A general information resource for our Provider community.
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Welcome to CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice). Your participation in one or all of our networks means that you have access to thousands of local and national employers and their employees. Our members have access to state-of-the-art facilities, some of the best physician and provider care in the country and medically proven advanced technology.

This manual gives you the information you need to service CareFirst and CareFirst BlueChoice members and to do business with us.

Specific requirements of a member’s health benefits are varied and may differ from and supersede the general procedures outlined in this manual.

If we make any procedural changes in our ongoing efforts to improve our service to you, we will update the information in this manual and notify you via BlueLink, our bi-monthly administrative newsletter.

If you have questions, please call Provider Services. Visit www.carefirst.com and click on Phone Numbers and Claim Addresses to obtain the correct phone number.

Note: For ease of communication, all references to “CareFirst” will refer to both CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., unless specified otherwise.

Per the terms of the Participating Agreement, all providers are required to adhere to the policies and procedures contained in this manual, as applicable to each type of provider.
Our Mission

Philosophy of Care

We represent a philosophy of health care that emphasizes active partnerships between patients and their physicians. We believe that comprehensive health care is best provided by networks of health care professionals who are held accountable for the quality of their services and the satisfaction of their patients. We are committed to high standards of quality and professional ethics and the principle that “patients come first.”

We believe that patients should have the right care, at the right time and in the right setting. This includes comprehensive care for acute and chronic illness, as well as preventive care-- in the hospital, at the doctor’s office and at home.

We believe that members should have a choice within their health plans of physicians who meet high standards of professional training and experience. That informed choice and the freedom to change physicians are essential to building active partnerships between members and doctors.

We believe that health care decisions should be the shared responsibility of members, their families and health care professionals, and we encourage physicians to share information with members on their healthy status, medical conditions and treatment options.

We believe that consumers have a right to information about health plans and how they work. We believe that working with people to keep them healthy is as important as making them well.

We value prevention as a key component of comprehensive care, reducing the risks of illness and helping to treat small problems before they can become more severe. We believe that access to affordable, comprehensive care gives consumers the value they expect and contributes to the peace of mind that is essential to good health.

Adapted from the American Association of Health Plans (AAHP).
Confidentiality Policy

CareFirst has policies and procedures to protect the confidentiality of member information. The following is a brief summary of how we use and protect member information.

General Policy

- All records and other member communication that has confidential medical and insurance information must be handled and discarded in a way that ensures the privacy and security of the records.
- All medical information that identifies a member (person who signs a policy with CareFirst or CareFirst BlueChoice) is confidential and protected by law from unauthorized disclosure and access.
- The release or re-release of confidential information to unauthorized persons is strictly prohibited.
- CareFirst limits access to a member’s personal information to persons who “need to know,” such as our claims and medical management staff.
- The disposal of member information must be done in a way that protects the information from unauthorized disclosure.

Routine Consent for Release of Information

By enrolling in a CareFirst health plan, the member provides routine consent for the release of information for administrative purposes. Note that routine consent applies whether the member enrolls electronically, by telephone or by completing and signing an enrollment form. Member information under this routine consent may be used for many purposes under routine consent, including:

- Payment of doctors and other providers
- Measurement and improvement of care and service
- Preventive health and disease management programs
- Member surveys
- Investigation of complaints and appeals
- Other purposes needed to administer benefits

The routine consent for release of information is in effect for as long as the member has health coverage with CareFirst. Routine consent can be extended past the last day of coverage to allow CareFirst to pay claims or resolve complaints or appeals. The routine consent from the member applies to the administrative use of information relating to all covered adults and dependents. Dependents are other members of the family who are also enrolled.

Consent for Release of Information for Other Purposes (Special)

The following uses of member information require special consent from the member:

- Data requested for a worker’s compensation or auto insurance claim
- Release of information that could result in another company contacting the member for marketing purposes
- Release of information from behavioral health care practitioners (mental health and substance abuse providers) to the member’s primary care physician or specialist
Confidentiality Policy (continued)

Member Access to Medical Records
Members may access their medical records by contacting the PCP’s office or the provider of care (such as a hospital). The member must follow the provider’s procedures for accessing medical information.

Treatment Setting
Practitioners and providers are expected to implement confidentiality policies that address the disclosure of medical information, patient access to medical information and the storage/protection of medical information. CareFirst review practitioner confidentiality processes during pre-contractual site visits for primary care physicians.

Quality Improvement Measurement
Data for quality improvement measures are collected from administrative sources, such as claims and pharmacy data, and/or from member medical records.

CareFirst protect member information by requiring that medical records are reviewed in non-public areas, and that reports do not include member-identifiable information.

Notice of Privacy Practice
CareFirst is committed to keeping the confidential information of members private. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to send our Notice of Privacy Practices to members of fully insured groups only. The notice outlines the uses and disclosures of protected health information, the individual’s rights and CareFirst’s responsibility for protecting the member’s health information.

