CareFirst
Family of health care plans

Administrative Functions

This manual provides information for CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and The Dental Network (CareFirst) Dental providers.

Per the terms of the Participating Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable. If we make any administrative or procedural changes, we will update the information in this manual and notify you through **email** and **BlueImpressions**, our online Dental provider newsletter.

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

Dental Credentialing

Providers who want to participate in the CareFirst provider networks are required to submit credentialing information. This information is verified to confirm that our credentialing criteria are met. This includes but is not limited to:

- Valid, current, unrestricted licensure
- Valid, current Drug Enforcement Agency (DEA) and Controlled Dangerous Substance (CDS) registration, if applicable
- ECFMG certificate, if applicable
- Appropriate education and training
- Specialty board certification, if applicable
- Review of work history
- Acceptable history of professional liability claims
- Professional liability coverage certification which must include the limits of coverage of $1M/$3M, the expiration date and the name of the provider covered under the policy; shared limits coverage is not acceptable

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

CareFirst encourages the use of the Council for Affordable Quality Healthcare (CAQH) ProView application. New practitioners can go directly to CAQH ProView and complete the credentialing application online through **CAQH ProView**. Once you have completed your application (CAQH will email you notification that your application is complete), and you have authorized CareFirst to access your data, download and print the **CAQH Provider Data Sheet**, fax it to CareFirst at 410-720-5080 or email it to **dentalcontracting@carefirst.com**. CareFirst will add you to our CAQH ProView roster. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

The CAQH credentialing system compiles and organizes comprehensive data from more than 600,000 providers in 23 health plans nationwide at no cost to providers. As a result, providers avoid redundant submission of credentialing information to participating health plans and health care organizations. Only one completed application per provider is needed.

If you have already completed the application through another CAQH member insurance company:

- Be sure that you have verified your data within the last ninety (90) days
- Authorize CareFirst to access your information via the **CAQH ProView**
- Complete the top portion of the **CAQH Dental Provider Data Sheet** and indicate that you have completed the CAQH application
- Fax the CAQH Dental provider Data Sheet or **Dental practice questionnaire** and a complete **Dental Billing Authorization Form** indicating the networks you are interested in joining to 410-720-5080

For more information on our credentialing process, go to **carefirst.com/dentalcredentialing**.

All providers in a participating practice must be credentialed through the CareFirst credentialing process. Claims submitted for providers that are not credentialed will be returned.

Re-credentialing

All contracted dental providers are re-credentialed using the same criteria and standards that were required during the initial application process. Providers are re-credentialed by a primary source verification vendor, on a two-year cycle so that every provider is not re-credentialed at the same time.

When you are scheduled for re-credentialing, you will receive notification from a primary source verification vendor suggesting you complete the CAQH application.

Dental Provider Networks

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

Participating Provider Network (PAR)

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

Preferred Provider Network (PPO)

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

Dental GRID+ and Dental GRID

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

The Blue Cross and Blue Shield Association has partnered with the GRID Dental Corporation to administer FEP BlueDental. FEP BlueDental members will be able to utilize the GRID+ network as an in-network provider source. Read the **FEP BlueDental Office Implementation Guide** if you have questions or for more information, you are able to access a complete breakdown of the FEP BlueDental benefits **here**.

Federal Employee Program (FEP) Preferred Dental Network

The FEP Preferred Dental Network provides a benefit for covered services based on the FEP Maximum Allowable Charge (MAC). This level of reimbursement applies to members covered under the FEP Standard and Basic Dental products.

Dental HMO (DHMO)

The DHMO participating provider network includes a general dentist and specialist network. Members covered under the DHMO must select a general dentist and have dental care coordinated through their selected participating DHMO provider. When the clinical examination and evaluation reveals that the member requires treatment from a specialist, the general dentist must provide a written referral to an in-network specialist.

Dental Exclusive Provider Organization (EPO)

The EPO products utilize CareFirst's Participating and Preferred Provider Networks. The level of reimbursement is determined by your contracted fee arrangement with CareFirst and applies to members covered under our EPO Dental plans.

