December 2024 | Vol 26| Issue #6

News for You

Breaking News

- Upcoming Chart Retrieval Requests
- What is CareFirst BlueCross BlueShield Group Advantage PPO?
- Request Your Provider Profile Score Today

In the Spotlight

- Coming Soon! Prior Authorization Lookup Tool

Mandates

- Maryland Lowers Cost Share for Certain Breast and Lung Cancer Benefits
- Maryland Law Mandates Hearing Aid Coverage for Adults
- Maryland Coverage for Prostheses
- Virginia EHB Benchmark Plan Updates for 2025
- Virginia Law HB238 Requires Coverage Updates for Colorectal Cancer Screening
- D.C. Lowers Cost-Share for Certain Cardiovascular and Cerebrovascular Benefits

Administrative Support

- Preparing for the New Year: Take Note of New Membership Identification Cards
- Do You Have Provider Portal Online Access Administrator (OAA) Access?

In Case You Missed It

- Effective January 1: New Medicare Advantage PPO Plans Launching in Maryland and Washington, DC
- Introducing the CareFirst MY24 Quality Toolkit
- Important Reminder: Inpatient and Observation Admissions Payment Policy
- Update and Attest to Your Provider Directory Data Every 90 Days

Noteworthy Stories

- Prior Authorization/Notification System Reminder: Always Select "Submit Request" on the MCG User Interface
- Attach Clinical Documentation to Prior Authorizations
- Check out Resources on the Learning and Engagement Center
- Stay Connected with the Latest Information from CareFirst
- Interested in Learning More about What's Happening with Our Dental Providers?

Visit carefirst.com/bluelink to view past issues of BlueLink.

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Government Programs Corner

- Complete the 2024 Mandatory Model of Care Training Attestation Today!
- Effective January 1: Electronic Prior Authorization Portal Available for CareFirst CHPMD and Advantage DualPrime Members
- Access CareFirst CHPMD and Advantage DualPrime Members in CareFirst Direct
- Upcoming Terminated Members Claims Payment Recovery Process
- Effective March 1: New Prior Authorization Requirements for CareFirst CHPMD Members
- Register Now: December Provider Live Webinar
- CareFirst CHPMD Monthly and Quarterly Formulary Updates: Pharmacy Benefit
- Clinical Practice Guidelines
- CareFirst CHPMD's Population Health Management Health Education Program Member Referrals
- Is your Provider Data Accurate?
- Doula Services Available at No Cost for all Eligible HealthChoice or Fee-For-Service (FFS) Medicaid Recipients

Events

- Provider Live Webinars Available for Registration
- Holiday Closings

Breaking News

Upcoming Chart Retrieval Requests

Each year, CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and their subsidiaries and affiliates (collectively "CareFirst") must retrieve medical records from our network providers to fulfill various regulatory requirements and audits.

For more details, access the **Provider News article**.

Back to top

What is CareFirst BlueCross BlueShield Group Advantage PPO?

CareFirst BlueCross BlueShield Group Advantage PPO is a Group Medicare Advantage or EGWP plan offered to retirees of employer groups who contract with CareFirst to offer the plan.

Can I See CareFirst BlueCross BlueShield Group Advantage Members if I Don't Participate?
If you are not part of the CareFirst BlueCross BlueShield Medicare Advantage PPO network, but you are a Medicare-accepting provider, then the answer is **YES!** You can treat and receive payment for patients who are enrolled in a CareFirst BlueCross BlueShield Group Advantage plan by billing claims electronically to CareFirst Medicare Advantage. CareFirst BlueCross BlueShield Group Advantage pays out-of-network providers according to the original Medicare fee schedule, less any applicable member cost-shares.

Here is some helpful information:

- Since the CareFirst Medicare Advantage BlueCross BlueShield Group Advantage (PPO) is a ***Passive PPO*** members have the same level of benefits for both in network and out of network services.
- Providers cannot balance bill CareFirst BlueCross BlueShield Group Advantage plan members.

- CareFirst BlueCross BlueShield Group Advantage will provide coverage for these members under a group (or an employer-sponsored) Medicare preferred provider organization (PPO) plan.
- Members of this plan are aware they can see out-of-network providers and may bring information to you from CareFirst explaining the plan.

Identifying CareFirst BlueCross BlueShield Group Advantage plan members:

1. CareFirst Medicare Advantage Logo
2. Product Name – CareFirst BlueCross BlueShield Group Advantage
3. Unique Prefix - EGE
4. Unique Plan Codes – 193/693
5. The "*MA*" in the suitcase indicates a member who is covered under the Medicare Advantage PPO national network sharing program
6. Claims Submission Information

Where can I find more information?

For more information about the CareFirst BlueCross BlueShield Group Advantage plan, information on eligibility and benefits, claims submission, etc. access our on-demand training course here.

Back to top

Request Your Provider Profile Score Today

To better understand the care provided to our members, CareFirst has developed a Provider Profile Score. The score is a composite of the practice's quality, member experience, cost efficiency and relationship health scores.

Eligible Practices can request their profile score report by emailing ProfileScore@carefirst.com. The email must contain the names of the providers in your practice, National Provider Identifier, Tax ID and Practice ID. Please note that the deadline for practices to appeal their score is Monday, Jan. 20, 2025.

To learn more about how the Provider Profile Score is calculated, review this resource that walks through the process.

