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Administrative Support

Learn About the CareFirst Claim and Enrollment System Migration

As part of CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and all its subsidiaries and affiliates (collectively "CareFirst") dedication to our members, providers and brokers, we are undergoing a transformation initiative to enhance and streamline our claims, enrollment and billing systems.

We are moving to an updated Facets platform. The extent of the changes will be largely behind the scenes with no direct impact on your day-to-day workflows or interaction methods with CareFirst.

The process of implementing the new Facets platform will be incremental. It began with a very small number of members on the new system beginning in November of 2023. We expect this migration to be completed in 2025.

Your Facets experience in CareFirst Direct, CareFirst on Call, and your notice of payments will remain the same. With the eventual migration of all our business to the new Facets system you will notice:

- Single source of data creates **streamlined data**
- A **consistent provider experience** and increased satisfaction
- There will be **no changes** to your portals and daily workflows

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Review the Latest Utilization Management Changes—Effective January 1, 2024

CareFirst is continually working with healthcare delivery partners to optimize Utilization Management (UM) strategies to increase efficiencies and control costs while ensuring members receive affordable, quality care. Starting next year, we are implementing several changes to streamline our processes and make it easier for you to work with us. Review the table below for more information.

Date	Line of Business/Department	Summary
January 1, 2024	Commercial	Please use the following revised forms: • Durable Medical Equipment (DME) Prosthetics and Orthotics Authorization Request Form • Utilization Management Behavioral Health Request for Authorization Form **(updates coming soon)**

Date	Line of Business/Department	Summary
		• Utilization Management Request for ABA Authorization Form **(updates coming soon)**
January 1, 2024	FEP	FEP members will no longer need to be managed by an FEP Care Management (CM) for admission into a SNF, Hospice or LTAC. Those requests can be made as is done for commercial members today (via the Provider Portal or fax)

January 1, 2024	FEP Standard and Basic Option	• New authorization requirements
		  • ART (AI and IVF)
		  • Sperm/egg storage for iatrogenic infertility
		  • Hearing aids
		  • Home hospice
		  • Genetic testing
		• Removed authorization requirements
		  • Surgical treatment of congenital anomalies
		  • IMRT
		  • Proton under age 21 and younger, or when care is related to nervous system including brain and spinal cord, thymus, Hodgkins and non-Hodgkins lymphoma
		  • Stereotactic Radiosurgery (SRS) for treatment of brain and eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, paraganglia, neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions or arteriovenous malformations
		• No longer require written consent and participation in CM prior to RTC admission

Date	Line of Business/Department	Summary

		• Bariatric surgery medical policy is used for review instead of brochure
		• Gender affirming coverage changes:
		  • Coverage for breast augmentation for male to female
		  • Coverage for mastectomy beginning at age 16 for female to male
		  • Reduction in hormone therapy requirements from 12 to 6 months
		• Only one letter of documentation will be required. Previously, two were required for medical necessity review
		• There is no longer a benefit for allogenic bone or marrow stem cell transplants with following diagnoses: colon cancer, epidermolysis bullosa; glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors ependymoma, glioblastoma multiforme); ovarian cancer; prostate cancer; or autologous bone or marrow transplants for retinoblastoma.

January 1, 2024	FEP BlueFocus	• New authorization requirements
		  • Hearing aids
		  • Genetic testing
		  • Home hospice
		  • ART (AI only)
		• Removed authorization requirements
		  • Surgical treatment of congenital anomalies
		  • IMRT
		  • Proton under aged 21 and younger, or when care is related to nervous system including brain and spinal cord, thymus, Hodgkins

Date	Line of Business/Department	Summary
		and non-Hodgkins lymphoma • Stereotactic Radiosurgery (SRS) for treatment of brain and eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations • Bariatric surgery medical policy is used for review instead of brochure
January 1, 2024	Commercial/Home Care	• Requests for members that are transitioning from the Hospital • Fax requests to 410-505-2588
January 1, 2024	Medicare Advantage Post Acute Authorization	• Requests for post acute authorization • Fax number changed to 410-505-2588 • **Note:** Fax option should only be used for requests that cannot be entered in the portal.
January 1, 2024	Commercial/New Post Acute Transition of Care	• Changes include documenting level of care request on the form (ex. SNF level 1-4, Hospice, Acute Rehab, LTAC), if faxing in. • **Note**: Fax option should only be used for requests that cannot be entered in the portal.

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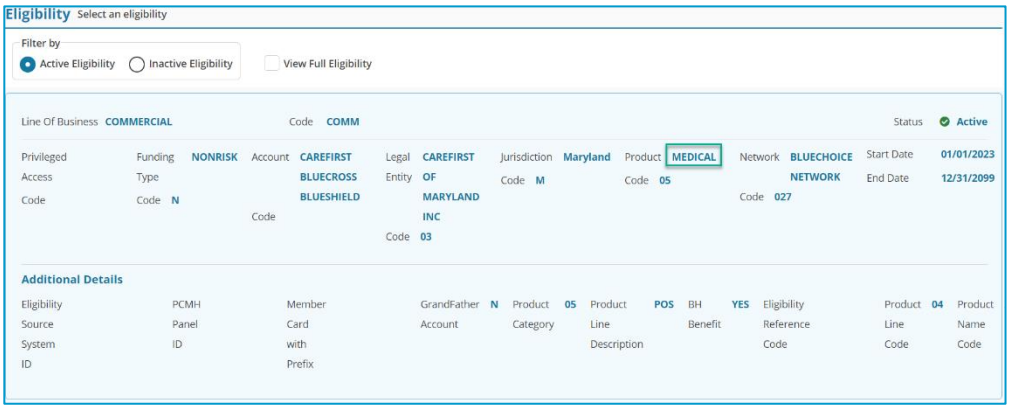
Check out the Latest Prior Authorization Entry Information and Best Practices

We realize many of our healthcare delivery partners utilize our electronic prior authorization system within our CareFirst Provider Portal regularly to assist their patients with getting the care they need. We have included a series of best practices to assist you in those efforts. Here are a few for you to take a look at today:

- **New View for Eligibility Available**

Now you can simply click on the box that indicates the Medical Product to move forward. **Note**: the box will turn light blue when selected.