Provider Agreements

Participating Agreement, Preferred Addendum, Federal Employee Program Amendment

Licensed, eligible dental providers accepted in one of our dental networks will agree to provisions as stated in the Provider Agreement, the Preferred (PPO) Addendum, and/or the Federal Employee Program (FEP) Amendment including, but not limited to:

- Participating providers who practice with multiple provider groups, or have more than one office location and use the same tax identification number, must maintain the same level of network participation in each group and/or location
- The participating provider agrees to file claims for services rendered to our members
- The participating provider agrees to accept our Allowed Benefit/Preferred Allowed Benefit/ MAC as payment in full for covered services

DHMO Participating Agreements

General Dentists and Specialists accepted into the DHMO agree to the provisions stated in the Participating Agreement, including but not limited to:

- The participating dentist agrees to offer appointments to members so that there will be no unreasonable waiting period for appointments
- The participating dentist agrees to accept the member copay as indicated on the Member Copayment Schedule
- The participating dentist agrees to refer all members requiring the services of a dental specialist to a participating specialist in the network

Provider Responsibilities

Administrative Services Policy

To help you evaluate your office's current practices, our Administrative Services policy is provided below. In short, providers cannot require the payment of charges above and beyond coinsurance, copayments and deductibles.

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against subscribers or members for covered services, including those that are inherent in the delivery of covered services. The practice of charging for office administration and expense is not in accordance with the Participating Dentist Agreement and Dental Provider Manual. Such charges for administrative services would include, by way of example, annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses, malpractice coverage increases, writing prescriptions, copying and faxing, lab fees, completing referral forms or other expenses related to the overall management of patients and compliance with government laws and regulations, required of health care providers.

The provider may look to the subscriber or member for payment of deductibles, copayments or coinsurance, or for providing specific health care services not covered under the member's Health Benefit Plan as well as fees for some administrative

services. Such fees for administrative services may include, by way of example, fees for completion of certain forms not connected with the providing of covered services, missed appointment fees, and charges for copies of medical records when the records are being processed for the subscriber or member directly. Fees or charges for administrative tasks, such as those enumerated above may not be assessed against all members in the form of an office administrative fee, but rather to only those members who utilize the administrative service.

Changes in Provider Information

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

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

Written notification should be mailed to:

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

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

Availability (DHMO)

If it is necessary for a Primary General Dentist (PGD) to be absent from the office for more than 10 days, it is required that the dentist contact us to obtain approval of providing acceptable coverage for our members. The dentist will be responsible for the cost of care rendered to their assigned members during his/her absence.

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

Specialty Referral Criteria (DHMO)

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

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

Primary General Dentist Responsibilities (DHMO)

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

Specialist Responsibilities (DHMO)

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

Note: The DHMO reserves the right to modify the Specialty Care Referral Guidelines at any time.

Reduction, Suspension or Termination of Privileges

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

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

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

To make final determinations, the Dental Director seeks advice from the Dental Credentialing Committee and may seek counsel from ad hoc dental specialists as ad hoc members for the purpose of offering specialized expertise in the dental field that is the subject of the case or issue presented. The committee may use information as part of its investigation that may include chart review of outpatient and inpatient care, complaint summaries, peer/staff complaints, and interviews with the practitioner.

The Dental Director notifies the practitioner in writing of the reason(s) for the termination and/or sanction, his/her right to appeal the determination, and the process for appeal of the determination. The practitioner may appeal the decision by submitting a written notice with relevant materials he/ she considers pertinent to the decision within 30 days of being notified of the decision. The practitioner forfeits his/her right to appeal if he/she fails to file an appeal within 30 days of receiving notification of the decision.

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

Quality of Care Terminations

Appeal requests relative to quality of care terminations are reviewed through a hearing panel. The hearing panel is comprised of clinical members of the Corporate Quality Improvement Committee who were not previously involved in the review or decision of the case, and at least three practitioners with no adverse economic interests connected to the appealing practitioner and similar experience in the appealing practitioner's expertise (if appropriate). The appealing practitioner is notified in writing of the hearing process. Following the hearing, the panel will make a final decision to affirm, amend or reverse the sanction or network

termination. The Dental Director, in consultation with CareFirst legal representative(s), notifies the practitioner of the decision in writing, provides a statement for the basis of the decision and informs the practitioner that the decision is final and not subject to further consideration with CareFirst.

Provider Reimbursement

Notice of Payment (NOP)

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. An NOP accompanies each check and enables providers to identify members and the claims processed for services rendered to those members. These can be accessed post-login on **CareFirst Direct**. Participating providers are reimbursed according to the CareFirst Allowed Benefit as listed on the Dental Fee Schedules.