Back to top

In the Spotlight

Coming Soon: Prior Authorization Lookup Tool

We are excited to share that a new self-service tool will be available in the coming months to assist providers in determining which services they provide require authorization. The implementation of this tool is something our provider community has asked for to help streamline the authorization process.

How will I access the new tool?

This tool will be located on the 'Prior Authorization/Notification' landing page once logged into the

CareFirst Provider Portal and will serve as a quick way to verify authorization requirements before entering a request.

What are the key features?

- User friendly interface where you can quickly enter required information to determine if a prior authorization is required.
- Links to applicable medical and payment policies as well as clinical guidelines.
- A clear 'Yes' or 'No' response for prior authorization requirements.
- Ability to enter multiple service codes for the same member.
- A direct link to the appropriate prior authorization system to enter your request.
- Access to your historical requests you completed using the new tool.

Be on the lookout for additional communication and training as we get closer to launching this new tool.

Back to top

Mandates

Maryland Lowers Cost Share for Certain Breast and Lung Cancer Benefits for Risk Accounts

Effective January 1, 2025 for Maryland fully insured members, image-guided breast biopsy will be included within the current coverage provided to members for supplemental breast examinations for all individual, small group and large group plans upon renewal. There will be no prior authorization requirements for lung cancer screenings and follow-up diagnostic imaging.

The changes below will impact Maryland medical risk accounts, including grandfathered accounts, all commercial markets excluding Medi-Gap and in-network and out-of-network (for plans with out-of-network benefits).

Cost share for all MD plans for outpatient services (including office and specialist visits)

- Non-HSA in- and out-of-network: code the $0 cost share and waive the deductible
- HSA-eligible plans In and out of network: code the $0 cost share after deductible is met
- Catastrophic and Young Adult Catastrophic plans in and out of network: code the $0 cost share after deductible is met

Codes for image-guided breast biopsy include the following:

19081	19283	10008	76942
19082	19284	10009	77002
19083	19285	10010	77021
19084	19286	10011	00400
19085	19287	10012	99152
19086	19288	88172	99153
19101	10005	88173	99156

19281	10006	88177	99157
19282	10007	76098	

Codes for lung cancer that will not require an authorization:

71271	31628	C34.31	C83.32	71260	31633
71270	31629	C34.32	C83.52	71250	31640
71260	31632	C34.80	C83.72	71275	31641
71250	31633	C34.81	C83.92	77021	31643
71275	31640	C34.82	C84.02	71550	31652
77021	31641	C34.90	C84.12	71551	31653
71550	31643	C34.91	C84.92	71552	31654
71551	31652	C34.92	C84.A2	71555	32096
71552	31653	C46.50	C84.Z2	76604	32097
71555	31654	C46.51	C85.12	76770	32098
A9579	77002	C46.52	C85.22	76775	32400
76604	00520	C78.00	C85.82	10005	32606
76770	00522	C78.01	C85.92	10006	32607
76775	00528	C78.02	D38.1	10007	32608
10005	00529	C7A.090	D49.1	10008	32609
32408	99151	C81.02	Z12.2	10009	39000
10006	99152	C81.12	Z85.110	10010	39010
10007	99153	C81.22	Z85.118	10011	39401
10008	99155	C81.32	Z85.12	10012	39402
10009	99156	C81.42	Z85.20	88172	77002
10010	99157	C81.72	Z85.21	88173	00520
10011	88305	C81.92	Z85.29	88177	00522
10012	88307	C82.02	Z85.89	32400	00528
88172	C33	C82.12	Z85.9	32408	00529
88173	C34.00	C82.22	Z80.1	31622	99151
88177	C34.01	C82.32	Z80.2	31623	99152
32400	C34.02	C82.52	Z80.8	31624	99153

31622	C34.10	C82.62	Z80.9	31625	99155
31623	C34.11	C82.82	R91.1	31627	99156
31624	C34.12	C82.92	R91.8	31628	99157
31625	C34.2	C83.02	71271	31629	88305
31627	C34.30	C83.12	71270	31632	88307

For more information about this mandate, please contact Mandates@carefirst.com.

Back to top

Maryland Law Mandates Hearing Aid Coverage for Adults

Effective January 1, 2025, CareFirst Maryland risk (fully funded) large group plans will provide coverage for medically necessary hearing aid coverage for adults 18 years of age or older.

This expanded coverage for adults enacted under Maryland House Bill 1339 and Senate Bill 778 is in addition to the current mandated benefit required under Md. Code Section 15–838, hearing aids for children.

Hearing aids for adults is currently a covered benefit under CareFirst MD ACA Consumer Direct and Small Group plans due to Maryland Benchmark Plan requirements.

As of January 1, 2025, CareFirst will provide coverage for the following:

- one (1) hearing aid per hearing-impaired ear every 36 months when medically appropriate and necessary if the hearing aids are **prescribed, fitted, and dispensed by a licensed audiologist**.
- up to $1,400 per hearing aid*

** The $1,400 dollar maximum will not apply to Patient Protection and Affordable Care Act (PPACA) compliant plans.*

For more information about this mandate, please contact Mandates@carefirst.com.

Back to top

Maryland Coverage for Prostheses

Effective January 1, 2025, CareFirst BlueCross BlueShield (CareFirst) must provide annual coverage for medically necessary prostheses, components of prostheses, repairs to prostheses, and replacements of prostheses or prosthesis components in accordance with coverage requirements for medical necessity outlined below. These requirements apply to Maryland risk (fully funded) members in individual and group commercial plans and CareFirst Community Health Plan Maryland (CHPMD) members.