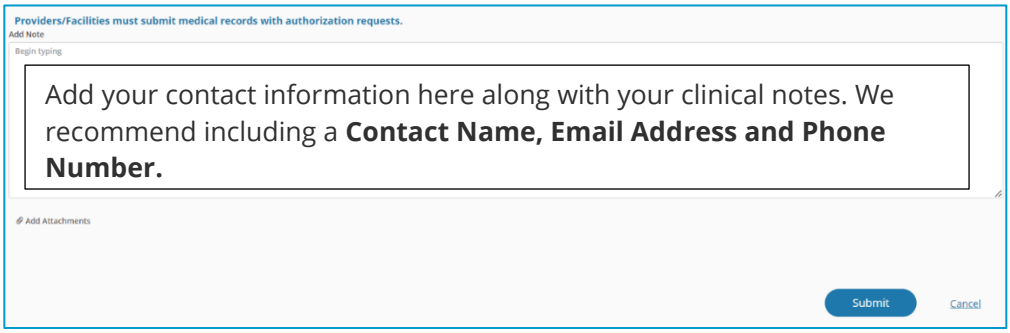
- **Upload your Clinical Documentation Electronically:**

  Clinical documentation should be attached as part of the initial online request within the prior authorization system or after the authorization has been submitting for concurrent review needs.

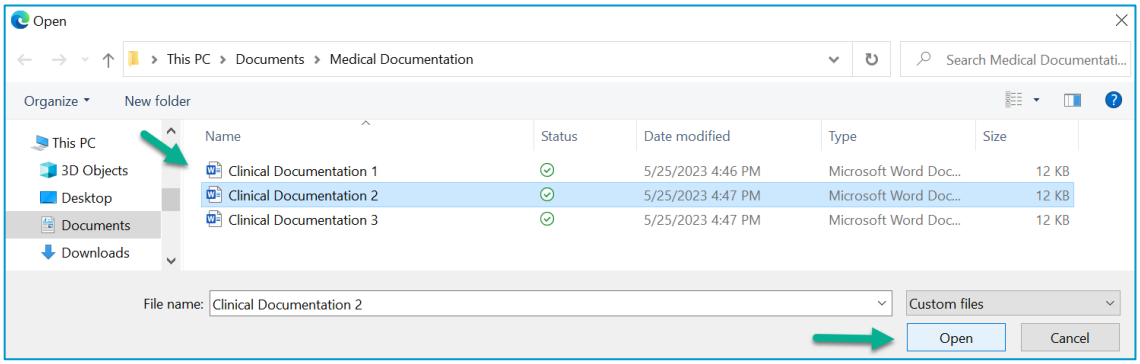
Where do I Upload Information When Submitting an Authorization?

When submitting your requests through the authorization portal you will notice this step where you can add notes and attachments prior to submitting:

- Here is where you are prompted to document any notes in the space provided and click on 'Add Attachments' to upload your clinical documentation.

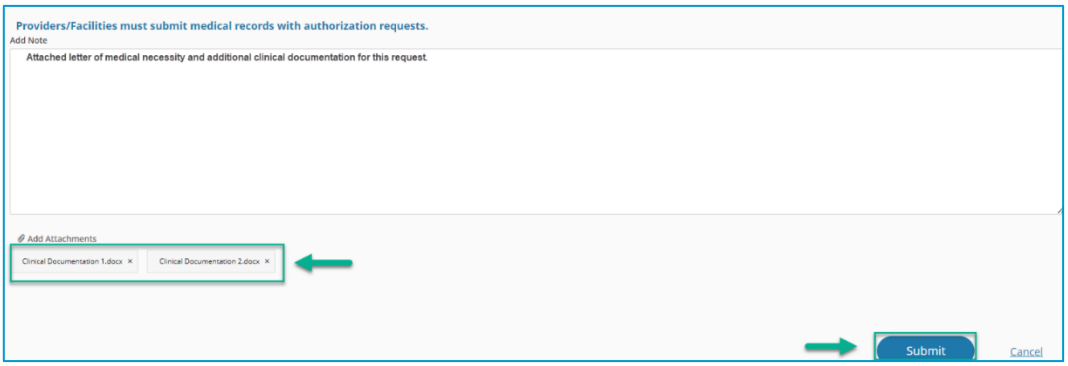


- When you select 'Add Attachments', it will open up your file folder so you can locate the documents you would like to upload. To do this, select the document(s) you would like to add and then select 'Open' to attach them to your request.



- You can select multiple documents to attach
- Document size allowed per file is 25 MB and 100 MB per submission
- Document types accepted are jpeg, png, jpg, pdf, doc, docx, txt, xlsx and xls
- Unsupported special characters will be removed from the file name while saving

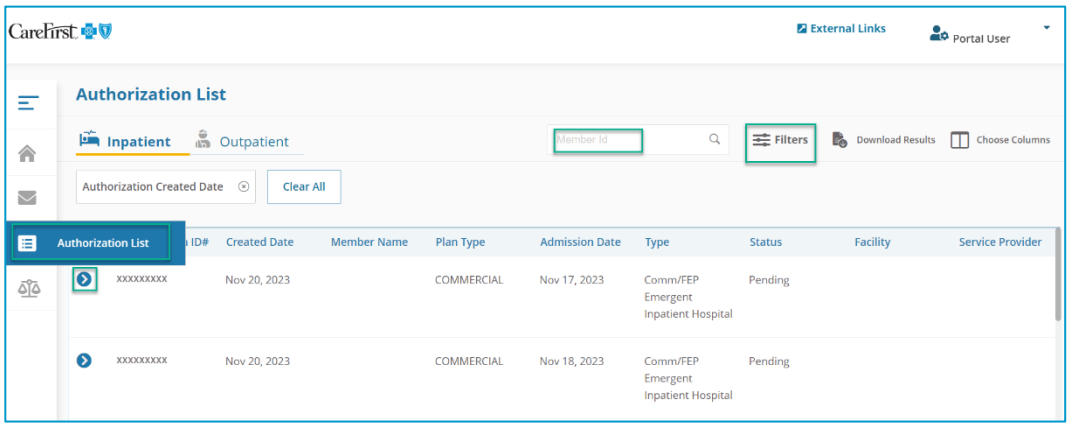
- Once you have added any notes and clinical documentation to your authorization request, select 'Submit' to move forward.



How do I Upload Information to an Authorization Already Submitted?

