.

CareFirst BlueCross BlueShield Medicare Advantage delegates formulary creation to its Pharmacy Benefits Manager (PBM), CVS Caremark®. The formulary is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other healthcare professionals who make sure the drugs on the formulary are safe and clinically effective. The Medicare formulary is also reviewed and approved by CMS. CareFirst BlueCross BlueShield Medicare Advantage chose the 5-tier generic strategy formulary. This means that there are generic options available on each tier, but also multiple tiers that have varying copays. These include:

Tier 1	Preferred Generics (lowest copay)
Tier 2	Generics (more expensive)
Tier 3	Preferred Brand (lowest copay for brand name)

Tier 4	Non-preferred Brand (more expensive brands and generics)
Tier 5	Specialty Tier (highest copay)

To ensure members are receiving the most appropriate medication for their condition(s), certain medications on the formulary may be subject to utilization management (UM). Below are some descriptions of the types of UM used in the formulary:

- Prior Authorization (PA) – We require providers to submit clinical information to ensure the medications written are appropriate for the situation. There is prior authorization on Part B and Part D drugs. This information may include diagnosis, lab results, your medical specialty and use of prior medications.
- Quantity Limit (QL) – For certain drugs, we limit the amount of the drug that a member can have. This may include the amount of medication that may be obtained per day or the amount of medication that can be obtained over a length of time. Quantity limits can apply to formulary and non-formulary drugs.
- Step Therapy (ST) – In some cases, we require members to try certain drugs before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, we may then cover Drug B.

CareFirst BlueCross BlueShield Medicare Advantage allows for extended day supplies, meaning up to 90-day fills, at both retail and mail order. We encourage you to write for these longer fill lengths for members with established histories of chronic medications such as those for hypertension, diabetes and hypercholesterolemia.

CareFirst BlueCross BlueShield Medicare Advantage also uses our PBM for mail order pharmacy. There are lower copays for members who use mail order to obtain 90-day supplies of their medications. The exception is drugs on tier 5, of which only 30-day supplies are available via the mail. Certain drugs are not available via mail order, and those are indicated on the formulary by the initials NM.

You can find the searchable and printable formularies, as well as Prior Authorization and Step Therapy criteria at carefirst.com/Medicare.

Exception Requests

Members and their doctors may submit a request for a drug exception for the following types:

- Non-Formulary Drug Exception – A request to cover a medication that is not on the formulary (drug must be Part D eligible)
- Tier Exception – A request to cover a medication that is on the formulary under a lower cost-sharing tier.
- Prior Authorization or UM Exception – A request to waive UM criteria such as prior authorization, quantity limit and step therapy

Requirements for Part B Drugs

Part B drugs include drugs that are administered in a provider's office, diabetes monitoring supplies, some vaccines and others. Just like Part D drugs, Part B medications may be governed by UM. CareFirst BlueCross BlueShield Medicare Advantage has certain medications that require Prior Authorization and/or Step Therapy. Our PBM handles initial requests, while CareFirst BlueCross BlueShield Medicare Advantage is responsible for appeals. Lists of medications, including those with PA or ST, are available at carefirst.com/Medicare.

Ensuring Appropriate Utilization of Opioids

CareFirst BlueCross BlueShield Medicare Advantage has safety edits for opioids on top of existing formulary listings and utilization management.

While those are posted in documents on carefirst.com/Medicare, these edits occur at the point of claim adjudication in three scenarios:

- Opioid naïve edit: Using a lookback period of 108 days, if a member is opioid naïve, their initial opioid prescription will be limited to a 7-day supply. The intent is to limit members who have not been exposed to opioids to help prevent problematic or habitual use
- Care coordination edit: When a member has opioid prescriptions written by three different prescribers and are at or above 90 Morphine Milligram Equivalent (MME), the claim will be rejected and allow for the pharmacist to review the situation. This ensures communication between providers, once high opioid levels are met, to prevent over prescribing
- High MME edit: When a member has opioid prescriptions written by three different prescribers and are at or above 200 MME, the claim will reject and require a coverage determination to process.

There are situations that override these edits (i.e. cancer diagnosis, multiple prescribers are all part of the same practice), but the intent is to help keep our members safe.

Transition Fills

Transition is a process to help ensure that Medicare beneficiaries can continue to receive medications they may have been taking before joining CareFirst BlueCross BlueShield Medicare Advantage, or for active members who have a history of medication use, but now the formulary coverage has changed. Below is a summary of transition information.