The covered benefits apply to prostheses determined by a treating healthcare provider to be medically necessary for:

- Completing activities of daily living.
- Completing essential job-related activities; or
- Performing physical activities, including running, biking, swimming, strength training, and other activities to maximize the whole-body health and lower or upper limb function of the insured or enrollee.

Coverage for Replacements

CareFirst must provide coverage for replacements of prostheses if an ordering healthcare provider determines that a replacement prosthesis or a component of the prosthesis is necessary:

- Because of a change in the physiological condition of the patient.
- Because of an irreparable change in the condition of the prosthesis or a component of the prothesis (unless caused by misuse); or
- Because the condition of the prosthesis or the component of the prosthesis requires repair, and the cost of the repair would be more than 60% of the cost of replacing the prosthesis or the component of the prosthesis (unless caused by misuse).

If the prosthesis or the component of the prosthesis being replaced is less than three (3) years old, CareFirst may require an ordering healthcare provider to submit documentation that the item meets the replacement requirements noted above.

Please note: *For CareFirst Community Health Plan Maryland members, CareFirst is* ***not required*** *to cover additional Healthcare Common Procedure Coding System (HCPCS) "L" codes for prosthetic procedures and devices other than those that are covered by CareFirst as of December 31, 2024.*

Back to top

Virginia EHB Benchmark Plan Updates for 2025

Virginia's Essential Health Benefit (EHB) Benchmark Plan was released in 2023 and sets required benefits that must be offered by Affordable Care Act (ACA) health plans in the state's Individual and Small Group market.

The changes below will go into effect January 1, 2025, **for all new or renewing ACA Individual and Small Group plans**. All 2025 VA ACA Individual and Small Group contracts will be updated to align with the VA Benchmark Plan and will reflect these changes.

- Enhanced prosthetics coverage, including expanded coverage for myoelectric, biomechanical or microprocessor-controlled devices that are deemed medically necessary. The following codes are impacted:

  L5859 L6648 L6920 L6945 L6970 L7040 L7185 L7360 L7368 L5926

  L6026 L6715 L6925 L6950 L6975 L7045 L7186 L7362 L9900 L5991

  L6611 L6880 L6930 L6955 L7007 L7170 L7190 L7364 L5615

  L6638 L6881 L6935 L6960 L7008 L7180 L7191 L7366 L5783

  L6646 L6882 L6940 L6965 L7009 L7181 L7259 L7367 L5841

- Updates to preventive services to comply with Federal guidance on essential health screenings

Screening for cervical cancer was expanded to include "Pap tests, also called Pap smears, and HPV (human papillomavirus) tests." 87623, 87624, 87625, 80081 (HPV), 87590, 87591, 87592, 87850, 87081

  - "Bone density screening" is listed in the benefit description (replacing the listing of "screening for osteoporosis" in the draft application). 77080, 77081 (DXA Scan)

- Annual Screening and Counseling for STIs

  80081 86780 87491 87621 99401 86570 87081 87492 87623 99402

  86592 87110 87590 87624 99403 86593 87270 87591 87625 99404

  86631 87320 87592 87810

- HIV PrEP is now considered an essential health benefit.
- Pharmacy coverage of Medical Formula/Enteral Nutrition is now considered to be an essential health benefit

Pediatric Dental has several updates and services to the VA Benchmark Plan as per guidance from the Centers for Medicare & Medicaid Services (CMS) and Virginia Board of Insurance (VBOI) guidance.

- Oral examination, including oral health risk assessment, beginning with the eruption of the first tooth, and no later than 12 months
- Unlimited Single Bitewings

Bitewing two, three or four images: each allowed one per year per provider per location

- Pediatric Panoramic Exam: one exam per five years
- Pediatric Intraoral Exam: one exam per five years

Pediatric Cephalometric X-ray: one exam per 36 months

- Gingivectomy or gingivoplasty limited to one treatment per 24 months per member per quadrant or per tooth
- Mucogingivals_Surgery limited to grafts and plastic procedures
- Pulpotomy, pulpal debridement, for deciduous teeth
- Pulpal therapy and pulpal regeneration
- Denture adjustments limited to: Full or partial removable (upper or lower) dentures: once per 12 months per denture, but not within six months of initial placement
- Denture relining limited to once per two years
- Replacement of a broken, lost, or stolen retainer allowed one per arch per lifetime, if necessary
- Removable and fixed appliance therapy to control harmful habits (includes appliances for thumb sucking and tongue thrusting)
- Palliative treatments

For more information, please contact Mandates@carefirst.com.

Back to top

Virginia Law (HB238) Requires Coverage Updates for Colorectal Cancer Screening

Effective January 1, 2025, upon plan enrollment and renewal, all CareFirst plans issued in the Commonwealth of Virginia must provide coverage for examinations and laboratory tests related to colorectal cancer screening. This requirement is in accordance with the most recently published

recommendations established by the U.S. Preventive Services Task Force for colorectal cancer screening, for which a rating of A or B is in effect with respect to the individual involved.

The legislation requires coverage to include a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test. Benefits are provided for both in-and out-of-network providers when applicable. In-network benefits are provided without any member cost-sharing.

