Breaking News

- Effective January 1: New Medicare Advantage PPO Plans Launching in Maryland and Washington, D.C.
- Coming Soon: CareFirst's Provider Satisfaction Survey
- Important Reminders: Inpatient and Observation Admissions Payment Policy
- Coming Soon: Prior Authorization Requirements Verification Self-Service Tool

Administrative Support

- Review Changes to our Payment Policies
- Updates to the Care Management Referral Process
- Medical Provider Manual Updates

In the Spotlight

- CareFirst Provider Service and Provider Relations Roles and Responsibilities

Noteworthy Stories

- Best Practices for Professional Practitioners Applying to Join an Existing Group
- Important Network Lease Accounts Address Update
- Reminder: MedStar Select Plan Administered by CareFirst BlueCross BlueShield (CareFirst)
- Are You Billing the Most Appropriate Code?
- Update and Attest to Your Provider Directory Data Every 90 Days
- Reminder: Prior Authorization Required for Advanced Imaging (Cardiology and Radiology)
- 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 for our Dental Providers?

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

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Government Programs Corner

Events

Breaking News

Effective January 1: New Medicare Advantage PPO Plans Launching in Maryland and Washington, D.C.

CareFirst is excited to share that we are launching three new Medicare Advantage PPO plans in Maryland and the District of Columbia with an effective date of January 1, 2025. With the launch of these new plans, the CareFirst BlueCross BlueShield Advantage Core (HMO) and the CareFirst BlueCross BlueShield Advantage Enhanced (HMO) will no longer be available for members to enroll in after December 31, 2024.

How Can you Support your Patients with this Change?

One or more of your patients could have insurance coverage through CareFirst BlueCross BlueShield Advantage Core (HMO) or CareFirst BlueCross BlueShield Advantage Enhanced (HMO) plans. These patients covered by these will need to make an active choice during the Annual Election Period (Oct. 15- Dec. 7) if they want private insurance coverage, Medicare Advantage or Medicare Supplemental coverage. If they do not make a choice for private insurance coverage, they will go back to Original Medicare coverage only.

Will my Patients be Notified?

Yes, all members impacted by this change will be notified by CareFirst the first week of October. We encourage you to contact any of your patients you believe will be impacted by this change to arrange any pending follow-up visits before December 31, 2024.

Please note that the Medicare Advantage HMO network will end on December 31, 2024; however, you may also be in our Medicare Advantage PPO network. We are launching three new plans in Maryland and the District of Columbia January 1, 2025—CareFirst BlueCross BlueShield Advantage Essential (PPO), CareFirst BlueCross BlueShield Advantage Complete (PPO) and CareFirst BlueCross BlueShield Advantage Salute (PPO). Please note your patients may choose one of these plans and continue with a new CareFirst Medicare Advantage plan.

How can I verify my network participation?

To verify your network participation, access the How to Determine Which CareFirst Networks You Are In user guide. If you participate with the new PPO plans you will see one or more of the following displayed within the **Plans Accepted** section of the Find a Doctor tool (Provider Directory):

- CareFirst BlueCross BlueShield Advantage Essential (PPO)
- CareFirst BlueCross BlueShield Advantage Complete (PPO)
- CareFirst BlueCross BlueShield Advantage Salute (PPO)

Register Now for a Live Webinar!

To support providers with more information about these new plans, we will be hosting several live webinars in December and January. 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

Back to Top

Coming Soon: CareFirst's Provider Satisfaction Survey

Starting in the Fall, you may receive an email from CareFirst inviting you to participate in our Provider Satisfaction Survey. CareFirst, along with Escalent, an independent research company, is reaching out to specific provider audiences.

The goal of this survey is to gather feedback and learn about the perceptions our providers have of CareFirst based on your overall experience working with us. The survey should take about 10-15 minutes to complete.

To ensure your computer doesn't block the survey email, please add CareFirstCustomerInsights@carefirst.com to your address book.

If you have any questions about the survey, please send an email to CustomerFeedBack@carefirst.com.

Back to Top

Important Reminders: 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 and August BlueLink Newsletters and in this Provider News email sent on July 23, 2024. These changes went into effect on August 1, 2024.

- **Reminder for Observation Notifications:** A separate inpatient authorization request is required if a member changes from observation to inpatient.
- **Add Level of Care (LOC) to NICU Requests:** The appropriate revenue code can be added within the procedure codes section of the precertification form.

Admission Level	Revenue Code
NICU LOC 2	172
NICU LOC 3	173
NICU LOC 4	174

- **For hospitals that do not provide CareFirst EMR access:** Include the LOC in the concurrent review information you submit. This can be added within the notes section when you upload your clinical documentation.
    - **Additional reminder:** When submitting concurrent review information, please only submit the documentation that supports the continued stay instead of full medical records
    - Access this course for more information: Uploading Clinical Documentation

Where can I find more information?