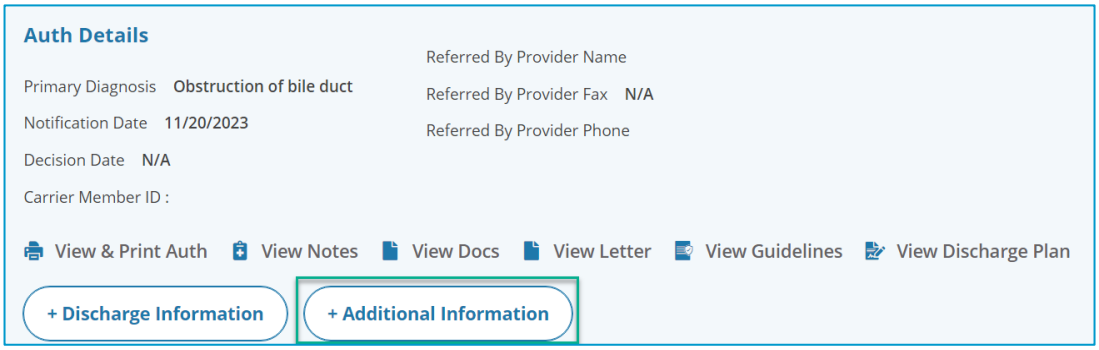
To upload information to an authorization in progress, follow these steps:

- From the authorization system home page, select the 'Authorization List'
- Locate the authorization you need (you can search by Member ID, or use the Filter options)



- Click on the 'arrow' to display the Auth Details and select 'Additional Information'

- From there you can follow the steps above to upload your clinical documentation to an authorization in progress.



- **Enter the request prior to the date of service:**
  To ensure there is ample time for your non-emergent authorization requests to be reviewed and decisioned prior to the date of service, be sure to enter your requests as far in advance as possible.

  Include your contact information in the 'Add Note' section:
  The CareFirst Clinical team often utilizes the 'Messaging' function within the electronic authorization system to reach out to users if they need additional information to decision an authorization. If you need help with how to use the 'Messaging' function, click here for a quick tutorial.

  We encourage you to regularly check for messages but realize you may not be in the authorization system every day. Therefore, we also recommend adding your contact information in the 'Add Note' section when requesting a prior authorization.
- **Additional best practices when submitting commercial authorizations**
  - Providers should notify CareFirst of emergency admissions.
    - Providers should notify CareFirst within 24 hours or one business day. Notification can include the authorization request.
    - Providers should attach clinicals to authorizations for admissions and continued stays.
    - Providers should ensure that authorization requests include all pertinent information (e.g., diagnosis codes, etc.)
  - Providers should provide notification of admission on scheduled/routine admissions within 24 hours of the admission.
  - To assist with care management needs, discharge plans may be attached to the admission authorization.
    - .

For additional information on Prior Authorizations, be sure to review these resources:

- Medical Provider Manual: Chapter 7—Care Management
- Learning and Engagement Center
  - You will find resources and training for Authorizations under the On-Demand Training Tab under 'CareFirst Essentials'
- Authorizations Frequently Asked Questions

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Important Information if you Utilize a Third-Party Billing Company

We realize many of our participating providers contract with third-party billing companies to support their administrative needs. These companies often reach out to our Provider Services unnecessarily requesting information that is easily accessible through our self-service tools, CareFirst Direct and CareFirst On Call.

Please review the important information below and follow up with your third-party billing companies to ensure they can obtain what they need electronically.

What are the top reasons why third-party biller's call?

- Member eligibility
- Benefit accumulations
- Claims Information (status, number, denial reason, date processed, etc.)
- Remittance Information (Check/EFT number, payment address, amount, request a copy, etc.)

What can third-party billers do instead of calling?

All the information for the call reasons above can be obtained using our self-service tools. Here is a great resource for you to provide to your contacts that addresses the following:

- Type of Information needed.
- How to obtain the information—Self-Service or Provider Service?
- Which self-service tool has the information needed—CareFirst Direct or CareFirst on Call?
- Resources that provide step by step instruction on how to find the information needed

What should I do to make sure my third-party biller has what they need?

- **Educate**
  - Reach out to your third-party biller contacts and share the information provided in this article.
- **Provide Access to CareFirst Direct**
  - Ask that they create an account for our Provider Portal (CareFirst Direct) Account
    - All they need is your Tax ID, Billing NPI and a valid email address to Eligibility and Benefits, Claims Status, Claims Inquiry System
  - Your Portal Admin can grant any additional access needed such as the ability to view and print electronic remittance/NOPs. Here are some great resources to help:
    - Adding Access to a Current User in CareFirst Direct
    - Managing User Access Requests in CareFirst Direct
  - **Need a Portal Administrator?** If your practice/facility does not currently have an active Portal Administrator, contact the Help Desk at 877-526-8390 for assistance. This access is crucial to ensuring your practice/facility can approve user access requests, complete required user access reviews, set up new users, and terminate user access as appropriate.
- **Remind them about CareFirst Direct Transaction IDs**

  - CareFirst Direct provides transaction IDs that correlate to all information they obtain in the system. These IDs serve as verification for the information obtained.
- **Show them Where to Find Resources** on our Provider Website
  - We suggest our Provider Quick Reference Guides for information on:
    - Member IDs
    - Products/ID Card Prefixes
    - Guidelines for Provider Self-Service
    - Applicable Provider Service Phone Number's (based on product and line of business)
    - Provider Self-Service Channels
    - Learning and Engagement Center
- **Ask that they Refrain From:**
  - Requiring multiple employees call Provider Service with questions that were already addressed or sending multiple inquiries for the same members for the same reasons. These practices can negatively impact hold times and cause delays.

We recognize third-party billers play an important role in your administrative processes, and we thank you in advance for your partnership in supporting their ability to utilize self-service tools for the basic information they need.

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Breaking News

Are Languages You Offer, including American Sign Language, Listed in Our Provider Directory? If Not, Add Them Today!