The following CPT Codes are applicable to this mandate:

45300, 45305, 45308, 45309, 45315, 45320, 45330, 45331, 45333, 45338, 45346, 45378, 45380, 45384, 45385, 45388, 74263, 74270, 74280, 81528, 82270, 82271, 00812, 99242, 99243, 99244, 99245, G0104, G0105, G0106, G0120, G0121, G0122, G0328, S0285.

For more information, please contact Mandates@carefirst.com.

Back to top

D.C. Lowers Cost-Share for Certain Cardiovascular and Cerebrovascular Benefits

Effective January 1, 2025, most Standard Individual and Small Group ACA plans in Washington, D.C. that feature Value-Based Insurance Design (VBID) will have $0 cost sharing for certain benefits and some medications related to the prevention and treatment of cardiovascular and cerebrovascular disease.

Note: *The $0 cost share does not apply to Standard High Deductible/HSA plans. These cost-sharing reductions apply only to Platinum, Gold, Silver, and Bronze ACA Standard VBID non-HSA plans in D.C.*

Key points of this mandate include:

- Services in scope for $0 cost share include primary care visits, cardiac rehabilitation and medical nutrition therapy, when related to the prevention and treatment of cardiovascular and cerebrovascular disease.
- Lab tests in scope for $0 cost share include blood pressure readings, urinalysis, blood cell count/blood chemistry, lipid panels, nicotine tests, troponin tests, electrocardiograms and CT scans.

Generic drugs related to treatment for hypertension, high cholesterol, tobacco use and post-event care are in scope for $0 cost share.

Condition	**Medication Classes/Groups at $0 Cost-Sharing**
Hypertension	Thiazide diuretics
	Calcium channel blockers
	Angiotensin-converting enzyme (ACE) inhibitors
	Angiotensin receptor blockers
	Beta blockers
Hypercholesterolemia	Statins
	Cholesterol absorption inhibitors

(table continues on next page)

Tobacco use	Nicotine replacement therapies
	Antidepressants (only Bupropion)
	Nicotine receptor partial agonist (Varenicline)
Post-event care	Aspirin (NSAIDs)
	Beta blockers
	Platelet inhibitors (Plavix)
	Anticoagulants

$0 Cost Sharing applies to generic medications related to the prevention and treatment of cardiovascular and cerebrovascular disease.

Member contracts for 2025 are being updated to include information about reductions in cost share for these services, tests and prescription drugs.

For more information about this mandate, please contact Mandates@carefirst.com.

Back to top

Administrative Support

Preparing for the New Year: Take Note of New Membership Identification Cards

As we approach the end of 2024, now is a great time to remember that many patients may be receiving new insurance cards with updated member coverage and benefit information.

Here are a few key reminders to help your office stay on top of these updates:

1. Always Ask for the Latest ID Card

Your patient's CareFirst member identification card is their key to accessing benefits. When patients come in for appointments, make it a standard practice to ask if they have the latest version of their ID card. This will help you avoid potential coverage issues and ensure you're billing with the correct information.

2. **Digital ID Cards are Readily Available**

Even if a patient doesn't have a physical copy of their ID card, they can still provide it to you digitally. CareFirst members can access their ID cards through the My Account application and save or download them as a PDF. They can easily share this version with your office directly from their smartphone, helping to make the process faster and more convenient.

3. **Access ID Cards via CareFirst Direct**

Your office has the option to access patients' updated member ID cards directly through CareFirst Direct. This allows you to confirm their latest insurance details with ease, ensuring that all patient information remains current in your records. Access this resource for more information.

By staying proactive with these simple steps, you'll be able to streamline patient services, reduce administrative delays, and start the new year smoothly. Thank you for helping make 2024 a seamless experience for your patients and your practice!

Back to top

Do You Have Provider Portal Online Access Administrator (OAA) Access?

Did you know that all CareFirst Direct Provider Portal accounts should have an Online Access Administrator (OAA) assigned?

What is an OAA?

The OAA is the person appointed to oversee all users who have access to the CareFirst Provider Portal in their practice/facility.

What are an OAA's Responsibilities?

An OAA's key responsibilities include adding, reviewing, terminating and modifying the access levels of the CareFirst Provider Portal users in their organization. They can also reset passwords, terminate accounts, make updates to demographic information, as well as access Fee Schedules and Notice of Payments/Remittances.

As a best practice having multiple portal administrators ensures your organization can access the information when needed. The primary OAA can assign User Administrators that will have similar roles.

Steps to Request OAA Access

Have the practice owner/CEO or primary provider email ProviderCFDAccess@carefirst.com to request the **Online Access Admin Designation Form.**

The form must be completed in its entirety and match the information that was used to register and create your profile for the CareFirst Direct Provider Portal.

The form must be signed and returned by the practice owner/CEO or primary provider to: ProviderCFDAccess@carefirst.com

Once access is granted you can use the step-by-step tutorials available on the Learning and Engagement Center for assistance or contact your Provider Relations Representative for training.

- Creating a New User in CareFirst Direct
- Resetting a Password in CareFirst Direct
- Locking and Unlocking an Account in CareFirst Direct
- Adding Access to a Current User in CareFirst Direct
- Terminating an Account in CareFirst Direct
- Managing User Access Requests in CareFirst Direct

Important Notes

- If the information on the form is not correct it will be returned.
- Third-party billers cannot be assigned as the OAA.
- Only ***one*** OAA can be assigned per tax ID by CareFirst.