Electronic Capabilities

New electronic capabilities include:

- **Electric Funds Transfer (EFT)**—Allows providers to receive payments electronically. A clearinghouse manages provider enrollment and validation date
- **Electronic Remittance Advice (ERA)**—Equivalent to the Notice of Payment. Some clearinghouses auto-post the ERA and EFT to the patient's account using the providers Practice Management System. Our new paperless submission capabilities are designed to improve efficiency, reduce administrative complexity and improve turnaround time. Claims for FEP and DHMO members can be submitted electronically

Other features include:

- Dedicated dental Electronic Data Interchange (EDI) staff members
- Around-the-clock systems monitoring
- Reliable, flexible and secure systems that use state-of-the-art technology
- Electronic transactions for eligibility, benefit, and claim status requests

If you do not currently submit claims electronically, contact one of our preferred clearinghouses:

- Change Healthcare at 1-844-217-1199
- Tesia Clearinghouse, LLC at 866-712-9584
- Dental Xchange at 800-576-6412

More information can be found at **carefirst.com/dentaledi**

Capitation (DHMO)

Capitation is paid to participating general dentists for each member who has selected his/her office as their primary dental site. The Capitation Report is mailed with the capitation check between the 15th and 20th of each month. Capitation rates for each plan are listed on each Member Copayment Schedule.

Member Copayments (DHMO)

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

Get Fees

Your office can now obtain fee schedule, copay schedules and reimbursement agreements on **CareFirst Direct**. This may require updating your permissions, which can be done by following the instructions on **this document**. When your permissions are properly set, your staff is able to retrieve full fee schedules and allowed amounts for specific sets of codes.

Indemnity Other Party Liability (OPL) Coordination of Benefits

Coordination of benefits (COB) is a cost-containment provision included in most group and member contracts and is designed to avoid duplicate payment for covered services. COB is applied whenever a member is covered under more than one health insurance plan.

CareFirst uses the Modified Aggregate (Non-Duplicating) method of processing COB for all plans, which states that we will coordinate claims up to the highest allowed benefits of the two coverages. The liability of CareFirst as the secondary carrier will never exceed the highest allowed benefit between the two coordinating coverages, and CareFirst's payment as secondary carrier will never exceed what we would have paid as primary.

When a member has more than one insurance carrier, the provider's office determines primary and secondary liability. Guidelines for determining primary and secondary liability in specific instances are listed below:

- Member is covered on two different policies and one has no COB provision: When a policy or coverage does not include a COB provision in its contract, it is always primary under any and all circumstances
- Member is covered under his or her own policy and a spouse's policy and there is a COB provision in both policies: The member's own insurance is primary and the spouse's coverage is secondary. This rule applies even if the member's employment is part-time and the spouse's employment is full-time
- Eligible dependent children whose mother and father live in the same household and there is COB provision in both policies: When both parents carry health insurance, the insurance carriers will base primary liability on either the birthday rule* or the gender rule**
- Eligible dependent children whose mother and father are divorced and there is a COB provision in both policies: When parents are divorced, the final divorce decree determines which parent's coverage will be primary payer
- When the patient has a CareFirst Medical plan and is eligible for embedded pediatric and is also covered under a CareFirst Employer Group dental policy (dual dental), the embedded CareFirst policy is primary and the CareFirst Employer Group is Secondary. When the patient has a CareFirst Medical plan and is eligible for embedded pediatric, and covered under a non-CareFirst dental policy (i.e. Delta Dental, Aetna, MetLife etc.) the CareFirst Pediatric Dental plan is primary and the other Dental carrier is Secondary
- If primary/secondary insurance liability is not addressed in the divorce decree, generally the custodial parent's insurance is considered primary
- Member is policyholder on two different policies with COB provisions: Coverage from full-time employment is primary to coverage associated with part-time employment. If the member is employed full-time at both jobs or part-time at both jobs, the policy with the earliest effective date is primary

* The Birthday Rule—We implement this rule, unless an employer requests otherwise. The carrier whose parent's birthday is closest to January 1st in the same calendar year is primary. (Example: A mother's birthday is April 29th and the father's birthday is June 3rd. The mother's insurance plan would be primary).