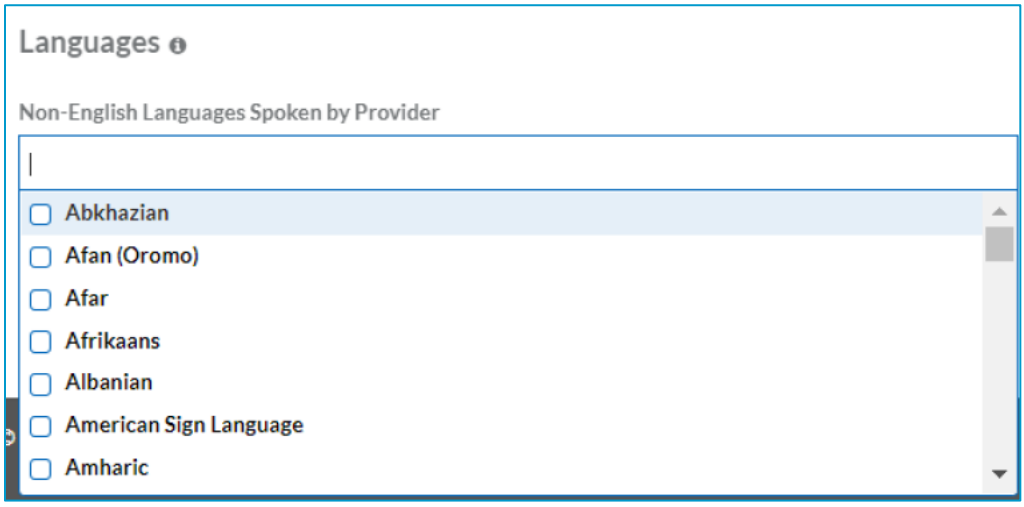
The CareFirst Provider Directory is the single most used resource available to our CareFirst members, your valued patients. It is where they go to find a doctor to meet their individual needs. One very important need your patients (future and current) have is ensuring they can effectively understand and communicate with their doctor. Providing patients with a way to easily identify your practice's linguistic capabilities will be beneficial.

How do I add the languages offered in my practice?

You can add the languages you offer, including American Sign Language, directly on your CAQH application. Follow these easy steps.

- Log into the CAQH Provider Data Portal.
- Update the Language section of your profile be selecting all the languages you offer from the drop down.

- For assistance, access the Provider Data Portal User Guide.



Once you update your application data, it will be sent to CareFirst to include in our Provider Directory, Find a Doctor, for members to access.

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Virtual Care Consolidation, CloseKnit Expansion Update

Effective January 1, 2024, CareFirst will consolidate in-house virtual care offerings for members and offer CloseKnit as its leading solution. CloseKnit currently offers both primary and urgent care services, as well as behavioral health therapy. By January 1, 2024, available services will include psychiatry, lactation consulting and nutritional counseling.

Important Note: CareFirst Video Visit will no longer be available to members after December 31, 2023, except for a short time to a limited subset of members entitled to Continuity of Care; those members have received a direct communication with instructions on how to access the service during this period.

Patients can learn more at closeknithealth.com.

This change does not impact your ability to offer telemedicine services to your patients. CareFirst values its provider networks and will continue to maintain a robust telemedicine policy so you can care for your patients, our members, virtually when appropriate. See the latest provider communication here.

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Review the Upcoming Additions and Changes to our Payment Policy Database

Check out the latest additions to our Payment Policy Database

The following Payment Policies will be effective March 1, 2024. The full policy will be loaded and available to providers no later than December 31, 2023.

- Policy PP CO 030.01 Operating Microscope (Professional)
- Policy PP CO 100.03 DME Owned in History & Rent to Own (Professional & DME Supplier)
- Policy PP CO 600.03 Modifier 26 (Professional)

The following Payment Policies are related to information previously located in the Medical Provider Manual. There is no change to information. However, it will now be in the Payment Policy Database.

- Policy PP CO 900.04 ASC (Facility)

Review changes to our Payment Policies

Please be aware that the previously communicated policies below to be effective January 1, 2024 have been delayed until March 1, 2024. They continue to be available for review in the Payment Policy database.

- Policy PP CO 400.05 – MPPR Well/Problem Visit E/M Pay Percent (Professional)
- Policy PP CO 400.06 – MPPR E/M with Global Days Pay Percent (Professional)
- Policy PP CO 010.012 – Place of Service (POS) E/M Services (Professional)

You can find this, along with other payment policies by going to carefirst.com/provider and selecting *'Programs/Services' > 'Payment Policy'.*

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Medications Added to Prior Authorization List—Effective January 1, 2024

Effective January 1, 2024, the medications below will be added to the list of drugs subject to prior authorization and site of care management to better manage rising specialty drug costs. These additions apply to all lines of business, except for FEP, Medicare Advantage, and Medicare Supplemental. These medications are covered under the medical benefit and are administered in the outpatient hospital, home or office settings.

The Specialty Drug List includes all medications covered under the medical benefit subject to prior authorization and/or site of care management. This list is updated monthly.

Why the change?

CareFirst is continually working with healthcare delivery partners to optimize utilization management strategies to increase efficiencies and control costs while ensuring members receive affordable, quality care. Prior authorization helps balance access with appropriate and safe utilization of these high-cost medications.

Through prior authorization, site of care criteria is applied for selected medications as an opportunity to help reduce overall healthcare costs without compromising quality of care. The outpatient hospital setting is generally recognized as one of the most expensive options for specialty infusions with costs up to three times higher compared to non-hospital settings.

Prior authorization additions

Prior authorization approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia and/or evidence-based practice guidelines. Failure to obtain prior authorization for these medications may result in the denial of the claim payment. The following medications require prior authorization effective January 1, 2024:

Drug Name	Drug Class
Rystiggo	Antimyasthenic agents

Ixifi*	Autoimmune disease

*Subject to PA upon drug launch.

How to request prior authorization

Providers may submit a prior authorization online by logging in to the Provider Portal at www.carefirst.com/providerlogin and navigating to the Prior Auth/Notifications tab. Training resources for entering prior authorizations are available on our Learning and Engagement Center.

As a reminder, the following specialties/scenarios are out-of-scope and do not require prior authorization for medications covered under the medical benefit:

- Ambulatory Surgery Centers
- Birthing Centers
- Dialysis
- Emergency Room
- Home Health Agencies
- Hospice
- Lithotripsy
- Inpatient Hospital Stay
- Mental Health Facilities & Halfway Houses
- Outpatient Department during Surgery
- Patients in Observation
- Skilled Nursing Facilities

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Medical Preferred Drug Strategy Update—January 1, 2024

Effective January 1, 2024, the preferencing strategy for select medications covered under the medical benefit will be updated. When medically appropriate, and subject to state law when applicable, the preferred medications listed in the chart below will need to be tried first before a non-preferred medication can be covered.