Back to top

In Case you Missed It

Effective January 1: New Medicare Advantage Individual PPO Plans Launching in Maryland and Washington, DC

CareFirst is excited to share that we are launching three new Medicare Advantage Individual PPO plans in Maryland and the District of Columbia with an effective date of 1/1/2025.

Register Now for a Live Webinar!

To support providers who participate in the Medicare Advantage PPO network with more information about these new plans, we will be hosting several live webinars in December and January to walk through all the details. Select 'Register Now' for the date and time that works best.

Date	Time	Registration Link
Thursday, December 12	10 – 11 a.m.	Register Now
Thursday, December 19	1 – 2 p.m.	Register Now
Tuesday, December 31	10 – 11 a.m.	Register Now
Tuesday, January 7	10 – 11 a.m.	Register Now
Thursday, January 9	1 – 2 p.m.	Register Now
Wednesday, January 15	10 – 11 a.m.	Register Now

Introducing the CareFirst MY24 Quality Toolkit

We are excited to announce the release of the CareFirst MY24 Quality Toolkit, now available on the Learning Engagement Center within the Quality Improvement section of our *On-Demand Training* page, and through our Practice Consultants. This essential resource is designed to help healthcare providers get credit for the clinical work they are already doing.

For more details, access the **Provider News article**.

Back to top

Important Reminder: Inpatient and Observation Admissions Payment Policy

At CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst), our priority is ensuring our members are consistently receiving the right care at the right time and the right level. Providers should be following the current inpatient and observation admissions requirements. These requirements are included in the Inpatient and Observation Care Notification Requirements Policy announced in the April, June, August and October BlueLink Newsletters and in this Provider News email sent on July 23, 2024.

Back to top

Update and Attest to Your Provider Directory Data Every 90 Days

The CareFirst Provider Directory is the most-used resource available to our CareFirst members. It is where they find a doctor to meet their healthcare needs. It is important to you and your patients (future and current) that the information in our directory is accurate. If not, patients get very frustrated trying to find a doctor in their time of need.

For more details, access the **Provider News article**.

Back to top

Noteworthy

Prior Authorization/Notification System Reminder: Always Select "Submit Request" on the MCG User Interface

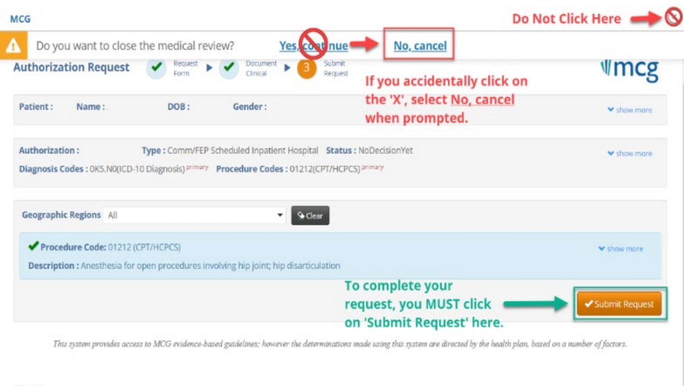
To assist you with the MCG user interface within the CareFirst Prior Authorization Portal, we want to share an important reminder to ensure your request is reviewed in a timely and accurate manner.

Many users are not submitting their prior authorization requests within the MCG user interface. It is important that you select **Submit Request** on **ALL** requests. Please review the following for more information.

MCG User Interface Important Reminders

1. **Do Not Click on the X to Close the Interface**

   In all situations, you **MUST click Submit Request** in the lower right corner for the MCG guidelines to attach to your request. **DO NOT CLOSE THE INTERFACE** as indicated below. If you close the interface using the **X** in the upper right corner and select **Yes–continue**, your authorization will automatically pend for review and any criteria integrated or selected as part of the MCG process will be lost, which could cause decision delays.



2. **Always Select *Submit Request***

   When completing the MCG interface information for your authorizations, select **Submit Request** in the lower right corner (you may need to scroll down to see it) after you save any guidelines selected. This ensures the information is transferred to the Utilization Management team.

Important: If you do not select *'Submit Request'* your request is not considered complete.

MCG

Authorization Request | Request Form | MCG Guideline Documentation Not Required | 3 Submit Request

mcg

Patient : Name : DOB : Gender : show more

Authorization : Type : Comm/FEP Scheduled Inpatient Hospital Status : NoDecisionYet show more

Diagnosis Codes : M25.01(ICD-10 Diagnosis) primary Procedure Codes : 20930(CPT/HCPCS) primary

Geographic Regions All Clear

Procedure Code: 20930 (CPT/HCPCS) MCG Guideline Documentation Not Required

Description : Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)

Submit Request

What should you do if you aren't sure which guidelines to select?

If you are not sure what to select when the guidelines display, you can select **Cancel** when you see the screen below, and a **No guidelines apply** option will appear for you to select so you can appropriately **Submit Your Request**.

MCG

Geographic Regions Maryland Clear

Maryland

Procedure Code: 95807 (CPT/HCPCS)

Description : Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist

A-0145 - Polysomnography (PSG), Sleep Center - (AC)

The procedure is/was needed for appropriate care of the patient because of ...

- ☐ Adult with obesity hypoventilation syndrome, suspected, as indicated by ...
- ☐ Adult with obstructive sleep apnea, suspected, as indicated by ...
- ☐ Central sleep apnea or sleep-related hypoventilation, suspected, as indicated by ...
- ☐ Child, infant, or adolescent with obstructive sleep apnea, suspected, and ...
- ☐ Insomnia and ...
- ☐ Narcolepsy, suspected, as indicated by ...
- ☐ Parasomnia, as indicated by ...
- ☐ Periodic limb movement disorder and ...
- ☐ Postoperative assessment needed after performance of surgery to treat sleep apnea in child, as indicated by ...
- ☐ Restless leg syndrome and ...