Here are direct links to useful tools and training to assist you:

- **All Lines of Business**
    - Frequently Asked Questions for Inpatient and Observation Payment Policy
- **Commercial, FEP, Medicare Advantage Members**
    - How to Add Level of Care to Inpatient Requests
    - How to Enter an Observation Notification
    - Entering Outpatient Authorizations *(for BlueChoice and Medicare Advantage observation services)*

Back to Top

Coming Soon: Prior Authorization Requirements Verification Self-Service 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.

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

Back to Top

Administrative Support

Review Changes to our Payment Policies

The following Payment Policies have been updated in the on-line Payment Policy Reference Manual.

- **Policy PP CO 100.01 DME Supplier Eligible Codes –** this policy has been updated to include information already found in the online Provider Manual. This update does not change how claims are currently processed.
- **Policy PP CO 050.01 Bilateral Services –** this policy has been updated to provide clarification on how multiple procedures are ranked based on RVU. This information is already found in the online Provider Manual and does not change how claims are currently processed.
- **Policy PP CO 900.01 Home Health –** this policy has been updated to remove the non-routine supply codes list from the CPT/HCPCS Codes section. An associated companion table for these codes, that are eligible for reimbursement, is now linked to the policy in the Payment Policy database. The new table now includes the addition of several more codes to be effective on December 15, 2024. The list, which was also previously under the Quick Reference Guide section of the CareFirst website, has been removed from that location.

Back to Top

Updates to the Care Management Referral Process

We are excited to share improvements to our referral process, designed to be simple and seamless for physicians and staff. Effective October 1, 2024, Care Management referrals for any CareFirst member (Commercial, FEP, Maryland Medicaid, Medicare Advantage and Dual-Eligible Special Needs) may be submitted directly to one team.

Here's what you can expect:

- **Easy Referrals:** Referrals can be made 24/7 regardless of insurance policy type.
  - Online referral form in the provider portal *https://provider.carefirst.com/providers/care-management/care-management-eform.page*
  - Secure/encrypted email to *caremanagement@carefirst.com*
  - Care Management fax—(410) 505-2122
  - Call Care Management direct line—(833) 536-2004
- **Timely Communication:** Confirmation of the Care Management referral can be expected within 24 business hours with ongoing communication throughout the care plan, including activation, graduation and acute event follow ups.

Behind the scenes our team will:

- **Check Care Plan Eligibility:** A Care Management Coordinator will review the referral and match members to the most appropriate suite of clinical support programs tailored to the patient's needs.
- **Holistically Support Your Patient:** The Care Management Support Team will focus on the reason for the referral while addressing Social Drivers of Health (SDOH), gaps in care, medications, behavioral health and follow-up appointments with providers.
- **Incorporate Specialized Care Management:** When needed, teams specializing in Oncology, High-Risk OB, Pediatrics and HIV will be engaged.

These enhancements will improve access and timeliness to expanded support and resources to you and your staff. Your CareFirst Population Health Strategy Consultant will remain the point of contact for all other matters.

Back to Top

Medical Provider Manual Updates

Check out the most recent changes to our Medical Provider Manual. Updates include:

- Clarified FEP Advance Benefit Determination information
- Added information regarding the use of third-party billing companies
- Added information regarding authorizations for cardiology and advanced imaging based on recent policy updates
- Updated information about prior authorizations for elective admissions based on recent policy updates
- Revised prior authorization and notification timeframes based on recent policy updates

Back to Top

In the Spotlight

CareFirst Provider Service and Provider Relations Roles and Responsibilities

Did you know that CareFirst Provider Relations and Provider Service have specific roles and responsibilities to help make doing business with CareFirst easier and more efficient? Please review the details below to

learn more!

How can Provider Service assist?

Provider Service is your first point of contact for all the following:

- Eligibility and benefits
- Claims Status
- Complaints and Appeals
- Check Status
- Payment retractions and overpayments *(which also includes having check payments reissued)*

Important: Keep in mind that you can always access self-service tools (CareFirst Direct and CareFirst on Call) for the majority of the information you may need. Access the following guide for assistance:

- Provider Billing Self-Service Guide

When you do need to contact Provider Service, it is helpful to record the name of the person you spoke with, date and time of the call, and the call reference number given by the representative.

- **Please note**: The call reference number is required before escalating to Provider Relations. The reference number gives Provider Relations a starting point to see what attempt has been made to resolve your concerns with the Provider Service and the next best steps.

An alternative method to calling Provider Service is to submit a claim inquiry through CareFirst Direct. *Be sure to record the control number given after the inquiry is submitted.*

- For step-by-step instructions on how to submit an claims inquiry please refer to Corrected Claims, Inquiries and Appeals on the Learning and Engagement Center.