To obtain a copy of our Notice of Privacy Practices, visit www.carefirst.com or call your Provider Relations Representative.
Medical Credentialing

Providers wishing to participate in the CareFirst BlueCross BlueShield and/or the CareFirst BlueChoice provider networks are required to submit credentialing information. Every practitioner must complete and submit an application for initial or continued participation in the CareFirst practitioner networks. Each application is verified to ensure our credentialing criteria is met. This includes, but is not limited to the following:

- Valid, current, unrestricted licensure
- Valid, current Drug Enforcement Agency (DEA) and Controlled Dangerous Substance (CDS) registration
- Appropriate education and training in a relevant field
- Board certification, if applicable
- Review of work history
- Active, unrestricted admitting privileges at a participating network hospital
- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
- Attestation to reasons for an inability to perform the essential functions of a clinical practitioner that could impose significant health and safety risks to members/enrollees; lack of present illegal drug use; history of loss of license and felony convictions; history of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage with minimum limits as indicated below:

<table>
<thead>
<tr>
<th>Number of Practitioners in Practice</th>
<th>Medical Practices Primary Layer</th>
<th>Medical Practices Excess Layer</th>
<th>Mid-Level Behavioral Primary Layer</th>
<th>Mid-Level Behavioral Excess Layer</th>
<th>PT/OT/ST Primary Layer Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1/$3M Individual</td>
<td>N/A</td>
<td>$.5/$1.5M Individual</td>
<td>N/A</td>
<td>$1/$3M Shared (up to 24)</td>
</tr>
<tr>
<td>2-5</td>
<td>$1/$3M Shared</td>
<td>N/A</td>
<td>$.5/$1.5M Shared</td>
<td>N/A</td>
<td>$1/$3M Shared (up to 24)</td>
</tr>
<tr>
<td>6-10</td>
<td>$2/$6M Shared</td>
<td>N/A</td>
<td>$1/$3M Shared</td>
<td>N/A</td>
<td>$1/$3M Shared (up to 24)</td>
</tr>
<tr>
<td>11-24</td>
<td>$2/$6M Shared</td>
<td>$5M Shared</td>
<td>$1/$3M Shared</td>
<td>$3.25M Shared</td>
<td>$1/$3M Shared (up to 24)</td>
</tr>
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<td></td>
<td>$1/$3M Shared</td>
<td>$10M Shared</td>
<td>$.5/$1.5M Shared</td>
<td>$7.5M Shared</td>
<td>$1/$3M Shared (up to 24)</td>
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<tr>
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<td>$2/$6M Shared</td>
<td>$10M Shared</td>
<td>$1/$3M Shared</td>
<td>$5M Shared</td>
<td>Individual Consideration</td>
</tr>
<tr>
<td></td>
<td>$1/$3M Shared</td>
<td>$15M Shared</td>
<td>$.5/$1.5M Shared</td>
<td>$10M Shared</td>
<td>Individual Consideration</td>
</tr>
<tr>
<td>51+</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
</tr>
</tbody>
</table>

CareFirst and CareFirst BlueChoice accept the Maryland Uniform Credentialing Form and the Coalition for Affordable Quality Healthcare (CAQH) Universal Credentialing Datasource application.

To ensure that CareFirst and/or CareFirst BlueChoice obtain correct information to support credentialing applications and make fair credentialing decisions, providers have the right, upon request, to review this information, correct inaccurate information and obtain the status of the credentialing process. Requests can be made by calling 877-269-9593 and 410-872-3500.
**Administrative Functions**

**Changes in Provider Information**

CareFirst health care providers who need to change their provider information must complete the Change in Provider Information Form.

Print the form and complete the applicable information, including the information regarding accepting new patients (open/close panel). Be sure to include your office letterhead when returning the completed form.

The mailing address is:

**CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.**

**Provider Information and Credentialing**

**Mailstop CG-41**

**10455 Mill Run Circle**

**Owings Mills, Md. 21117-0825**

You may also fax the completed form to: 410-872-4107.

**Reimbursement**

Participating providers agree to accept a plan allowance (also called allowed benefit or allowed amount) as payment in full for their services. Participating providers may not bill the member for amounts that exceed the allowed amount for covered services. Members are liable for non-covered services, deductibles, copayments and coinsurance.

A physician fee schedule is a list of plan allowances that are reviewed regularly. When adjustments to the fee schedule are made, providers receive a list of the top 100 billing codes according to their specialty.

**Reimbursement for Limited Licensed Providers (LLPs)**

CareFirst reimburses limited licensed providers (LLPs) at a percentage of the physician fee schedule. This reimbursement policy applies to both Group Hospitalization and Medical Services, Inc. (GHMSI) and CareFirst of Maryland, Inc. (CFMI) provider contracts.

<table>
<thead>
<tr>
<th>Specialties affected and related percentage of the physician fee schedule:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>Nurse midwives</td>
</tr>
<tr>
<td>Social workers</td>
</tr>
<tr>
<td>Psychiatric nurses</td>
</tr>
<tr>
<td>Nurse practitioners</td>
</tr>
<tr>
<td>Dieticians/Nutritionists</td>
</tr>
<tr>
<td>Licensed counselors (pastoral, chemical dependency, professional, etc.)</td>
</tr>
<tr>
<td>Licensed nurses (registered, professional, practical, clinical specialist, etc.)</td>
</tr>
<tr>
<td>Mental health clinicians</td>
</tr>
<tr>
<td>Nursing school administered</td>
</tr>
<tr>
<td>Surgical Assistants reimbursed at 20%</td>
</tr>
</tbody>
</table>

**HIPAA Compliant Codes**

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), CareFirst and CareFirst BlueChoice will add the HIPAA-compliant codes and corresponding reimbursement rates to your fee schedule when they are released from AMA or CMS. These updates are made on a quarterly basis through the calendar year.