Save Cancel

Submit Request

Is training available?

Yes! To assist you further, access the MCG User Interface Walk-Through course for step-by-step instructions. For additional resources and training, please access our Frequently Asked Questions and our full suite of Prior Authorizations/Notifications on-demand training on the Learning and Engagement Center.

Back to top

Attach Clinical Documentation to Prior Authorizations

Including clinical documentation with your electronic prior authorization requests is the most efficient and effective way to ensure you submit a complete request. Prior authorization requests that do not include necessary clinical documentation cannot be decisioned until it is received, causing potential delays.

When utilizing the CareFirst Prior Authorization/Notification Portal you will notice messaging reminding you to attach clinical documentation to your request.

How do I upload clinical documentation?

Access our course, Uploading Clinical Documentation, for step-by-step instructions. You will also find this course on our Learning and Engagement Center. It is located within the **On-Demand Training** heading, under the CareFirst Essentials section.

Important Note: When uploading clinical documentation, please only submit the documentation that supports the authorization request or continued stay instead of the entire medical record.

Back to top

Check out Resources on the Learning and Engagement Center

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

As we have increased the number of courses available for you to access, a new search bar has been added to help make it easier to find the topics you need. You can access it from any page on the Learning and Engagement Center.

Back to top

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.

Back to top

Interested in Learning More about What's Happening with Our Dental Providers?

Check out our BlueImpressions quarterly newsletter on our provider website. From the Newsletter Page, select *BlueImpressions* from the menu on the right to display links to the publications.

Back to top

Government Programs Corner

Complete the 2024 Mandatory Model of Care Training Attestation Today!

All providers who see CareFirst BlueCross BlueShield Advantage DualPrime (HMO-SNP) members **must** complete their mandatory Model of Care training upon enrollment in our network and then annually after that. 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. Continue reading for more information on why and how to complete the training.

⇒ **Access the training here and complete your attestation in less than 10 min now!**

What is Model of Care (MOC) training?

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNP) to 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.

Thank you for helping us meet our members' needs and comply with federal regulations.

Back to top

Effective January 1: Electronic Prior Authorization Portal Available for CareFirst CHPMD and Advantage DualPrime Members

CareFirst announced on September 27, 2024, the CareFirst Electronic Prior Authorization Portal will be available to utilize for CareFirst CHPMD and Advantage DualPrime members beginning 1/1/2025. This system is fully integrated within the CareFirst Provider Portal (https://provider.carefirst.com) allowing you to submit your requests electronically and offers easy-to-read dashboards, streamlined real time decisioning capabilities, and a user-friendly interface.

Register Now for a Live Webinar: To support impacted providers with this upgrade, we will be hosting several live webinars in December and January to walk step-by-step through the system.

Date	Time	Registration Link
Tuesday, December 17 (CHPMD/DSNP December Quarterly Webinar)	1 – 2 p.m.	Register Now
Wednesday, December 18 (CHPMD/DSNP December Quarterly Webinar)	10 – 11 a.m.	Register Now
Tuesday, December 26	11 – 12 p.m.	Register Now
Thursday, January 2	2 – 3 p.m.	Register Now
Tuesday, January 8	3 – 4 p.m.	Register Now
Wednesday, January 14	10 – 11 a.m.	Register Now

For more details, access the **Provider News article**.

Back to top

Access CareFirst CHPMD and Advantage DualPrime Members in CareFirst Direct

Did you know that you could check eligibility, benefits and claims status for CareFirst CHPMD and Advantage DualPrime members in the CareFirst Provider Portal (CareFirst Direct)?

Which providers have access in CareFirst Direct?

Providers who participate in both our Commercial networks as well as our CHPMD and/or Advantage DualPrime networks are able to access CareFirst Direct for eligibility, benefits and claims status.

Important Note: Providers who ONLY participate in our CHPMD or Advantage DualPrime networks will continue using MyHealth Portal at this time.

How do I access CareFirst Direct?

- **Register for access to the CareFirst Provider Portal.**

Go to https://provider.carefirst.com and select the **Register** link. (set up your account *before* the launch date).

  - You will need your Tax ID, Billing NPI and email address to create the account.
  - **You do not need to create a new account if you already have one.**

- **Review the library of Authorization and CareFirst Direct courses and guides** on the CareFirst Learning and Engagement Center (**On-Demand Courses** tab) to help you navigate through the process. Here are direct links to a few to start with:
  - Accessing and Registering for CareFirst Direct
  - Checking Eligibility and Benefits in CareFirst Direct
  - Checking Claim Status in CareFirst Direct

Back to top

Upcoming Terminated Members Claims Payment Recovery Process

Effective February 6, 2025, CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) will implement a process to recover incorrect payments for members who lost their Medicaid eligibility before or during the date(s) of service billed by providers.

The recovery process is due to daily eligibility files from the Maryland Department of Health (MDH) that includes if a CareFirst CHPMD member's eligibility was terminated prior to or during the receipt of healthcare service and will be implemented prospectively for dates of service beginning February 6, 2025.