Drug Class	Non Preferred Product(s)	Preferred Product(s)
Acromegaly	Lanreotide Acetate	Sandostatin LAR Somatuline Depot
Amyloidosis	Tegsedi	Onpattro Amvuttra
Antimyasthenic Agents	Rystiggo	Vyvgart Vyvgart Hytrulo Soliris Ultomiris

Drug Class	Non Preferred Product(s)	Preferred Product(s)
Autoimmune	Actemra Orencia Tysabri (if not using for multiple sclerosis)	Cimzia Entyvio Ilumya Simponi Aria Stelara Skyrizi
Autoimmune Infused Infliximab	Remicade Infliximab Ixifi Inflectra Renflexis	Avsola
Bevacizumab (oncology)	Avastin Vegzelma Alymsys	Mvasi Zirabev
Botulinum Toxins	Botox Myobloc Vyepti	Dysport Xeomin
Complement Inhibitors	Empaveli Enspryng Uplizna	Ultomiris Soliris
Fertility Regulators—FSH	Follistim AQ	Gonal-F
Gonadotropin Releasing Hormone (GnRH)—CPP	Lupron Depot-PED Eligard	Fensolvi Supprelin LA Triptodur
Hematologic, Erythropoiesis—Stimulating Agents (ESA)	Epogen Mircera Procrit	Aranesp Retacrit
Hematologic, Neutropenia Colony Stimulating Factors—Short Acting	Granix Leukine Neupogen Releuko	Nivestym Zarxio

Drug Class	Non Preferred Product(s)	Preferred Product(s)
Hematologic, Neutropenia Colony Stimulating Factors—Long Acting	Neulasta syringe/Neulasta Onpro Fulphila Ziextenzo Rolvedon Stimufend Fylnetra	Nyvepria Udenyca
Hemophilia A	Esperoct Hemlibra Advate Adynovate Recombinate Afstyla Novoeight Roctavian	Altuviio Eloctate Jivi Kogenate Kovaltry Nuwiq Xyntha
Hemophilia B	Idelvion Ixinity Rebinyn Rixubis Mononine Alphanine Profilnine	Alprolix Benefix
Hereditary Transthyretin Amyloidosis	Tegsedi	Amvuttra Onpattro
Lysosomal Storage Disorders—Gaucher Disease	VPRIV Elelyso	Cerezyme
Osteoarthritis, Viscosupplements	1% sodium hyaluronate Gel-One Gelsyn-3 Genvisc 850 Hyalgan Hymovis Monovisc Orthovisc Supartz fX Synojoy Synvisc Synvisc-one Triluron Trivisc Visco-3	Durolane Euflexxa

Drug Class	Non Preferred Product(s)	Preferred Product(s)
Pulmonary Arterial Hypertension	Remodulin	treprostinil
Retinal Disorders Agents	Lucentis Susvimo Beovu	Avastin Eylea/Eylea HD Byooviz Cimerli Vabysmo
Rituximab	Rituxan Rituxan Hycela Ruxience	Riabni Truxima
Severe Asthma	Cinqair	Tezspire Fasenra Nucala Xolair
Trastuzumab	Herceptin Herceptin Hylecta Trazimera Ontruzant Herzuma	Kanjinti Ogivri

Why the change?

CareFirst's Medical Preferred Drug Strategy supports utilization of preferred medications which are equally safe and clinically effective as non-preferred medications and leverages lower drug costs associated with biosimilar therapies to manage cost.

What this means for impacted patients

- If a patient is taking a non-preferred medication, they can continue to take that medication until the current prior authorization expires.
- If a patient needs to continue medication therapy with the non-preferred medication, their doctor can submit a new prior authorization upon the expiration date of the current prior authorization.
- The new prior authorization may result in an approval for an alternative, preferred medication, which is as clinically effective and safe as the non-preferred medication.
- If their doctor believes the non-preferred medication must be continued, their doctor can submit information within the new prior authorization request to obtain a medical necessity exception.

How to request prior authorization

Providers may submit a prior authorization online by logging in to the Provider Portal at www.carefirst.com/providerlogin and navigating to the Prior Auth/Notifications tab.

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Skilled Nursing Facilities and Hospice Providers—Enter your Authorizations Electronically

As a reminder, effective November 1, all prior authorization requests for Skilled Nursing Facilities and Hospice should be entered electronically using our prior authorization system available through the Provider Portal (CareFirst Direct)

This system allows you to:

- Enter prior authorizations 24/7
- Receive immediate authorization numbers
- Attach clinicals to the prior authorizations
- Monitor the status of your authorizations online

View a Recorded Live Webinar to Learn More

Several live webinars occurred in October and November to support this effort. If you were unable to attend, you can still view a recording of this live webinar to learn more about how to enter your authorizations electronically.

Click here to view the live webinar.

Don't have a Provider Portal (CareFirst Direct) account set up?

No problem. It's easy to set up an account to access our Provider Portal (CareFirst Direct) and begin entering your authorizations online. All you need is your Tax ID, Billing NPI and an email address. Once you have your account set up, you do not need any additional access to begin entering authorizations online.

Use the 'Accessing and Registering for CareFirst Direct' user guide to walk you step-by-step through the process.

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In the Spotlight

Need to Update your Tax ID, Practice Address, Phone Number, etc.? Here's How!

Per Federal law, professional providers in our Commercial and Medicare Advantage networks are required to attest/update their directory information every 90 days. You can find information about how to attest/update your data by going to our Update Practice Information webpage.

Important Reminder: Updating your data in CAQH doesn't satisfy the requirement to update/attest your provider directory information. You must also attest/update your directory information directly with CareFirst.

Why do I need to keep my information updated?

Correct provider and practice information is essential to doing business with CareFirst. When you update and maintain accurate data in our system, it:

- Allows members to locate you (and your practice) more easily.

- Allows us to process your claims more quickly and accurately.
- Results in more accurate delivery of mail and email notifications.
- Satisfies your legal obligation to keep your data updated.
- Prevents your provider directory listing from being removed.

Is there training available?

Yes! Our Provider Directory Updates and Attestation training is a 'Featured Course' available on the Learning and Engagement Center home page 24/7.

What should I do next?

If you haven't already, we encourage you to register for CareFirst Direct. This will be the primary resource used to update and verify provider directory information. Refer to this user guide for assistance.

Important Reminder: Please be sure to update/attest your data AFTER you register for CareFirst Direct. Registering for our Provider Portal doesn't satisfy the 90-day requirement. If you need additional assistance with attesting/updating your data, review the Provider Directory Updates and Attestation Course on the Learning and Engagement Center.

Is there an update to the new self-service launch?