**In-Office Injectable Drugs Standard Reimbursement Methodology**

In-Office Injectable drugs are reimbursed at a percentage of the Average Sales Price (ASP). In-Office Injectable drugs without an ASP are reimbursed at a percentage of the lowest Average Wholesale Price (AWP). The ASP is calculated by the Centers for Medicare & Medicaid Services (CMS) and available at [CMS.gov](https://www.cms.gov). The AWP is based on the most cost effective product and package size as referenced in Thomson’s Red Book.

Reimbursement for all in-office injectable drugs is updated quarterly on the first of February, May, August and November. The rates are in effect for the entire quarter but are subject to change each quarter. P4 Oncology and P4 Rheumatology fee schedules are not included in this reimbursement methodology.
Administrative Functions (continued)

Claims Overpayment
If a claims overpayment is discovered and you wish to return the payment to CareFirst, please mail it to the following address:

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
P.O. Box 791021
Baltimore, Maryland 21279

Please include with your check:

- Membership number
- Patient name
- Claim number
- Reason for the refund

Make the check payable to CareFirst BlueCross BlueShield or CareFirst BlueChoice, Inc.

Collection of Retroactively Denied Claims
A provider reimbursement may be offset against a retroactively denied claim by an affiliated company of CareFirst, Inc.

Timely Filing of Claims
To ensure quick and accurate claims processing, please report services for only one practitioner per claim. If more than one provider in your practice renders services for a given member, separate claims must be submitted for each practitioner.

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

Reconsideration
Claims submitted beyond the timely filing limits generally are rejected as not meeting these guidelines. If your claim is rejected, but you have proof that the claim was submitted to CareFirst within the guidelines, you may request processing reconsideration.

Timely filing reconsideration requests must be received within six months of the provider receiving the original rejection notification on the provider voucher or notice of payment. Requests received after six months will not be accepted and the charges may not be billed to the member.

Documentation is necessary to prove the claim was submitted within the timely filing guidelines.

For electronic claims:
A confirmation from the vendor or clearinghouse that CareFirst successfully accepted the claim. Error records are not acceptable documentation.

For paper claims:
A screen print from the provider’s software indicating the original bill creation date along with a duplicate of the clean claim or a duplicate of the originally submitted clean claim with the signature date in field twelve (12), indicating the original bill creation date.
Coordination with Other Payers

Coordination of Benefits
Coordination of benefits (COB) is a cost-containment provision included in most group and member contracts which is designed to avoid duplicate payment for covered services. COB is applied whenever a member covered under a CareFirst contract is also eligible for health insurance benefits through another insurance company or Medicare.

If CareFirst is the primary carrier, benefits are provided as stipulated in the member’s contract.

The member may, however, be billed for any deductible, coinsurance, non-covered services or services for which benefits have been exhausted. These charges may then be submitted to the secondary carrier for consideration. Group contracts may stipulate different methods of benefits coordination, but generally, CareFirst’s standard method of providing secondary benefits for covered services is the lesser of:

- The balance remaining up to the provider’s full charge; or
- The amount CareFirst would have paid as primary, minus the other carrier’s payment (i.e., the combined primary and secondary payments will not exceed CareFirst allowance for the service).

**Note:** When coordinating benefits with Medicare, the amount paid by CareFirst—when added to the amount paid by Medicare—will not exceed the Medicare allowable amount. Claims for secondary benefits must be accompanied by the explanation of benefits (EOB) from the primary carrier.

Subrogation
Subrogation refers to the right of CareFirst to recover payments made on behalf of a participant whose illness, condition or injury was caused by the negligence or wrongdoing of another party. Such action will not affect the submission and processing of claims, and all provisions of the participating provider agreement apply.

No-Fault Automobile Insurance
The no-fault automobile insurance laws may require the automobile insurer to provide benefits for accident related expenses without determination of fault. A copy of the record of payment from the automobile insurer must be attached to the claim form submitted to CareFirst.

Workers’ Compensation
Health 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, the Longshoreman’s Act, or a similar law. Affected claims should only be filed if workers’ compensation benefits have been denied or exhausted. In the event that CareFirst benefits are inadvertently or mistakenly paid despite this exclusion, CareFirst will exercise its right to recover its payments.

Injectable Drugs
Medications administered in the physician’s office are covered under the member’s medical benefit, not their prescription drug benefit. Prescription drug benefits cover injectable medications only when they are self-administered.

Providers shall obtain office administered injectable medications and bill CareFirst directly. Providers shall not write a prescription for the medication and have the member obtain the medication from the pharmacy with the intent of the member delivering the drug to the provider as these medications are not covered by the member’s prescription drug benefit.*

For commercial members, providers may obtain injectable medications from a source of their choice. CareFirst and CareFirst BlueChoice have contracts with ICORE Healthcare (ICORE specialty pharmacy), Medmark (Walgreens specialty pharmacy) and OncoSourceRx to ship single doses of most injectable medications and vaccines on an individual patient-prescription basis directly to the provider office for provider administration. This option is available for most office injectables eliminating the upfront cost of stocking expensive specialty injectables. ICORE, Medmark and OncoSourceRx obtain eligibility and benefits then bill CareFirst and CareFirst BlueChoice directly. Your practice should continue to bill CareFirst and CareFirst BlueChoice for the administration by following CPT guidelines and using the appropriate CPT code.

*
Orders for non-refrigerated, refrigerated and frozen medications and vaccines are packed in temperature controlled containers and shipped directly to your office—typically within 48 hours. Priority overnight delivery is also available. This is an optional service made available to our providers and not a guarantee of availability or supply by CareFirst. Not all drugs or individual prescriptions are available using this option. Please note that the arrangement with these specialty pharmacies does not apply to members whose primary coverage is Medicare.