What Can Providers Expect?
CareFirst CHPMD will notify providers of claims adjustments and related recoveries for retroactively ineligible Medicaid members via letter. CareFirst CHPMD follows the MDH claims recovery guidelines.

Have a question?

For general updates on the new process, consider joining one of our quarterly webinars in December 2024.

Date	Time	Registration Link
Tuesday, December 17	1:00 p.m. – 2:00 p.m.	Register Now
Wednesday, December 18	10:00 a.m. – 11:00 a.m.	Register Now

Please reach out to CareFirst CHPMD at 410-779-9359 or Toll Free at 800-730-8543 with claims specific questions after February 6, 2025.

A Provider News email on this topic was sent to CareFirst CHPMD providers on November 6, 2024. We will issue additional guidance closer to the implementation date.

Back to top

Effective March 1: New Prior Authorization Requirements for CareFirst CHPMD Members

CareFirst Community Health Plan Maryland (CareFirst CHPMD) is continually working with healthcare delivery partners to optimize care management strategies while ensuring members receive affordable, quality care. Prior authorization helps balance access with appropriate utilization. Effective March 1, 2025, Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) services will require prior authorization for CareFirst CHPMD members.

What is changing?

Providers will need to submit prior authorization requests for CareFirst CHPMD members needing PT, OT, and ST services for dates of service beginning March 1, 2025.

Note: *Any PT, OT, ST services rendered by participating CareFirst CHPMD providers prior to March 1, 2025, do not require prior authorization. PT, OT, ST services requested on March 1, 2025, and beyond will require prior authorization.*

Services performed without authorization may not be reimbursed for healthcare services, and providers may not seek reimbursement from members.

How will I request prior authorization?

For dates of service beginning March 1, 2025, you will submit a prior authorization request according to the instructions outlined below:

- **For providers who participate in both our Commercial and CareFirst CHPMD Networks:**
  1. From our provider website, log into the CareFirst Provider Portal (CareFirst Direct).
  2. Select the ‘*Prior Auth/Notification*’ tab.
  3. Select ‘*Start Now*’ within the Medical Prior Authorizations section to access the Prior Authorization Portal and enter your authorization.

Important Note: Providers participating in both our Commercial and CareFirst CHPMD Networks will transition to the CareFirst Prior Authorization system on January 1, 2025. For more information, access the Provider News article sent on September 27, 2024 and the October BlueLink Newsletter sent on October 20, 2024 (includes live webinar registration links).

- **For Providers who only participate in our CareFirst CHPMD Network:**
  1. Log into the CareFirst CHPMD MyHealthPortal to access the digital prior authorization form.
  2. Once logged in, select '*Submit an Authorization*'
  3. Complete the required fields and submit your prior authorization request.
     a. For step-by-step instructions, access the Entering Prior Authorizations for CareFirst CHPMD Members course.

What's Next?

Be on the lookout for additional communication and resources as we get closer to implementing these new requirements. Thank you for your continued support of our CareFirst CHPMD members.

Back to top

Register Now: December Provider Live Webinar

There is one more opportunity to participate in a CareFirst CHPMD and DualPrime plan providers live webinar in 2024. Register now to ensure you have the information you need. **The December live webinar will cover a step-by-step walk through of the electronic prior authorization portal available for CareFirst CHPMD and DSNP members beginning January 1, 2025.**

Please register for one option listed below:

Month	Live Webinar Options
December	Tuesday, December 17, from 1-2 p.m. Wednesday, December 18, from 10-11 a.m.

Back to top

CareFirst CHPMD Monthly and Quarterly Formulary Updates: Pharmacy Benefit

CareFirst CHPMD posts monthly and quarterly formulary updates in its website's *Drug List* section. https://www.carefirstchpmd.com/find-a-drug-or-pharmacy/drug-listformulary-updates

For a non-formulary drug, provider can either switch to a formulary alternative or submit a Prior auth/Medication Exception request to CVS/Caremark to support why the member is unable to use up to three of the formulary products. Documentation is required for approval: name of medication(s) tried and reason for treatment failure: inadequate treatment response, intolerance, contraindication, adverse effect, whichever are applicable. Prior authorizations can be submitted electronically, by fax or by phone. https://www.carefirstchpmd.com/find-a-drug-or-pharmacy/pharmacy-authorizations

If the provider would like to do a Peer-to-Peer review, they can call CVS/Caremark CareFirst CHPMD Prior

Authorization line for Specialty drugs at 1-866-814-5506 or non-Specialty drugs at 1-877-418-4133. A Peer-to-Peer review is only allowed PRIOR to an Appeal being requested. Appeals are processed by the Plan; guidance is included in the Adverse Determination (Denial) letter.

Back to top

Clinical Practice Guidelines

CareFirst CHPMD Clinical Practice Guidelines are designed to assist clinicians with the treatment of the most common medical issues by providing an analytical framework for evaluation and treatment. CareFirst CHPMD's Provider Advisory Committee reviews and approves the Clinical Guidelines yearly. The latest Clinical Guidelines can be found here: Medicaid Clinical Practice Guidelines | CareFirst Community Health Plan Maryland (carefirstchpmd.com)

Note: CareFirst CHPMD publishes medical guidelines from a number of well-respected national sources. These guidelines may have some differences in recommendations. Information contained in the guidelines are not a substitute for a healthcare professional's clinical judgment and is not always applicable to an individual. Therefore, the healthcare professional and patient should work in partnership in the decision-making process regarding the patient's treatment. Furthermore, using this information will not guarantee a specific outcome for each patient. None of the information in the guidelines is intended to interfere with or prohibit clinical decisions made by a treating healthcare professional regarding medically available treatment options for patients.