As efforts continue in preparation for the launch of our new self-service tool, you can continue to utilize the current self-service tool in the CareFirst Provider Portal to complete your provider directory updates and attestations. Please continue to keep your data accurate with us, and we will continue to keep you informed about when the new tool will launch.

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Noteworthy Stories

Review the Latest Changes to the Medical Provider Manual

To keep you informed of changes and improvements, CareFirst has updated our Medical Provider Manual. Updates were made to the following chapters:

- Chapter 3 and 4
  - Added reference to ASC payment policy—Payment Policy PP CO 900.04
- Chapter 3
  - Clarified Appointment Wait Time Standards for Maryland and D.C. commercial plans
- Chapter 7
  - Clarified virtual care options for CareFirst members
- Chapter 10
  - Added Appointment Wait Time Standards for Medicare Advantage

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Check Out the Provider Profile Score On-Demand Training

On Wednesday, December 6, CareFirst hosted a training webinar to help you learn more about the Provider Profile Score. If you were unable to attend, then you can watch a recording of the webinar, which will be posted soon. You can find the recording by going to carefirst.com/learning, selecting 'Webinars' and the 'Provider Profile Score' accordion.

You can also find more information by reviewing our Provider Profile Score Methodology document. You will need to log in to view the document.

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The Latest Resources on the Learning and Engagement Center

We are excited to offer some new and exciting resources for you and your staff that make doing business with CareFirst easy and efficient.

Here are the latest resources that have been added for you to access on the Learning and Engagement Center.

Course Name	Description
Behavioral Health Webinar: Alcohol Use Disorder and Liver Disease	Watch this recorded webinar to learn about alcoholic liver disease (ALD) and how to manage the stress and anxiety of liver transplants.
Behavioral Health Webinar: Psychodynamic Psychopharmacology	Watch this recorded webinar to learn more about how patients experience the symptoms of their mental diagnosis while using evidence-based psychiatric solutions to navigate their treatment.
Behavioral Health Webinar: Transcranial Magnetic Stimulation and Spravato for Treatment Resistant Depression	Watch this recorded webinar to learn more about the role that transcranial magnetic stimulation has in the clinical journey of treatment resistant depression.
BlueChoice Advantage: SHORT	An overview of the BlueChoice Advantage Product
CareFirst CHPMD and DSNP Quarterly Meeting	Watch this recorded webinar to learn about the latest happenings at CareFirst.
CareFirst Direct Portal Administrator Access	How to request Office Administrator Access to access NOPs and fee schedules within the CareFirst Direct portal
Disease Management: Diabetes	A quick resource reviewing best practices for managing patients with diabetes.
Documentation and Coding: Chronic Kidney Disease	Review specific disease states and coding tips
Entering Electronic Authorizations (SNF and Hospice)	Watch this webinar to learn how to minimize calls and faxes to our Utilization Management Team.
Risk Adjustment – Chart Retrieval: SHORT	A short video on the chart retrieval process and why it is vital that provider networks partner with health plans to access member medical records through EMR access

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Stay Connected with the Latest Information from CareFirst

Are you and your staff receiving CareFirst Provider News and our BlueLink Newsletter via email? If not, take a minute and sign up here. CareFirst is also collecting your preferences to design and deliver a more personalized newsletter experience in the future.

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Effective Dates, Current Procedural Terminology (CPT®) Codes and Policy Updates

Our Healthcare Policy department continuously reviews medical policies and operating procedures as new, evidence-based information becomes available regarding advances on new or emerging technologies, as well as current technologies, procedures and services.

You can review the Healthcare Policy Updates for November and December on our Medical Policy webpage.

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

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

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

Click on the links below for details on topics that can help you improve your patients' care:

General Guidelines and Survey Results	
Topic	**Website Link**
CareFirst's Quality Improvement Program Includes processes, goals and outcomes	carefirst.com/qualityimprovement
Clinical Practice Guidelines Includes evidence-based clinical practice guidelines for medical and behavioral conditions	carefirst.com/clinicalresources > *Clinical Practice Guidelines*
Preventive Service Guidelines Includes evidence-based preventive health guidelines for perinatal care, children, adolescents and adults	carefirst.com/clinicalresources > Preventive Service Guidelines
Accessibility and Availability of Appointments Includes medical and behavioral health accessibility and availability standards for routine care appointments, urgent care appointments and after-hours care	carefirst.com/clinicalresources > *Pracitioner Office Standards*

Care Management Programs	
Topic	**Website Link**
Access to Care Management Includes instructions for making referrals for both medical and behavioral health. Or you can call 800-245-7013	carefirst.com/providermanualsandguides
Practitioner Referrals for Disease Management Includes information on how to use services, how a member becomes eligible and how to opt in or opt out	carefirst.com/clinicalresources > Disease Management
Pharmaceutical Management	
Topic	**Website Link**
Pharmaceutical Management Includes the formularies, restrictions/preferences, guidelines/policies and procedures	carefirst.com/rx
Utilization Procedures	
Topic	**Website Link**
Utilization Management Criteria Includes information on how to obtain utilization management criteria for both medical and behavioral health	carefirst.com/bluelink > *February 2023*
Physician Reviewer Includes instructions on how to obtain a physician reviewer to discuss utilization management decisions for both medical and behavioral health	carefirst.com/bluelink > *February 2023*
Decisions about Medical and Mental Health, and Pharmacy Includes affirmative statement for anyone making decisions regarding utilization management	carefirst.com/bluelink > *February 2023*
Member Related Resources	
Topic	**Website Link**
Quality of Care Complaints Includes an email address for complaints involving medical issues or services given by a provider in our network	carefirst.com/qoc > *Quality of Care Complaints*

How to File an Appeal Includes policies and procedures for members to request an appeal of a claim payment decision	carefirst.com/appeals
Members' Privacy Policy Includes a description of our privacy policy and how we protect our members' health information	carefirst.com/privacy > *Member's Privacy Policy*
Members' Rights and Responsibilities Statement Outlines responsibilities to our members	carefirst.com/myrights

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Mandates

Note: All the mandates listed below are effective **January 1, 2024.**

Plan Design Changes for Hair Prosthesis Benefits

All Maryland ACA Individual new and renewing medical plans are required to provide coverage for one medically necessary hair prosthesis when prescribed by a provider. CareFirst will provide coverage for one hair prosthesis (wigs) per benefit period when prescribed by a physician and deemed medically necessary.