** The Gender Rule—The gender rule requires that the father's coverage is primary. Few carriers practice this rule. In the event that one carrier uses the birthday rule and the other carrier uses the gender rule, the gender rule prevails.

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

Primary Carrier: CareFirst Traditional and Preferred Dental Products

Benefits are provided as stipulated in the member's contract. Benefits are provided as stipulated in the member's contract. The member may be billed for any deductible, coinsurance, non-covered services, or services for which benefits have been exhausted as indicated on Notice of Payment (NOP). These charges may then be submitted by the member or the provider on the member's behalf to the secondary carrier for consideration.

Secondary Carrier: CareFirst Traditional or Preferred Dental Products

When CareFirst is the secondary carrier, there are three different methods for calculating our payment (Regular, Aggregate or Modified Aggregate, as described below), depending on the member's contract.

Regular Method
The regular provision in a member's contract considers the amount paid by the primary carrier and our Allowed Benefit (AB). If the amount of the primary carrier's payment exceeds or equals the AB, we pay nothing. This method is primarily used by our national accounts, such as the Federal Employee Program (FEP).

The participating provider must accept the AB as payment in full for covered service and cannot balance bill our members. Participating providers can only bill members for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance not covered by the secondary carrier.

Aggregate Method
The aggregate provision in a member's contract considers the provider's total charge, the amount paid by the primary carrier and the AB. We subtract the primary carrier's payment from the total charge and pay the difference, as long as the balance does not exceed the AB.

The provider cannot balance bill the subscriber if the primary carrier and our reimbursement does not equal the total billed charges. The participating provider can only bill for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance.

Modified Aggregate Method
The modified aggregate provision in a member's contract considers the primary carrier's AB, the amount paid by the primary carrier and our AB. We subtract the primary carrier's payment from the higher of the two ABs and pay the difference, as long as the balance does not exceed our AB.

The participating provider cannot balance bill the subscriber if the primary carrier and our reimbursement does not equal the total billed charges. The participating provider can only bill for claims that are rejected as non-covered or over maximum and for any deductibles and coinsurance.

Primary Commercial Carrier Rejected Claims
If the primary carrier appropriately denies benefits for rendered services, we automatically become the primary carrier for covered services.

COB Provision

Most member contracts feature a Front End COB provision, which requires the provider to determine the primary carrier, file the claim with that carrier and submit a claim to the secondary carrier along with a copy of the primary carrier's explanation of benefits.

If we receive your claim without the other insurance information section completed and/or an EOB from the primary carrier (if appropriate), it may be returned or rejected.

Workers' Compensation

Dental benefits programs administered by CareFirst exclude benefits for services or supplies to the extent that the participant obtained or could have obtained benefits under a Workers' Compensation Act or a similar law. Affected claims should only be filed if workers' compensation benefits have been denied or exhausted. In the event that benefits are inadvertently or mistakenly paid despite this exclusion, we will exercise the right to recover its payments.

A participating provider cannot balance bill the member or CareFirst for any amount not covered under Workers' Compensation. Regulations applicable to Workers' Compensation require the provider to accept reimbursement as payment in full.

Claims filed indicating that the member has sustained or suspects injuries or illnesses arising out of or in the course of employment will be rejected.

Exceptions: The Federal Employee Program requires that payment be made at the time the claim is submitted. If the claim is later paid by Workers' Compensation, money originally paid will be recouped. If Workers' Compensation determines that the injury or illness is not compensable, the claim will be processed, regardless of timely filing guidelines.

Subrogation

Subrogation refers to our right to recover payments made on behalf of a participant whose illness, condition or injury was caused by the negligence or wrong-doing of another party. Such action will not affect the submission and processing of claims, and all provisions of the participating provider agreement apply. Subrogation provisions are included in many group and member contracts.

We will process claims and make payments to the participating provider for covered services. When settlement is made by the liable carrier(s), we will recover its payments from the party receiving settlement. At that time, the provider is no longer bound by the terms of the participating agreement. The provider can bill the subscriber up to the total charges, if the subscriber is held harmless and the amount awarded in settlement or by the court is less than the total charge.

If the court ruling or settlement specifies that the losses are for other than medical care (for example, wages, loss of consortium, sorrow, etc.), we may be unable to recoup its entire medical payment and may need to negotiate a settlement. In these instances, the participating provider must accept the Allowed Benefit (AB) as payment in full and cannot balance bill the subscriber. If you receive payments from multiple carriers in excess of billed amounts, contact the appropriate Provider Service area to determine proper distribution of excess payment.