Description	Transition Fill Days' Supply
New and Renewing Beneficiaries	
■ Not in long-term care (LTC) ■ In LTC	■ 30 days' supply within first 90 days in the plan; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed. ■ 31 days' supply within first 90 days in the plan, oral brand solids are limited to 14 days' supply with exceptions as required by CMS guidance, multiple fills for a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed/first 90 days.
Non-LTC Resident Level of Care Change	

Description	Transition Fill Days' Supply
■ Beneficiary released from LTC facility within past 30 days	■ Non-LTC: 30 days' supply; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed.

The transition supply allows you time to talk to your patient about pursuing other options available within our formulary or for you to submit the necessary information to obtain an exception or coverage determination.

Medication Therapy Management Program

A medication therapy management (MTM) program is a CMS requirement for MA-PD plans. Pharmacists in various settings work with members to review their current medication regiments to:

- Ensure optimum therapeutic outcomes through improved medication use.
- Reduce the risk of adverse events.
- Help identify issues where medications may not work well together and address these issues with providers.

Members qualify for the program by having:

- Three or more of the following chronic illnesses: osteoporosis, chronic heart failure (CHF), diabetes, depression, asthma, chronic obstructive pulmonary disorder (COPD), cardiovascular disorders, HIV/AIDS
- Eight or more chronic medications for these illnesses
- Total drug spend of at least $4,376 annually on medications, which is projected from three months' worth of claims.

Qualified members will be enrolled automatically and can opt-out.

CareFirst BlueCross BlueShield Medicare Advantage MTM members will receive a comprehensive annual review of medications, as well as outreach for potential targeted medication reviews. You may receive letters requesting changes to your patient's medication regimens pursuant to these reviews.

Medication Reconciliation Post-Discharge

Medication reconciliation is a critical part of post-discharge care coordination for all members. CareFirst BlueCross BlueShield Medicare Advantage will perform outreach to members who have been recently discharged from the hospital and review their medications. CareFirst BlueCross BlueShield Medicare Advantage may send providers documents detailing our discussions with them and may ask for certain changes to the medication regimen discussed.

Pre-Treatment Estimate Submission Process

Dental providers and/or members who wish to obtain a clinical review for dental treatment prior to services being rendered may request a Pre-Treatment Estimate (PTE). CareFirst BlueCross BlueShield

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Medicare Advantage strongly encourages providers to submit PTEs and required attachments electronically through your clearing house and NEA. Hard copy PTEs should be submitted on a completed American Dental Association® (ADA) claim form. Check the box for "Dentist's pre-treatment estimate" and leave the date of service blank. Include the following information on the form:

- ADA Current Dental Terminology® (CDT) procedure code(s)
- Appropriate supporting documentation for the service(s) to be rendered (see Reference Guide for Required Attachments). Providers with electronic capabilities are encouraged to submit attachments via one of our preferred trading partners.

The PTE process is an optional service limited to procedures which are subject to Utilization Review and listed in the Reference Guide for Required Attachments. The PTE is not a guarantee of payment or a prior authorization.

In the PTE process, benefits will be considered based on current eligibility and clinical guidelines. Providers will be notified on the Estimate of Eligible Benefits (EEB) form indicating approval or denial. Upon completion of treatment, the EEB form should be used to request reimbursement by completing the date of service, signing and submitting the EEB to the appropriate claim submission address indicated on the form. Resubmitting supporting documentation is not necessary when submitting for reimbursement. Payment will be considered based on the following conditions:

- PTE was approved less than 270 days prior to the date service was completed
- The Member was eligible on the date service was completed
- Frequency and annual maximums have not been exceeded
- The service must be a covered benefit at the time the service was rendered.
- Services rendered are consistent with those indicated on the PTE

Note: If CareFirst BlueCross BlueShield Medicare Advantage receives a claim form for previously approved services instead of the EEB form, we will request supporting documentation. Therefore, it is best to submit your approved EEB form in lieu of the claim form.

Providers and/or members who choose not to request a PTE must continue to submit claims with the required attachments (radiographs, periodontal charting, etc.) for services requiring clinical documentation. You can check CareFirst Direct to verify if the claim has been received by CareFirst BlueCross BlueShield Medicare Advantage.

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. and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), 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 DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., 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.
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