To determine the best Provider Service telephone number to call based on the members CareFirst ID prefix, access the Provider Quick Reference Guide.

How can Provider Relations assist?

As a Participating Provider of CareFirst BCBS, you have access to a Provider Relations Representative. Provider Relations key responsibilities include:

- Training and education to providers and their staff. Here are few helpful links:
  - Looking for Support?
  - CareFirst Learning and Engagement Center
- Clarify CareFirst policies and procedures:
  - Professional Provider Manual (carefirst.com)
  - Medical Policy Reference Manual | CareFirst BlueCross BlueShield
  - Payment Policy | CareFirst BlueCross BlueShield
- Identify industry trends
- Assist with resolving **escalated** claims issues after attempts to resolve the issue with Provider Service has been exhausted.

Who is my Provider Relations Representative?

If you aren't sure who your Provider Relations Representative is, call 410-872-3512 and leave a message with your name, telephone number, email address and tax ID and a representative will reach out within a few days.

Back to Top

Noteworthy Stories

Best Practices for Professional Practitioners Applying to Join an Existing Group

If you are a professional practitioner joining an existing group, it is important that you upload the following documentation when completing the CareFirst Questionnaire:

- A detailed cover letter describing your request on your organization's letterhead
- CAQH Application
- If you do not have a CAQH ID or a CAQH application, then you must add a completed Uniform Credentialing application
- Applicable Group Tax IDs and Billing NPIs
- A complete list of applicable practitioners, including CAQH IDs or Rendering NPIs
- An electronic copy of licenses
- An electronic copy of insurance policies

For Joining an Existing Group: Please be sure your CAQH Authorization Settings accurately reflect the desired organization access.

All of these documents are required for your application to be complete. For more information visit the How to Apply page on the provider website to ensure you are completing all required steps.

Back to Top

Important Network Lease Accounts Address Update

Effective immediately, all Netlease claims and correspondence should be sent to the following address:

P.O. Box 11415
Lexington, KY 40512

Do not use the previous address in El Paso, TX as this is no longer being utilized.

As a reminder, CareFirst jointly administers – with third-party administrators (TPAs), self-insured employers, and health and welfare funds – the Network Lease claims product. This product enables

employers to use the CareFirst network of providers while still designing and administering their health benefits. CareFirst is actively involved and responsible for collecting and pricing claims, training and the maintenance of provider networks. The TPAs are responsible for issuing ID cards, handling claims adjudication, benefit and claims inquiries, correspondence, appeals, etc. Participating providers agree to accept the CareFirst allowance as payment in full for services rendered, minus any deductibles and coinsurance amounts.

For more information about Network Lease, access the Provider Manual (Chapter 2) and the CareFirst TPA/Network Lease Accounts guide.

Back to Top

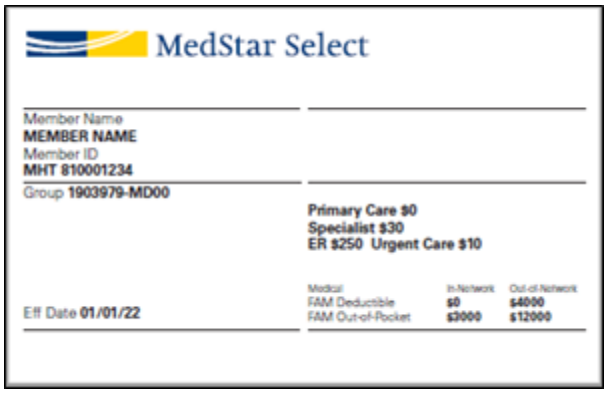
Reminder: MedStar Select Plan Administered by CareFirst BlueCross BlueShield

As a reminder, in January 2022, CareFirst BlueCross BlueShield began administering the MedStar Select plan.

Who is impacted?

CareFirst commercial members participating in the MedStar Select plan, identified by the plan name on their CareFirst member ID card.

- Please check the back of the card for updated health plan contact information for service, claims, medical, behavioral health and substance use disorder.



What do you need to know?

- Eligibility and benefits for MedStar Select members can be obtained through CareFirst Direct.
- Claims should be submitted to CareFirst.
- Authorizations entered for members should be submitted through CareFirst's Prior Authorization Portal.
- Appeals should be submitted to the following addresses:

Professional Providers	Institutional Providers
Mail Administrator P.O. Box 14114 Lexington, KY 40512-4114	Clinical Appeals and Analysis Unit (CAU) Mail Administrator CareFirst BlueCross BlueShield

P.O. Box 17636
Baltimore, MD 21298-9375

- Behavioral Health: Contact CareFirst's Mental Health and Substance Use Disorder line at 800-245-7013. Select option 2 for assistance with mental health support services and care management.

Back to Top

Are You Billing the Most Appropriate Code?