Personal Injury Protection (PIP)

If a member's contract includes a PIP provision, we will offset or reduce its benefit payments for those medical expenses paid or payable under the PIP provision of the automobile insurance.

Participating providers are required to submit claims on the member's behalf to comply with the participating agreement and to meet timely filing guidelines, established by the subscriber's contract. We will reimburse for covered services exceeding the PIP protection. If settlement is subsequently made, we will recover payments from the receiving party.

If we are able to pursue recoupment from the receiving party, the provider can bill the subscriber up to the total charges. If we are unable to recoup its total medical payments and negotiate a settlement, the participating provider must accept the Allowed Benefit (AB) as payment in full and cannot balance bill the subscriber.

DHMO Coordination of Benefits (COB)

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

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

NOTE: DHMO providers can only bill the secondary carrier the member's copayments.

When coordinating benefits between two Capitation Plans, the following rules apply:

Primary General Dentist (PGD)

- For a case in which the PGD participates with both of the capitation plans, the patient should be charged in accordance with the lesser of the two copayment schedules. This rule applies regardless whether the two capitation plans are administered by the same managed care company or by two different managed care companies (see Example 1)

- If the PGD only participates with one of the capitation plans, the PGD has no choice but to charge in accordance with the capitation plan in which he/she participates

Specialist

For a case in which the specialist participates with both of the capitation plans and both of the capitation plans are administered by the same managed care company, the patient should be charged in accordance with the lesser of the two copayment schedules and the Specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the capitation plan.

For a case in which the specialist participates with both of the capitation plans and the capitation plans are NOT administered by the same managed care company, the patient should be charged in accordance with the plan that has been determined as the primary plan. The specialist should submit a claim for additional payment (if applicable) in accordance with the guidelines set forth by the primary plan.

When the specialist submits a claim for additional payment (if applicable) to the secondary plan, the claim must include an Explanation of Benefits (EOB) from the primary plan. If the secondary plan is a CareFirst DHMO plan, there will not be any additional payment to the specialist if the combined payment from the patient and the primary plan to the specialist is equal to or greater than the amount guaranteed to the specialist by the DHMO.

Example 1

Provider is a PGD

Member copayment under first capitated plan:	$350
Member copayment under second capitated plan:	$300

When coordinating benefits between a capitated plan and an indemnity plan (Traditional or PPO) where the capitated plan is primary, the following rules apply:

- The PGD should submit the patient copayment as specified by the capitation plan to the indemnity plan. The patient is responsible for paying the difference between the amounts reimbursed by the indemnity plan and his/her copayment (see Example 2)
- The Specialist should submit the patient copayment as specified by the capitation plan to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan and the copayment. The Specialist should then submit a claim for additional payment (if applicable) to the capitated plan in accordance with his/her contract (see Example 3)

Example 2

Provider is a PGD

Member copayment under capitated plan:	$350
Indemnity plan pays:	- $200
Balance:	$150

The PGD should submit the patient copayment as specified by the capitation plan ($350) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($200) and the copayment. In this example, the patient is responsible for a $150 copayment.

Example 3

Provider is a Specialist

Member copayment under capitated plan:	$300
Indemnity plan pays:	- $150
Balance:	$150
Specialist's guarantee with DHMO:	$350

The Specialist should submit the patient copayment as specified by the capitation plan ($300) to the indemnity plan. The patient is responsible for paying the difference between the amount reimbursed by the indemnity plan ($150) and the copayment. In this example, the patient is responsible for a $150 copayment.

Orthodontia

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

Primary Carrier ACA embedded Pediatric Dental

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

In cases where dual orthodontic coverage exists between a standalone option and a medical plan which includes pediatric dental (ACA embedded pediatric dental), the provider should determine if the patient's orthodontia is medically necessary. When claims are submitted in these situations, CareFirst will process under both plans simultaneously. It is important to note that if the treatment does commence before authorization is received from CareFirst, no benefit will be allowed under the embedded ACA pediatric dental plan. Additionally, cases which have been denied through the Dental Director authorization process will also deny under the embedded ACA pediatric dental plan.

Member Complaints

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

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

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

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

Please include the following information when submitting a complaint:

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

PM0015-1E (12/20)