Claims and Billing Guidance

- Eligible CPT codes include A9282.
- Ineligible hair prosthesis diagnosis codes include these: L64.0, L64.8, L64.9, L65.0, L65.8, or L65.9.
- Hair prosthesis with an ICD10 code listed above is considered cosmetic and will deny as not medically necessary.

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Plan Design Changes for Diagnostic and Supplemental Breast Cancer Screenings and Enhanced Lung Cancer Imaging and Screenings

Note: Both of these mandates apply only in Maryland to our fully insured and individual medical plans. Self-insured plans may opt in.

Beginning January 1, 2024, Maryland-regulated insurers (including CareFirst) must comply with the following Maryland mandates as signed into law during the 2023 Legislative session.

Please note: the resulting changes to cost sharing will be instituted on a rolling basis as contracts renew in 2024.

HB376 (Diagnostic and Supplemental Breast Cancer Screenings)

If providing coverage for "diagnostic" or "supplemental" breast examinations (see below) for the detection of breast cancer, insurers must waive all cost sharing for those examinations.

Note: If enrollees are covered under an HSA-eligible or catastrophic plan, they will be subject to the deductible before those examinations are covered at no cost share.

CareFirst members in non-HSA eligible plans will have a $0 copayment/0% coinsurance/deductible waved. Members in HSA-eligible plans and catastrophic plans will have a $0 copayment/$0 coinsurance after satisfying their deductible.

HB815 (Enhanced Lung Cancer Imaging and Screenings)

Insurers must provide coverage for recommended follow-up diagnostic imaging (see below) to assist in the diagnosis of lung cancer, and they must do so without imposing a cost-sharing requirement (copayment, coinsurance, deductible) that is greater than for breast cancer screening and diagnosis.

Note: If enrollees are covered under an HSA-eligible or catastrophic plan, they will be subject to the deductible before this imaging is covered.

CareFirst members in non-HSA eligible plans will have a $0 copayment/$0 coinsurance after satisfying their deductible.

Definitions

A "diagnostic" breast examination can include a diagnostic mammogram, breast ultrasound, and/or breast magnetic resonance imaging (MRI) performed after an abnormality seen or suspected from a prior screening exam for breast cancer or detected by another means.

A "supplemental" breast examination can include breast ultrasound and/or breast MRI performed if there is no abnormality seen or suspected from a prior exam but there is personal or family medical history or other factors that may increase the risk of breast cancer.

Recommended follow-up diagnostic imaging for lung cancer can include diagnostic ultrasound, MRI, computed tomography, and/or image guided biopsy for those for whom screening is recommended by the U.S. Preventative Services Task Force.

Claims and Billing

- No changes will be made to existing preventive care benefits for either breast cancer or lung cancer screening.
- $0 cost-share (or $0 cost-share after deductible) services will apply only to applicable CPT codes (listed below) and non-preventive ICD10 codes.
- $0 cost-share (or $0 cost-share after deductible) services will apply only to outpatient services at the following places of service, regardless of whether they are in-network or out-of-network:
  - An independent non-hospital facility.
  - An outpatient department of a hospital.
  - A doctor's office.

CPT Codes

- Breast Cancer Screenings: 77061, 77062, 77063, 77065, 77066, 77067, 76641, 76642, 77046, 77047, 77048, 77049, A9579, G0279
- Lung Cancer Screenings: 71271, 71270, 71260, 71250, 71275, 76604, 76770, 76775, 77021, 71550, 71551, 71552, A9579, 71555

FAQ/Reminders

When must CareFirst coverage begin complying with these mandates?
The insurance provisions for HB815 and HB376 take effect on January 1, 2024, and apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State of Maryland on or after that date.

Why were these mandates passed by the Legislature?
Supporters of the bills believe that eliminating financial barriers to follow-up and/or supplemental breast and lung cancer imaging will help save the lives of Maryland residents and address health inequities through better education on the need for screenings throughout the community. These bills received unanimous support from both the House and Senate.

Do these changes apply to any other jurisdictions?
These mandates are for commercial plans in Maryland only. Groups and members in Virginia and Washington, D.C., are not in scope. These mandates are also not applicable for Medicare Advantage/Medigap, Medicaid, and FEP/FEHBP plans.

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Plan Design Changes for Maryland Biomarker Testing

CareFirst is required to provide coverage for certain biomarker testing for all our Maryland 51+ Risk plans and grandfathered individual plans.

Covered Biomarker testing includes single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

For more information, refer to AIM Specialty Health's Clinical Appropriateness Guidelines and the following CareFirst Medical Policies:

- 11.01.036 Lipoprotein-Associated Phospholipase A2 (Lp-PLA2)
- 11.01.037 Serum Biomarker Panels for Assessment of Hepatic Fibrosis
- 11.01.045 Proteomics-Based Testing for Evaluation of Ovarian Masses
- 11.01.061 Proteomic Testing for Targeted Therapy in Non-Small Cell Lung Cancer
- 11.01.073 Genetic Testing
- 11.01.076 Circulating Tumor Cell Detection in Management of Cancer Patients
- 11.01.078 Multibiomarker Disease Activity Blood Test for Rheumatoid Arthritis
- 11.01.079 Serum Biomarker Panel Testing for Systemic Lupus Erythematosus and other connective tissue diseases

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D.C. Lowers Cost-Share for Certain Pediatric Mental Health Benefits

Effective 1/1/24 for Standard NON HSA Individual ACA and Standard Small Group ACA Plans (Medical and Pharmacy)

In 2020, the Health Benefit Exchange Authority (HBX) formed an advisory working group, the Social Justice and Health Disparities Working Group (SJHDWG) to focus on healthcare inequities in D.C. As a result of

recommendations, fully insured standard individual and small group ACA plans offered in D.C. will be revised to lower member cost-sharing for certain treatments of pediatric mental health and behavioral health conditions. The following changes will be implemented January 1, 2024:

- A $5 member copayment—applicable up to the member's 19th birthday—for the following services:
  - Outpatient visits, both office and specialist visits. There is no visit limitation.
  - Certain classes of prescription medications and specified medications.
  - Certain Gender Dysphoria Specified labs, imaging and procedures.

To confirm if your patient(s) are impacted by this change, remember to verify eligibility and benefits in CareFirst Direct.

Frequently Asked Questions

When does the mandate take effect?

The pediatric mental health benefits take effect January 1, 2024. CareFirst is implementing this mandate on January 1, 2024.

What benefits does the mandate change?