FEP members only: Providers must obtain office injectables from CareMark.

* Exception: Depo-Provera® (when used for contraception) is the only non-self-administered injectable covered under the prescription drug benefit.

**Inquiry Process**

Providers should use CareFirst Direct or call Provider Services regarding claim inquiries. Many inquiries can be handled to the providers’ satisfaction in the appropriate Provider Services area. If the inquiry cannot be satisfied in the Service area, the provider will be instructed to submit a written inquiry on a Provider Inquiry Resolution Form (PIRF) to document the reason for the request along with pertinent or supportive records, literature or claims documentation to CareFirst Provider Services.*

To review the CareFirst claims adjudication and payment policies, please refer to the Contents section in this manual. These sections are especially helpful in describing multiple claims billing guidelines, including but not limited to Modifier Reimbursement Guidelines, Bilateral Procedures Reimbursement Guidelines, Team Surgery and Preventive Services.

*Please request reviews of processed claims within 6 months or 180 days (whichever is greater) of the determination.

**Appeal Process**

**Professional Appeal Process**

A provider or physician may appeal a decision in writing within six months or 180 days (whichever is longer) from the date of notification of denial. All appeals must be submitted in writing to your Provider Services Correspondence department by sending a letter of appeal with the specific appeal reason along with pertinent or supportive records, literature or claims documentation.

**Professional Grievance Process**

A grievance is a dispute of a denial for medical necessity, cosmetic or experimental/investigational reasons. The grievance must be submitted in writing within six months or 180 days (whichever is longer) from the date of notification of the denial. The grievance must include a letter of medical necessity and the appropriate and pertinent medical records. CareFirst may require additional information from the provider. There is also an emergency/ expedited review process available, where an issue may require a response within 24 hours of the request to CareFirst. An emergency includes a service not yet provided (i.e., a prospective service that is not yet a claim.) The grievance will be reviewed by a physician not involved in the initial denial determination. There is a full and fair review process for all grievance decisions.

**Necessary Information for both Appeals and Grievances**

A letter describing the reason(s) for the appeal and the clinical justification/rationale is required, including the following information, if possible:

- Patient name and identification number
- The claim number to be reviewed
- Admission and discharge date (if applicable) or date(s) of service
- Physician name
- A copy of the original claim or EOB denial information and/or denial letter/notice
- Supporting clinical notes or medical records including as an example, pertinent lab reports, x-rays, treatment plans, progress notes, etc.
- All appeal and grievance decisions are answered in writing
Quality of Care

The CareFirst and CareFirst BlueChoice Quality of Care (QOC) department investigates complaints related to the quality of care and service of providers in our networks and takes action, when appropriate. We evaluate complaints annually to identify and address opportunities for improvement across all networks.

Should CareFirst and CareFirst BlueChoice receive a complaint from a member, the QOC department will contact the provider in question for additional information. At the conclusion of our investigation, we 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 practitioner or provider. You may submit the complaint in one of three ways:

- Send an e-mail to: quality.care.complaints@carefirst.com
- Fax a written complaint to: 301-470-5866
- Mail a written complaint to:
  CareFirst BlueCross BlueShield/
  CareFirst BlueChoice
  Quality of Care Department,
  Central Appeals Unit
  PO Box 17636.
  Baltimore, Md. 21297

Please include the following information when submitting a complaint:

- Your telephone number
- Your provider number
- Member’s name
- Member’s ID number
- Date(s) of service
- As much detail about the event as possible

Providers play an important role in resolving member complaints and help improve member satisfaction.
Overview
Claim adjudication policies and associated edits are based on thorough reviews of a variety of sources including, but not limited to:

- CareFirst medical policy
- American Medical Association (AMA) guidelines (i.e., Current Procedural Terminology, CPT®)
- Centers for Medicare and Medicaid Services (CMS) policies
- Professional specialty organizations (e.g., American College of Surgeons, American Academy of Orthopaedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Current healthcare trends
- Medical and technological advances
- Specialty expert consultants

Therefore, our policies and edits are developed through a compilation of information gleaned from a variety of sources, not one single source. Our edits are designed to verify the clinical accuracy of procedure code relationships on professional (non-institutional) claims. CareFirst utilizes McKesson ClaimCheck® software as a part of the overall editing process for claims. This software is updated at least twice per year, usually in the spring and late fall, or more frequently if necessary. These updates provide a means for our claims systems to recognize new and/or revised CPT® and HCPCS codes, including any reclassifications of existing CPT® codes as CPT® modifier -51 exempt. Providers are notified of key policy changes through BlueLink and/or News Flash updates in the Providers & Physicians section of the CareFirst Web site. It is recommended that providers also regularly access and review these policy statements to keep current with changes and updates.

Inclusion of codes from CPT®, HCPCS, or ICD-9 reflect the use of nationally published and recognized clinical coding systems of definitions and clinical rationales for use in claims processing to fully communicate and accurately identify the services being rendered by the healthcare provider. Each is a HIPAA compliant code set, and reference to and/or use or interpretation of the codes does not represent an endorsement of any procedure or service or any related consequences or liability by the organizations that developed the codes.