Providers should ensure they have selected the most appropriate and comprehensive code for services provided. If separate, individual services have components that are similar or overlapping and could be billed using a comprehensive code, providers should bill the comprehensive code. For example, it is not appropriate to bill codes 87491, 87591, and/or 86661 separately for each individual organism on the same claim, for the same patient, for the same date of service. The correct code for this scenario is 87801 (multiple organisms). Due to the multi code re-bundling edit, CareFirst may deny the individual codes and replace them with the appropriate comprehensive code for the combined services, before adjudication. If CareFirst does not replace the codes, the provider may receive a denial and must then rebill with the comprehensive code. Reference to this is found in the Medical Provider Manual, under the Claims Adjudication section in Chapter 9.

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.

CareFirst has a self-service tool within the Provider Portal (CareFirst Direct) that lets you quickly update and/or attest to your provider and practitioner information.

How often should I update and attest?

Per Federal law, professional providers in our Commercial and Medicare Advantage networks must attest/update their data every 90 days. The CareFirst Provider Directory Updates and Attestations self-service tool is the fastest and easiest way to satisfy this requirement and ensure your data is always up to date. This includes your practice URL and email addresses as well.

IMPORTANT: CareFirst's self-service tool is not integrated with CAQH ProView. Providers in our Commercial and Medicare Advantage networks must attest/update their data every 90 days with CareFirst directly.

How do I access the self-service tool?

Step by step instructions are available 24/7 by accessing our Provider Directory Updates and Attestations

course. We have also pulled together an FAQ document to help answer any questions.

For more information, visit the Update Practice Info page on the provider website.

Back to Top

Reminder: Prior Authorization Required for Advanced Imaging (Cardiology and Radiology)

In May and July, we shared that CareFirst and EviCore are collaborating to provide services for CareFirst members enrolled in our **fully insured commercial plans (on the Facets system)** for Cardiology and Radiology Advanced Imaging. Ordering providers should submit prior authorization for outpatient services to EviCore for these members.

How do I identify commercial fully insured members on Facets?

Commercial members are those NOT part of these Government Program plans:

- Federal Employee Program (FEP) ('R' prefix)
- Federal Employee Health Benefit Plan (FEHBP or Group ND50)
- Medicare Advantage ('MAC' or 'EGE' prefixes)
- CareFirst Community Health Plan Maryland (CareFirst CHPMD)
- Advantage DualPrime.

You can verify if a member is commercial fully insured on Facets by logging into our Provider Portal (CareFirst Direct) at https://provider.carefirst.com. Here are a few resources to help with step-by-step instructions

- How to Identify Commercial Fully Insured Members in CareFirst Direct
- Prior Authorization Requirements for Advanced Imaging (Cardiology and Radiology)

Are training and resources available?

Yes! Several live webinars were held in July to help familiarize providers with these changes. If you couldn't attend, you can access the recording here. In addition, here are links to additional resources:

- Please visit EviCore's Provider Resources page for information on associated clinical guidelines, specific services requiring authorization and FAQs.
- Ordering providers can access this course for step-by-step instructions: How to Request Prior Authorization for Advanced Imaging (EviCore's CareCore National Portal)
- Servicing providers can access this course for step-by-step instructions: Authorization Lookup for Servicing Providers - Advanced Imaging (EviCore's CareCore National Portal)

Back to Top

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

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively "CareFirst") are continually looking for ways to assist in expediting requests that come through our prior authorization/notification system. This occurs by integrating the MCG clinical criteria you experience as part of the request submission process. To assist you with the MCG user interface, we wanted to share some helpful tips to ensure your request is reviewed in a timely and accurate manner.

MCG user interface overview

MCG uses evidence and analytics to proactively manage care, predict resource needs and benchmark the recovery process. MCG care guidelines work seamlessly with our prior authorization/notification portal to reduce authorization time while maintaining decision quality.

The authorization/notification system will automatically trigger the MCG guidelines, allowing you to complete any additional information needed within the user interface. The information requested will depend on the combination of diagnosis and procedure codes entered for the patient. There will be times when you will:

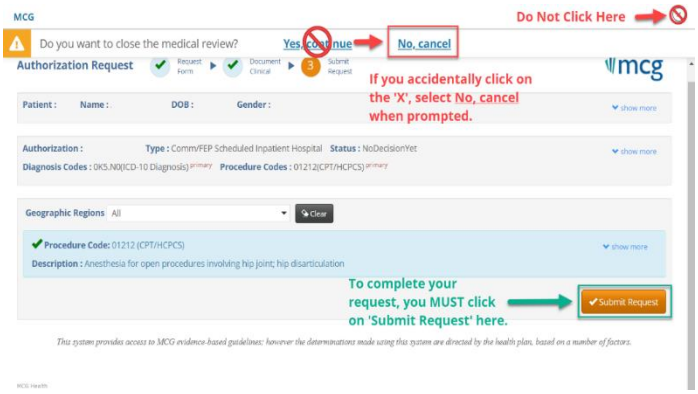
Add/select guidelines based on the patient's situation and provide additional clinical details

Add/select **No Guidelines Apply** when appropriate for the patient

- You will be notified in the disclaimer box that no guidelines apply and be asked to click **Submit Request**.