Effective January 1, 2024, CareFirst value-based insurance design (VBID) fully insured Standard Individual and Small Group Standard (non-HSA) ACA plans offered in D.C. will be modified to include the following:

- The $5 member's copay is applicable for pediatric mental and behavioral health conditions up to the member's 19th birthday. Once a member turns 19, these benefits will revert to standard benefit cost-sharing amounts.
- The mandated $5 copay applies to outpatient visits only, both office and specialist visits. There is no visit limitation.
- Specified labs, imaging, and procedures for gender dysphoria are covered with a $5 copay.
- Certain classes of mental health prescription medications and specified medications will be reduced to a $5-member copayment. CareFirst's CVS/PBM team will create the medication list and will be housed here.
- When a generic version of the medication is available, CareFirst will only cover the generic version of the medication at the reduced $5 member copay.
- The Exchange Formulary is the only one used for ACA business.
- The impacted medications will apply to medical and pharmacy benefits—visit carefirst.com/rx for the list to see which benefit applies—medical and pharmacy or pharmacy only.
- The $5 copay will only apply to the specific, listed medications for individuals under 19 years of age. One a member turns 19, these medications will no longer be $5. They will change to standard benefits.

Does this mandate apply to all outpatient visits?

The $5 member copayment applies to outpatient, office and specialist visits (no visit limitation) for:

- Members with an applicable ICD10 codes for Mental Health, Behavioral Health and Substance Use Disorder Services as defined by CareFirst.
- Members with the following CPT Codes:
  - 11981, 90791, 90792, 90832, 90833, 90834, 90865, 90836, 90837, 90838, 90839, 90840, 90846, 90847,

90853, 96127, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99244, 99245, 99417, 99442, 99443, 99484, 99492, 99493, 99494, 36415, 36416, 99000, 99001, 84402, 84403, 82670, 85014, 85018, 85025, 80053, 82306, 80061, 84146, 77080, 77072, 96372

- Members with the following HCPCS J-codes:
  - J9218, J1071, J3121, J1380

Which markets/plans does this mandate apply to?

This mandate applies to the following fully insured standard individual and small group ACA D.C. plans:

Does a member with an HSA high deductible plan need to meet their deductible before receiving care at the lower cost?

Members in HSA plans are out of scope for this mandate.

What happens if a member has a lower copay than $5 for any of the medications?

If the member has a lower copay of $5 for any of these medications, they will pay their copay.

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Virginia Law Requires Coverage Updates for Hearing Aids, Related Services for Minors

Effective January 1, 2024, upon plan enrollment and renewal, CareFirst's Virginia fully-insured commercial business and certain self-insured business, and CareFirst Administrators (CFA)*, will provide coverage for one hearing aid per hearing-impaired ear every 24 months, up to $1,500 per hearing aid, for children 18 years of age or younger.

Benefits are provided both in- and out-of-network when applicable. In-network benefits are provided without any cost-share (no deductible, copayment or coinsurance), except for HSA compatible plans which will apply a deductible. Out-of-network benefits may apply cost-sharing depending upon the member's contract.

Additional coverage updates

- Coverage for hearing aid services and equipment must be provided upon the recommendation of an otolaryngologist, licensed audiologist, or licensed hearing aid specialist.
- Hearing aids are defined as any wearable, non-disposable instrument or device designed or offered to aid or compensate for impaired human hearing—parts, attachments, accessories, or earmolds included. However, coverage does not extend to associated batteries and cords.
  - **Important note:** Hearing aids are not to be considered durable medical equipment.
- Covered hearing aid-related services include office visits and fittings, earmolds, and other necessary equipment, maintenance, and adaption training.
- A member must be allowed to choose a higher-priced hearing aid and may pay the difference in cost above $1,500, with no financial penalty to the member or to the provider of the hearing aid.
- The following CPT Codes are applicable to this mandate: 92590, 92591, 92592, 92593, 92595, V5010, V5011, V5014, V5020, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5095, V5100, V5110, V5120, V5130, V5140, V5150, V5160, V5171, V5172, V5181, V5190, V5200, V5211, V5212, V5213, V5214, V5215, V5221, V5230, V5240, V5241, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5264, V5266, V5267, V5275,

V5298.

**includes self-insured businesses that opt-in who are using CFA.*

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Government Programs

Important: Mandatory Model of Care Training Attestation is Due

All providers (including out-of-network) who see CareFirst Dual Special Needs Plan (D-SNP) members must complete their mandatory Model of Care training upon enrollment in our network and then annually thereafter. Attestation for the annual training may be done at the practice level and takes less than 10 minutes.

Failure to complete the attestation will be considered a violation of your contract with CareFirst. For more information on why and how to complete the training, continue reading below.

What is Model of Care (MOC) Training?

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNP) have a Model of Care (MOC). MOC training is offered to meet CMS regulatory requirements and ensures that all providers have the specialized training that this unique population requires. CMS also requires all SNPs to conduct initial and **annual** training (that reviews the major elements of the MOC for providers).

Upon completion of the training, providers will be able to:

- Describe the basic components of the CareFirst MOC.
- Explain how medical management staff coordinates care for dual eligible (Medicare Advantage and Medicaid) members.
- Describe the essential role of providers in the implementation of the MOC program.

How to access the training?

We recently enhanced our MOC training process to make participation easier. Providers can view our new on-demand module here and submit an attestation on behalf of their entire practice, versus having each practitioner complete individually.

Thank you for helping us to meet the needs of our members and comply with federal regulations.

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Stay in Control of Your Data—Need to Update Your Address, Phone Number, NPI, etc?

As a MD Medicaid and DSNP provider, correct provider and practice information is essential to doing business with CareFirst. When you update and maintain accurate data with us, it:

- Allows members to locate you (and your practice) more easily.
- Allows us to process your claims more quickly and accurately.
- Results in more accurate delivery of mail and email notifications.
- Satisfies your regulatory requirement to keep your data updated.

Providers must inform CareFirst of any changes to their address, telephone number and/or group affiliation as well as additional practitioners joining their practice to ensure accurate data is published in provider directories and accurate claims payment information.

Where do I send my updates?

Please send updated demographic information as changes occur to MDMCcredentialing@carefirst.com.

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Events

Holiday Closings

- Christmas Day—Monday, December 25, 2023
- New Years Day—Monday, January 1, 2024
- Martin Luther King Jr. Day—Monday, January 15, 2024
- President's Day—Monday, February 19, 2024

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