Professional services and procedures are identified by the appropriate and current CPT® or HCPCS reporting code. The descriptor of the code is used to fully communicate and accurately identify the services provided to the subscriber. ICD-9 diagnosis codes are utilized to indicate the appropriate patient diagnoses for which these services or procedures were provided. Claims are filed utilizing these reporting codes and are reviewed/edited to determine eligibility for reimbursement. If services are determined to be incidental, mutually exclusive, integral to or included in other services rendered, or part of a global allowance, they are not eligible for separate reimbursement. Participating providers may not balance bill members for these services.
Policy Statements (continued)

Claims are edited for:

- Services reported together on the same claim
- Services reported on separate claims
- Services performed on the same date or within global periods
- Procedure code/modifier validity
- Age conflict
- Gender conflict
- Allowed frequency
- Duplicate procedures
- Unbundled procedures
- Incidental, integral, included in procedures
- Mutually exclusive procedures
- Assistant at surgery
- Cosmetic procedures
- Experimental/investigational procedures

The inclusion of a code in CPT®, HCPCS, or ICD-9 does not imply that the service is a covered benefit, or that it will be reimbursed by CareFirst. Codes are not reassigned into another code or considered ineligible for reimbursement based solely on the format of code descriptions in any codebook (e.g., indentions). In addition, codes are not automatically changed to ones reflecting a reduced intensity of service when codes are among or across a series that include those that differentiate among simple, intermediate, and complex; complete or limited; and/or size.

Please Note: this policy does not apply to:

- Crossover claims which are reimbursed by CareFirst as secondary to Medicare; or
- Claims for DME, supplies, equipment, orthotics/prosthetics, or drugs for which there is no comparable CPT® code; or
- Select services as outlined in the Federal Employee Program Benefit Plan (FEPBP) manual.

Reporting ICD-9-CM Diagnosis Codes

Carefully follow coding guidelines outlined in the most current ICD-9-CM coding book. Of particular importance are the following:

- Code to the highest level of specificity, to include 4th and 5th digits, as appropriate;
- List the primary, or most important diagnosis for the service or procedure, first;
- Code chronic complaints only if the patient has received treatment for the condition;
- When referring patients for laboratory or radiology services, code as specifically as possible and list the diagnosis that reflects the reason for requesting these services.

Claims that are not coded properly may be returned to the reporting provider, which will delay adjudication.

Requests for Clinical Information

In order to accurately adjudicate claims and administer subscriber benefits, it is often necessary to request medical records. The following is a list of claims categories from which we may routinely require submission of clinical information, either before a service has been rendered or before or after adjudication of a claim. Some of these (e.g., specific modifiers) are discussed in more detail throughout this manual.

- Procedures or services that require precertification/preauthorization
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies
- Procedures or services that are or may be considered cosmetic or experimental/investigational
Policy Statements (continued)

- Claims for which we cannot determine from the claim submitted if it involves a covered service and thus a benefit determination cannot be made without reviewing medical records
- Claims involving pre-existing condition issues
- Procedures or services related to case management or coordination of care
- Procedures or services reported with “unlisted,” “not otherwise classified,” or “miscellaneous” codes
- Procedures or services reported with CPT® modifiers 22, 62, 66, and 78
- Quality of care and/or quality improvement activities (e.g., data collection as required by accrediting agencies, such as NCQA)
- Claims involving coordination of benefits
- Claims that are being appealed
- Claims that are being investigated for fraud and abuse or potential inappropriate billing practices
- Claims that are being investigated for fraud or potential misinformation provided by a member during the application process

This list is not intended to limit the ability of CareFirst to request clinical records. There may be additional individual circumstances when these records may be requested.

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

Note: These claim adjudication and associated reimbursement policies are applicable to local CareFirst BlueCross BlueShield lines of business. Adjudication edits/policies may differ for claims processed on the national processing system (i.e., NASCO) depending on the account’s “home” plan.

Note: Current Procedural Terminology (CPT)® codes and descriptions only are copyright of the 1966 American Medical Association. All rights reserved.

Basic Claim Adjudication Policy Concepts

Unbundled Procedures

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

Incidental Procedures

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

Integral/Included In Procedures

Procedures that are considered integral or included in occur in a variety of circumstances, including, but not limited to services that are a part of an overall episode of care; and multiple surgery situations, when one or more procedures are considered to be an integral part of the major procedure or service. An example of this is a procedure code designated by CPT® as “separate procedure.” “Separate procedures” should not be reported when they are carried out as an integral component of a total service or procedure. Integral or included in procedures are not eligible for reimbursement.

Note: Refer to CPT® guidelines for reporting “separate procedures” when they are not a component of a total service. CPT® Modifier –59 should be appended to the “separate procedure” code to indicate that it is a distinct, independent procedure, and not related to the primary procedure.

Mutually Exclusive Procedures

Mutually exclusive procedures include those that may differ in technique or approach but lead to the same outcome. In some circumstances, the combination of procedures may be anatomically impossible.

Procedures that represent overlapping services are considered mutually exclusive. In addition, reporting an initial and subsequent service on the same day is considered mutually exclusive. Procedures reported together on the same anatomic site with terms such as open/closed,
Policy Statements (continued)

partial/total, unilateral/bilateral, simple/complex, single/multiple, limited/complete, and superficial/deep usually result in mutually exclusive edits. In these instances, if both procedures accomplish the same result, the procedure with the higher relative value unit (RVU) will usually be eligible for reimbursement. The higher valued procedure is likely to be the more clinically intense procedure, but the RVU will determine which procedure/service is reimbursed.