MCG user interface best practices

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

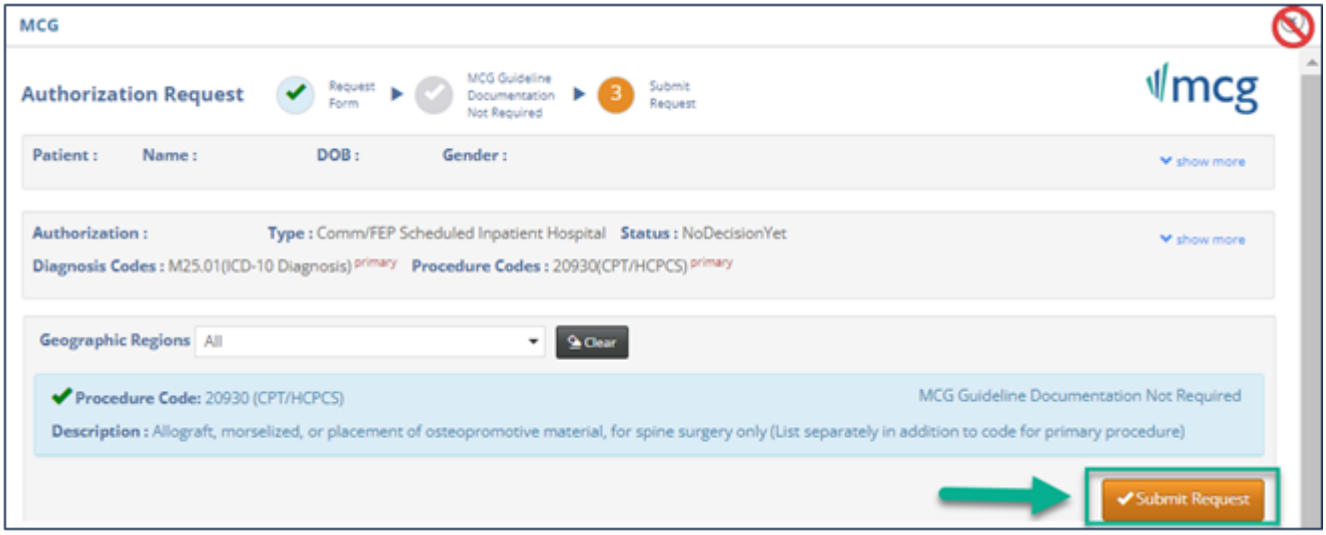


In all situations listed above, you **MUST click Submit Request** in the lower right corner for the MCG guidelines to attach to your request. **DO NOT CLICK ON THE X** as indicated below. If you close the interface using the *X* in the upper right corner and select *Yes–continue*, your authorization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

2. **Always Select Submit Request**

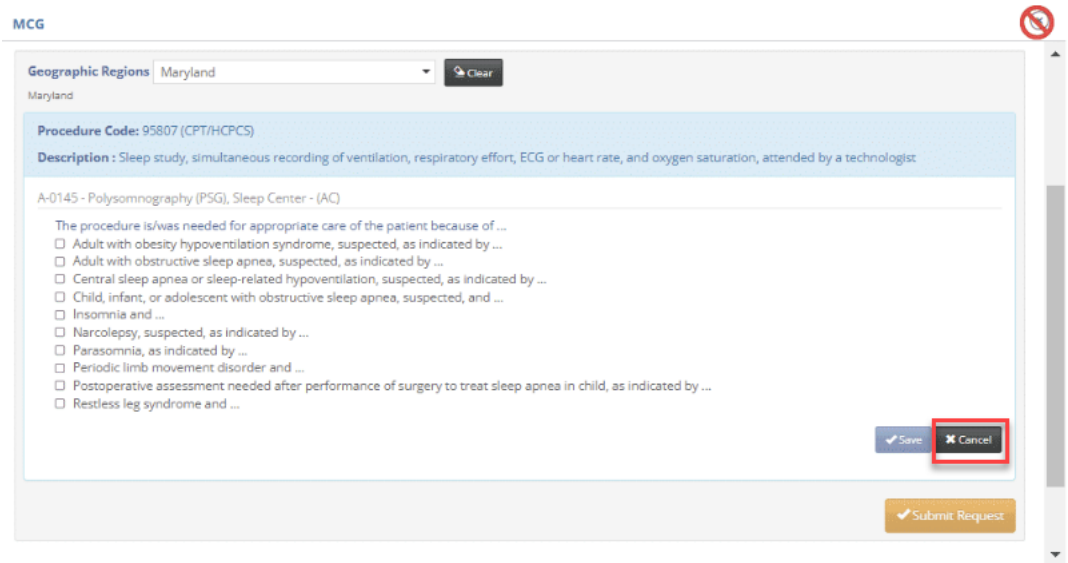
When completing the MCG interface information for your authorizations, select **Submit Request** in the lower right corner (you may need to scroll down to see it) after you save any guidelines selected. This ensures the information is transferred to the Utilization Management team.