Back to top

CareFirst CHPMD's Population Health Management Health Education Program Member Referrals

CareFirst CHPMD encourages providers to submit a CareFirst CHPMD Member referral to the Population Health Management Health Education Program for any, but not limited to the following reasons:

- Assist member with transportation to medical appointments.
- Assist member with locating a Primary Care Physician (PCP).
- Educate member about Managed Care Organization (MCO) processes.
- Connect member to a Special Needs Coordinator.
- Connect member to community-based services/education programs.
- Assist member with appointment scheduling.
- Follow up education for emergency department overutilization.
- Follow up education for repeated missed appointments.
- Other

CareFirst CHPMD Member referrals can be made by using the Provider Referral Form located here: Provider Referral Form (carefirstchpmd.com)

The completed form can be emailed to qualityMD@carefirst.com or faxed to 410-779-3957.

Members can also be directed to CHPMD's Health & Wellness webpage for a variety of health education resources. Health Resources | CareFirst Community Health Plan Maryland (carefirstchpmd.com)

Back to top

Is your Provider Data Accurate?

Our CareFirst CHPMD and DualPrime members, your patients, rely on our information about you and your practice in our provider directories. They use these resources to find new physicians, determine plan participation and contact providers to schedule appointments.

Benefits of updating your status:

- You comply with your contractual requirements, specifically if CareFirst or a third party audits your data.
- You will likely receive fewer calls to your office from potential patients you have to turn away.
- Our members have access to the most accurate provider data in our directories and spend less time trying to navigate the healthcare system.

How do I update my information?

You can send updated demographic information changes, including documenting whether your panel is open or closed, and your accepting new patient status in the following ways:

Logging in to the MyHealth Portal and going to **Document Changes**. Select the **Update Contact Information** link and document your updates using the electronic form. Then submit.

- Emailing updates to MDMCcredentialing@carefirst.com.

Back to top

Doula Services Available at No Cost for all Eligible HealthChoice or Fee-For-Service (FFS) Medicaid Recipients

Did you know that pregnant HealthChoice or Fee-for-Service (FFS) Medicaid recipients are eligible for doula services as part of their plan? Help get the word out on this important topic.

What is a doula?

A doula, also known as a birth worker, is a trained professional who provides physical, emotional, and informational support to a birthing person and their partner or spouse. Doulas are non-clinical providers and cannot perform the work of a nurse-midwife, or nurse practitioner or doctor.

What services can they provide?

Doulas can provide services throughout the maternity continuum. They can provide support during the prenatal period, during the birth and during the postpartum period.

Doulas make birth better by providing education, advocacy, physical support, emotional support and partner support. They can also guide pregnant persons to community resources that help connect them to a network of support needed to sustain a healthy pregnancy and promote positive maternal outcomes.

How many prenatal and postpartum visits are covered?

- Up to eight (8) perinatal visits (this can be a combination of prenatal and postpartum visits.

Plus:

- One (1) attendance during labor and delivery.

Who is eligible for this service?

Pregnant Maryland HealthChoice or FFS Medicaid members.

- Maryland HealthChoice or FFS Medicaid members who have been pregnant in the previous 180 days.

How can you connect your patient with Doula Services?

- You can direct CareFirst Community Health Plan Maryland members to call CareFirst Member Services at **1-410-779-9369** or 1-**800-730-8530** and ask to speak with their Care Manager.
- You can send a referral through the CareFirst CHPMD provider portal. See link to form https://www.carefirstchpmd.com/wp-content/uploads/2023/11/Provider-Referral-Form.pdf
- You can also send a message to CareFirst's Medicaid Care Management email CHPMDHealthServices@carefirst.com and your request will be routed to the appropriate team that will promptly follow up with the member.

More information about the Doula Program can be found on the Maryland Department of Health's website: https://health.maryland.gov/mmcp/medicaid-mch-initiatives/Pages/DoulaProgram.aspx

Back to top

Events

Provider Live Webinars Available for Registration

We will have several live webinars available for you to attend in December and January and additional will be offered throughout 2025. Please register for those that apply to you by clicking on the links below.

Professional Quarterly Webinars

2025 Schedule coming soon!

Miss our latest professional quarterly webinar? Check it out here!

Hospital Quarterly Webinars

Tuesday, December 10, from 10-11 a.m.

Wednesday, December 11, from 1-2 p.m.

Miss our latest hospital quarterly webinar? Check it out here!

Behavioral Health Quarterly (Professional) Webinars

Wednesday, December 11, from 10-11 a.m.

Miss our latest behavioral health (professional) quarterly webinar? Check it out here!

Home Health Provider Webinar

Thursday, December 19, from 11-12 p.m.

When you click a link, a registration form should appear. Fill out all fields on the form and submit your registration.

Once the registration is submitted, you will receive an auto-generated confirmation email from no-reply@zoom.us. This confirmation email will include a link to the webinar. You will use this link to join the webinar on the date and time selected (indicated in the email).

Need help registering? Check out this interactive guide!

Back to top

Holiday Closings

- Christmas Day: Wednesday, December 25
- New Years Day: Wednesday, January 1
- Martin Luther King, Jr. Day: Monday, January 20
- President's Day: Monday, February 17

Back to top