Global Allowances
Reimbursement for certain services is based on a global allowance. Services considered to be directly included in a global allowance are considered integral to that allowance and are not eligible for separate reimbursement. See Global Surgical, Anesthesia, and Maternity Reimbursement Guidelines (page 18.)

Add-On Procedures
Procedure codes designated as add-on (or “List separately in addition to the code for primary procedure” per CPT®), are only reported in addition to the specific code for the primary (or “parent”) procedure. These add-on codes are not eligible for separate reimbursement when reported as stand-alone codes or, in some instances, when the primary procedure is not covered.

Add-on codes are not subject to multiple procedure fee reductions as the relative value units (RVU’s) assigned to these add-on procedure codes have already been reduced to reflect their secondary procedure status.

If several procedures are performed during the same session by the same physician, and the primary (or “parent”) code needs to be distinguished as a distinct procedure (i.e., CPT® modifier –59 is appended to the primary code), then CPT® modifier –59 must also be appended to any add-on codes related to the “parent” code. (See also Oncology, page 20.)

Note: A list of these add-on codes can be found in Appendix D in the CPT® manual.

Duplicate Services and Procedures
Procedure or service codes that are reported multiple times on the same or different date of service; and are not specifically identified with an appropriate modifier, may be assumed to be duplicate procedure reporting. The procedures will be flagged as a possible duplicate service, and the claim will be reviewed and/or denied. Appending certain CPT® modifiers (e.g., 59, 76, 91) to the appropriate procedure code indicates that procedures or services are not duplicates. Medical record documentation must support this.

Also, paying more than one provider for the same procedure or service represents duplicate procedure reimbursement. This includes, but is not limited to, multiple interpretations or reviews of diagnostic tests such as laboratory, radiology, and electrocardiographic tests reported with CPT® modifier -26 (professional component) or CPT® 76140 (consultations on x-ray exams performed at other sites.)

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

Unlisted Procedures
The Centers for Medicare and Medicaid Services (CMS) establishes and publishes, in the Federal Register, relative value units (RVU’s) for most CPT® and some HCPCS Level II codes. RVU’s are a weighted score used to determine the fee scales for procedures and services performed by professional providers. These RVU’s are used to determine allowances for reimbursement. CMS, however, does not assign RVU’s to all procedure codes. Some codes are “unlisted” (no specific definition) and no RVU is assigned. Therefore, the unlisted code has no established allowance.

Unlisted CPT® and HCPCS codes should only be reported when there is not an established code to describe the service or procedure provided.

Submissions of claims containing an unlisted code are reviewed by our Medical Review Department. A reimbursement allowance is established based on this review using a variety of factors including, but not limited to, evaluating comparable procedures with an established RVU. To be considered for reimbursement, an unlisted CPT® or HCPCS code must be submitted with a complete description of the service or procedure provided. Any applicable records or reports must be submitted with the claim.

All applicable reimbursement policies will apply (e.g., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with unlisted codes.
Do not report modifiers with any unlisted procedure codes. All modifiers will be considered invalid with unlisted codes.

**Fragmented Billing**
Reporting services provided on the same date of service on multiple CMS 1500 claim submissions is considered fragmented billing. This practice may lead to incorrect reimbursement of services, including delays in claims processing or retractions of overpaid claims. Historical claims auditing is performed to ensure that all services or procedures performed on the same date are edited together. Therefore, services or procedures performed by a provider on the same date must be reported together on the same claim whether submitted electronically or on a paper form.

**Modifier Reimbursement Guidelines**
CareFirst accepts all valid CPT® and HCPCS modifiers. A modifier enables the provider to indicate that a service or procedure performed has been altered in some way but that the standard definition and associated reporting code remains unchanged. Modifiers may be used to indicate that:

- A service or procedure was provided more than once
- A service or procedure was performed on a specific anatomical site
- A service or procedure has both a professional and technical component (page 18)
- A bilateral procedure was performed
- A service or procedure was performed by more than one provider and/or in more than one location
- A service was significant and separately identifiable from other services or procedures

Up to four modifiers may be reported per claim line. CareFirst claims systems are capable of adjudicating multiple modifiers. Modifiers that may affect reimbursement should be listed first.

Services reported with an invalid modifier-to-procedure code combination will be denied. Claims must be resubmitted with the correct modifier (or without the invalid modifier) in order to ensure appropriate claim adjudication.

Modifiers may or may not affect reimbursement. Certain modifiers are for informational purposes only and assist in correct application of benefits.

**Note:** Additional information about reporting modifiers for particular services can be found in past issues of BlueLink.

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<th>Examples of modifiers that may affect how member benefits are determined and reimbursed:</th>
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Policy Statements (continued)

CareFirst follows Medicare (CMS) guidelines [see the current Medicare National Physician Fee Schedule Relative Value File] when determining if particular diagnostic or therapeutic tests and procedures can be reported as a global (“total”) service, or if they can also be reported as either a technical or professional component of the service. It is important to report these services according to the following guidelines:

- Report the procedure as a global (total) service (without a modifier) if you own the equipment, administer the test, and provide the interpretation.
- Report the procedure as a technical component (along with HCPCS modifier TC) if you only perform the technical portion of the procedure.
- Report the procedure as a professional component (along with CPT® modifier –26) if you only perform the interpretation and/or supervision portion of the procedure.