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



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**.



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 using 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 for 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

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

CareFirst is excited to announce 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.

Which Providers are Impacted?

For this launch, providers who participate in both our Commercial networks as well as our CareFirst CHPMD and/or Advantage DualPrime networks are impacted by this launch.

Important Note: Providers who ONLY participate in our CareFirst CHPMD or Advantage DualPrime networks will continue using the digital prior authorization form and MyHealth Portal at this time.

Will Eligibility and Benefits be Available in CareFirst Direct as Well?

Yes! Providers impacted by this launch will utilize the CareFirst Provider Portal (CareFirst Direct) to check eligibility and benefits for their CareFirst CHPMD and DualPrime members as well.

What's Next?

- **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

- 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
- Authorization System Basics
- Entering Outpatient Prior Authorizations
- Entering Inpatient Prior Authorizations

Back to Top

2024 Mandatory Model of Care Training Attestation is Due

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.

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 ensure 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 it individually. We will also facilitate the MOC training during our quarterly DualPrime live webinars (see registration links below).

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

Back to Top

Access Health Equity Courses on the CareFirst Learning and Engagement Center

We believe that every person should have the opportunity to live their healthiest and happiest life, regardless of where they live, work or play. We are focused on eliminating the obstacles and taking steps to advance health equity in the communities we serve.

One of the ways we can better promote health equity is through provider and community collaboration. As we focus more on value-based care and community health, understanding the language and topics related to health equity will be at the core of this initiative.

That's why we are committed to bringing you high quality resources, including trainings, articles, case studies and more.

Where can I find the available courses?

Navigate to the Health Equity section of the CareFirst Learning and Engagement Center to access the courses or click on one of the course links below to get started today!

- LGBTQ+ Cultural Competency
- Structural Competence: Moving Beyond Stereotypes
- Understanding Implicit Bias (1.0 AMA PRA Category 1 Credit for In-Network Providers)
- What's Happening in my Backyard?

Back to Top

Register Now: 2024 Provider Live Webinar Schedule

We are excited to, once again, offer our CareFirst CHPMD and DualPrime plan providers live webinars that will cover important topics like electronic claims submission, prior authorizations, appeals and grievances, Model of Care training and much more.

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

Invitation to Join our Medicare and Medicaid Pharmacy & Therapeutics Committee

Are you interested in joining the Medicare and Medicaid P&T Committee as an advisor? The primary purpose of the Pharmacy and Therapeutics Oversight Committee (P&T) is to ensure Medicare and Medicaid health plans have adequate oversight and evaluation of its Pharmacy Benefit Manager (PBM), CVS, related to medication use. Your clinical expertise will be crucial in evaluating drug therapies, formulary decisions and policy development.

When does the committee meet?

The committee meets quarterly, from 5:30-6:30 p.m.on the first Tuesday of February, May, August and November via Teams. Benefits include a quarterly stipend, professional development and network opportunities.

How can I find out more information?

Please reach out to MedicaidPharmacyTeam@carefirst.com for more information. This position is open to physicians, pharmacists, nurses and other healthcare professionals.

Back to Top

Safe Opioid Prescribing Tips

General Recommendations:

- Consider utilizing non-pharmacologic and non-opioid pain control measures first.
- Check the Prescription Drug Monitoring Program (PDMP) [Chesapeake Regional Information System for

our Patients (CRISP)] for controlled substance utilization history.

- Always offer naloxone prescription for opioid users.
- Review patients with multiple prescribers for potential "doctor shopping" behavior and discuss risks of using multiple prescribers with the patient.
- For chronic opioid users, make sure patients sign an Opioid Treatment Agreement form with your clinic and conduct random urine drug screens.

HEDIS Measurement Improvement Tips:

- Utilize the lowest dose of opioids for the shortest amount of time and review treatment plan for new opioid users prior to the 30-day and 62-day period.
- Set expectations at start-of-care that member will only use one provider for opioid medications.
- Allow for only one primary prescriber per patient for opioid medications within your clinic.