In instances where one provider is reporting the technical component and another is reporting the professional component, both providers should submit separate claims, with the same procedure code(s), with the appropriate modifier, and with the same date of service. As noted above, services reported with an invalid modifier-to-procedure code will be denied and must be resubmitted. (See also: Duplicate Services and Procedures)

Submissions of claims containing the following CPT® modifiers are reviewed by our Medical Review Department, and should be submitted with the pertinent medical records (e.g., complete operative record, office notes, etc.) in order to be appropriately and expeditiously adjudicated. Documentation should clearly support the intent of the modifier and demonstrate the reason for its submission.

- CPT® modifier –22: Not valid with E/M codes. Pertinent medical records that clearly demonstrate the reason that the procedure/service requires “substantial additional work” than that of the reported procedure must accompany the claim. This modifier should be reported only when the procedure or service is clearly out of the ordinary for the particular procedure. While not required, it is often helpful for the provider to attach a separate letter to the medical records that outlines why the procedure or service was particularly unusual.

- CPT® modifier –62*: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed distinct and separate parts of a procedure must accompany the claim. Each surgeon submits a separate claim for the operative session. CPT® modifier –62 should be appended only to procedures performed by the two surgeons. Do not use in lieu of CPT® modifier –66 or CPT® modifiers –80, –81, –82, or HCPCS modifier -AS. (For additional information, see section Multiple Provider Participation in Surgical Procedures on page 21.)

- CPT® modifier –66: Only valid with surgery procedure codes. Operative records that clearly demonstrate that each surgeon performed components of a procedure in a team fashion must accompany the claim. (For additional information, see section Multiple Provider Participation in Surgical Procedures on page 21.)

- CPT® modifier –78: Only valid with surgery procedure codes. Operative records that clearly demonstrate that a related procedure had to be carried out during the post-op period must accompany the claim.

* Effective with claims processed on and after January 1, 2012, providers will no longer be required to submit operative reports or other clinical records to be reimbursed for claim lines containing modifier 62 alone. Our revised policy will be to reimburse each surgeon at 50% of the allowed amount for the procedure after all other edits (e.g., multiple surgery reductions, incidental, mutually exclusive, etc.) have been applied.

Providers will need to send in the appropriate clinical documentation for claim lines that contain modifier 62 and any other modifier on the same line that would potentially impact reimbursement. If an additional modifier, such as modifier 22 or 78 is appended to a procedure also containing modifier 62, then the appropriate clinical documentation will be reviewed to determine an appropriate reimbursement.

Global Surgical, Anesthesia, and Maternity Reimbursement Guidelines

Surgical procedures described in CPT® (see “CPT® Surgical Package Definition” in the CPT® manual) usually include, at a minimum, the following components, in addition to the surgery itself:

- Local infiltration, select blocks or topical anesthesia*
- After the decision for surgery is made, one E/M visit on the day before or on the day of surgery (including history and physical exam)
Policy Statements (continued)

- The surgical procedure/intraoperative care
- Immediate post-operative care
- Interacting with the patient’s significant other and other care providers
- Writing post-operative orders
- Assessing the patient in the post-anesthesia care area
- Usual post-operative follow-up care.

**Note:** CareFirst considers all forms of anesthesia provided by the operating surgeon(s), including moderate conscious sedation, to be included in the reimbursement for the procedure. Refer to Medical Policy Operating Procedures 9.01.001A, 9.01.003A, 9.01.007A in our Medical Policy Reference Manual.

Combining the above services and reporting them under a single fee as a “surgical package,” is referred to as global billing. In the event that only a component of the surgical package is provided, follow CPT® guidelines for reporting the following "split care" CPT® modifiers: –54, –55, and –56.

Depending on the nature of the procedure, subscriber or provider contract, or specific policies, certain services may include additional components in the global allowance, such as for maternity or anesthesia services. Examples of services that are reimbursed with a global allowance can be found in the following references:

- Maternity Services that are and are not included in the global allowance—refer to Global Maternity Services, 4.01.006A in our Medical Policy Reference Manual.
- Anesthesia Services that are and are not included in the global anesthesia allowance. Refer to Anesthesia Services, 9.01.001A in our Medical Policy Reference Manual.
- Procedures containing the term “One or more sessions” in the description. When reporting services where the procedure code indicates “one or more sessions,” the CPT® code should be reported only one time for the entire defined treatment period, regardless of the number of sessions necessary to complete the treatment. While the defined treatment period is determined by the physician and varies depending on the patient, diagnosis, and often the location of treatment, these services may be reported only once during the global postoperative period assigned to the specific code. Refer to CPT® guidelines.

CPT® modifiers –58, –76, –77, –78, and –79 identify procedures performed during the global surgical period. Follow CPT® reporting guidelines for these modifiers. Submissions of claims containing CPT® modifier –78 are reviewed by our Medical Review Department, and should be submitted with a complete operative record in order to be appropriately adjudicated.

CPT® modifier –24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT® reporting guidelines for this modifier.

### Bilateral Procedures Reimbursement Guidelines

Bilateral procedures are defined as surgeries rendered by the same provider, during the same operative session, on paired anatomical organs or tissues.

Bilateral procedures are typically reimbursed at 150% of the allowance of the unilateral procedure (i.e., 100% for one side, and 50% for the other side). For bilateral secondary surgical procedures, bilateral surgical adjudication edits are applied first, and then multiple surgical edits are applied. Thus, the primary bilateral procedure is reimbursed at 150% (100% for the first side, and 50% for the second side). The second bilateral procedure is reimbursed at 100% (50% for the first side and 50% for the second side).