Back to Top

CareFirst CHPMD (Maryland Medicaid) Wegovy Coverage

Effective September 15, 2024, Managed Care Organizations (MCOs) began covering Wegovy when used to reduce the risk of major adverse cardiovascular death, or non-fatal stroke in adults with established atherosclerotic cardiovascular disease (ASCVD) and who are either obese or overweight. Patients with diabetes cannot be treated with Wegovy. Documentation is required to support cardiovascular disease and BMI greater than or equal to 27 kg/m2. *Patients with diabetes may be treated for risk reduction of cardiovascular events with Ozempic.* At this time, oral drugs or injections for central nervous system stimulants, anorectics, and any other agents when used for controlling weight will still not be covered per Maryland Department of Health regulations.

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 member is unable to use up to three of the formulary products. Documentation is needed for approval and must include name of medication(s) tried and reason for treatment failure(s), intolerance and/or contraindication, whichever are applicable. Prior authorizations can be submitted electronically, faxed or by phone. https://www.carefirstchpmd.com/find-a-drug-or-pharmacy/pharmacy-authorizations

Back to Top

Are You Accepting New Patients?

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.

But what if you aren't accepting new patients or your panel is closed?

Suppose your panel is closed, or you are only accepting new patients under certain circumstances. In that case, we need your information as soon as possible to ensure your data is accurate. Notifying us if you only accept certain new patients (e.g., referrals) is also important. In those situations, your status is considered "Not Accepting New Patients" and must also be updated in our provider directory.

Important Note: "Accepting New Patients" status is listed and updated at the practitioner level. Individual practitioners will need to ensure their status is correct.

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.

Member outreach:

CareFirst members often report what they feel is inaccurate information with our provider directories. When our members hear comments from provider offices like, "We are unable to get you an appointment until several months from now," or "Our scheduler is not open for new patients right now," they assume you are not accepting new patients and contact us. It's important that, if you are accepting new patients, you reinforce that fact with our members even if you can't schedule an immediate appointment. This will reassure our members and reduce potential calls from CareFirst to follow up on reported directory inaccuracies unnecessarily.

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 into the MyHealth Portal 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

Is Your Pregnant Patient a Maryland Medicaid Participant?

Completing the Maryland Prenatal Risk Assessment (M-PRA) is a Medicaid participant requirement and should be completed at the first prenatal care visit.

Completing the Maryland Prenatal Risk Assessment (M-PRA) for every pregnant Medicaid participant is an important part of Maryland's overall strategy for reducing maternal and infant mortality and closing the gap in healthcare disparities.

This required task can be completed in three easy steps:

Please note: The M-PRA does not need to be filled out by a physician. Office staff can complete it.

- **Step 1**: Fill out the M-PRA form (DHMH 4850) at the patient's first prenatal visit.

  Why: *The M-PRA identifies pregnant person is at risk for low birth weight, pre-term delivery and other healthcare conditions that may put them and/or their infant at risk.*

- **Step 2:** Fax the form to the local health department where the patient resides.

  Why: *The local health departments use the M-PRAs to identify pregnant individuals who may benefit from local programs, or need assistance navigating the healthcare system. They also forward M-PRAs to the patient's MCO so they can link them to care coordination and case management services.*

- **Step 3**: Develop a plan of care based on the pregnant person's risk factors.

  Why: *Having a plan helps anticipate problems and facilitates early intervention. A plan also helps with health promotion, education and shared decision-making.*

More to know…

- You can be reimbursed for completing this process.
- Use HCPCS code H1000. Only one risk assessment per pregnancy.

Timing is Everything!

Timely completion and faxing of the M-PRA ensures pregnant individuals connect to case management services faster! It should be completed within 10 days of the first prenatal care visit.

Learn more about the Maryland Prenatal Risk Assessment and download a copy with instructions and fax numbers for local health departments.

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, 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 people 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 perinatal visits (this can be a combination of prenatal and postpartum visits).

Plus:

- One 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 6 months.

How can you connect your patient with Doula Services?

- You can direct CareFirst CHPMD 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

Medicaid Provider Satisfaction Survey Results

The Center for the Study of Services (CSS) administered the 2023 PCP Satisfaction Survey for the Maryland Department of Health on behalf of all the HealthChoice Managed Care Organizations (MCOs) in Maryland. PCPs were asked to rate their satisfaction with the specified MCO they participate with. The survey included questions on claims, preauthorization, customer service and provider relations.

CareFirst CHPMD's 2023 PCP Satisfaction Summary of Results are as follows:

Measure Category	2023 Composite Score	2022 Composite Score	HealthChoice Aggregate 2023
Overall Satisfaction	89.1%	84.5 %	83.4%
Claims	71.3%	47.1%	53.5%
Preauthorization	61%	45.3%	41.5%
Customer Service/Provider Relations	59.7 %	41.7%	50.2 %
Case Management/Care Coordination	62.7 %	46.3 %	44.8 %

In MY 2023, CareFirst CHPMD demonstrated significant improvement in all major categories when compared to MY 2022. CareFirst CHPMD also performed better in every category when compared to the aggregate scores of all MCOs combined.

CareFirst CHPMD is committed to improving the experience of our network providers by acting on the opportunities of improvement that were identified and implementing timely and meaningful interventions.

CareFirst CHPMD's 2024 PCP Satisfaction Action Plan includes the following:

- Removing the prior-authorization requirement for physical, occupational and speech therapies.
- Using claims data to match members with their PCP.
- Creation of a new online referral form for providers to directly refer members that need outreach.
- Creation of provider-education webinars hosted by the Provider Relations Team
- Increase use of claims auto-adjudication to improve timeliness.
- Provider incentives for certain quality initiatives.

  Enhancement to the Provider Portal.

A copy of the most recent State of Maryland Executive Summary Report for HealthChoice PCP Satisfaction can be viewed here: 2023 State of Maryland Executive Summary Report on PCP Satisfaction.

Medicaid Member Survey Results (CAHPS®)

The State of Maryland Department of Health (MDH) contracts with the Center for Study of Services (CSS), a National Committee for Quality Assurance (NCQA)-certified survey vendor, to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Adult and Child Medicaid Survey. The survey measures the patient experience of care and gives a general indication of how well the health plan meets member's expectations. The overall goal of the survey is to provide performance feedback that MCO's can act upon to improve overall member experience.

CareFirst CHPMD's MY 2023 Member Satisfaction Summary of Results are as follows:

Adult Members:

Measure Category	2023 Composite Score	2022 Composite Score	HealthChoice Aggregate 2023
Getting Needed Care	81.70%	79.30%	78.19%
Getting Care Quickly	77.07%	78.58%	78.34%
Rating of Personal Doctor	73.25%	64.41%	64.89%
Rating of Specialist Seen Most Often	66.25%	60.00%	61.79%
Rating of All Health Care	58.27%	56.25%	55.19%
Coordination of Care	95.65%	77.78%	82.55%
Rating of Health Plan	56.28%	52.87%	55.93%
How well Doctors Communicate	96.58%	88.99%	91.78%
Customer Service	90.89%	90.83%	88.60%

In MY 2023, CareFirst CHPMD demonstrated improvement in seven of nine adult categories when compared to MY 2022. There were notable improvements in the "Coordination of Care" and "How Well Doctors Communicate" categories. CareFirst CHPMD also performed better in eight out of nine categories when compared to the aggregate scores of all MCOs combined.

Child Members:

Measure Category	2023 Composite Score	2022 Composite Score	HealthChoice Aggregate 2023
Getting Needed Care	75.38%	74.71%	77.9%
Getting Care Quickly	78.93%	79.58%	81.67%
Rating of Personal Doctor	69.11%	71.82%	73.65%
Rating of Specialist Seen Most Often	71.43%	67.44%	67.36%
Rating of All Health Care	62.30%	62.25%	67.84%
Coordination of Care	75.32%	90.91%	77.94%
Rating of Health Plan	63.02%	67.28%	66.83%
How well Doctors Communicate	88.93%	91.06%	90.77%
Customer Service	72.97%	93.86%	82.70%

In MY 2023, CareFirst CHPMD only demonstrated improvement in two of nine child-focused categories when compared to MY 2022. CareFirst CHPMD scored below the MCO aggregate scores for all MCOs in eight out of nine categories.

CareFirst Community Health Plan of Maryland is committed to improving member experience by acting on the opportunities for improvement identified and implementing timely and meaningful interventions.

CareFirst Community Health Plan of Maryland's 2024 Adult and Child Member Satisfaction Action Plan includes the following:

- A comprehensive plan to educate staff and network providers regarding member satisfaction best practices.
- Deploying several member micro-surveys throughout the year with follow up calls to determine root-cause of dissatisfaction.
- Creation of a dedicated member-services trainer position.
- Monthly Access and Availability audits to better understand member access to care barriers.
- Enhancements to Call Center Metrics monitoring.

A copy of the State of Maryland Executive Summary Report for Health Choice MCO's can be viewed here: State of Maryland 2023 Executive Summary Report on Member Satisfaction

Back to Top

Events

Provider Live Webinars Available for Registration

We will have several live webinars available for you to attend in the coming months and additional will be offered throughout 2024. Please register for those that apply to you by clicking on the links below.

Professional Quarterly Webinars

- Wednesday, December 4, from 10-11 a.m.
- Thursday, December 5, from 1-2 p.m.

Did you 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.

Did you miss our latest hospital quarterly webinar? Check it out here!

Behavioral Health Quarterly (Professional) Webinars

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

Did you 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

- Election Day: Tuesday, November 5
- Veterans Day: Monday, November 11
- Thanksgiving Day: Thursday, November 28
- Day after Thanksgiving: Friday, November 29
- Christmas Day: Wednesday, December 25

Back to Top