**Policy Guidelines for Reporting Bilateral Procedures:**

Bilateral procedures are reimbursed based on either CPT® coding guidelines or the CMS list of procedure codes that are eligible for CPT® modifier –50. When CPT® modifier –50 is valid, the appropriate code for the bilateral procedure should be reported on one line with the CPT® –50 modifier appended, and a frequency of one (1) in the Units field. If a claim for a bilateral procedure is not submitted this way, the claim will be returned with a request to resubmit it properly. Claims submitted with a procedure that is invalid with
Policy Statements (continued)

CPT® –50 modifier will be returned with a request to resubmit a corrected claim.

When reporting bilateral primary and secondary procedures, CPT® modifier –50 should be reported in the first modifier position. CPT® modifier –51 may be reported in the second modifier position.

HCPCS Level II modifiers –RT (right side) and –LT (left side) are used when a procedure is performed either on one side of the body rather than both sides, or when CPT® modifier –50 is not valid for a procedure code but the procedure is performed on both sides of paired organs. When –RT and –LT modifiers are both used for the same procedure, report the procedure code on two lines with the –RT and –LT appended to each code.

If the description of the procedure code contains the phrase “bilateral,” it is eligible for reimbursement only once on a single date of service. Report the single procedure code with a frequency of one (1) in the Units field.

If the description of the procedure code contains the phrase “unilateral/bilateral,” it is eligible for reimbursement only once on a single date of service. If the code includes “unilateral/bilateral” in the description, it is not appropriate to report the code with CPT® modifier –50. The fee schedule allowance is the same regardless if it is performed on one side or both sides. Report the single procedure code with a frequency of one (1) in the Units field.

If the description of the procedure code specifies “unilateral” and there is another code that specifies “bilateral” for the same procedure, the bilateral code will replace the unilateral codes when they are reported more than once for the same date of service. Code replacements will also occur when one procedure code specifies a single procedure and a second procedure code specifies multiple procedures. Do not report CPT® modifier –50 in this circumstance. Always report the most comprehensive code for the procedure(s) performed.

Certain procedures may only be reported a specified number of times on a single date of service. Once the maximum number is reached, all additional submissions of the procedure code will not be eligible for reimbursement.

Multiple Surgical and Diagnostic Procedures Reimbursement Guidelines

General Guidelines:
Multiple surgical and select diagnostic procedures (including endoscopic, and colonoscopic procedures) are edited to ensure appropriate reimbursement for the benefit.

Covered procedures performed during the same operative session, through only one route of access and/or on the same body system, and that are clinically integral to the primary procedure, are usually considered incidental, integral to/included in, or mutually exclusive to the primary procedure. The primary procedure is reimbursed at 100% of the allowed benefit. Incidental, integral to/ included in, or mutually exclusive procedures are not eligible for reimbursement.

Covered procedures performed during the same operative session that are not clinically integral to the primary procedure (e.g., those that are performed at different sites or through separate incisions) are usually eligible for separate reimbursement. The most clinically intense procedure is reimbursed at 100% of the allowed benefit; and the second and subsequent procedure(s), at 50% of the allowed benefit.

Multiple procedures not considered to be integral to the primary procedure should be reported with the CPT® –51 modifier appended to the second and subsequent procedure codes.*

Some surgical, diagnostic, or therapeutic procedures may appear to be integral, included in, mutually exclusive or duplicates of other procedures performed during the same encounter or session by the same provider. In order to distinguish these procedures as distinctly different (e.g., different operative site or procedure, separate incision, etc.), CPT® modifier –59 should be appended to these select procedures. Carefully follow CPT® guidelines for reporting CPT® modifier –59.

As one factor in determining a fee schedule allowance, CareFirst typically uses the Fully Implemented Non-Facility Total RVU (as published annually in the CMS National Physician Fee Schedule) for all places of service. In addition to including the provider work and malpractice factor, this RVU also includes a robust practice expense (PE) component. The use of this RVU
Policy Statements (continued)

is particularly significant when multiple procedures are performed during the same session by the same provider, as its value determines the ranking of these procedures (i.e., what is considered the primary procedure, and how any subsequent/secondary procedures are ranked.) It should be noted that beginning in 2007, CMS has changed the way it determines the resource-based direct and indirect practice expenses. In order to lessen the impact to practices, there will be a transition period whereby the PE RVU’s will be calculated on the basis of a blend of RVU’s calculated using the new resource based methodology and the 2006 PE RVU’s, weighted by 25% in CY 2007, 50% during CY 2008, 75% during CY 2009, and fully implemented at 100% in CY 2010 and thereafter (i.e., in 2011). PE RVU’s for new codes established during this transition period will be calculated using only the new methodology. As a result of the changes to the Physician Fee Schedule described above, CareFirst will utilize the Transitioned Non-Facility Total RVU (Column P) as published by CMS for both new and pre-existing codes beginning in mid-April, 2007 at the time of our next claims software upgrade. For additional information on this new methodology visit the CMS website at http://www.cms.hhs.gov/PhysicianFeeSched/.

*Note: Certain procedures are considered exempt from the use of CPT® modifier –51. A list of these codes can be found in Appendix E of the CPT® manual. CPT® modifier –51 exempt codes are not subject to multiple procedure fee reductions as the RVU’s assigned to these procedure codes have already been reduced.

Multiple Endoscopic Procedures Through the Same Scope:
When an endoscopic procedure is considered to be a component of a more comprehensive endoscopic procedure, the more clinically comprehensive procedure is usually eligible for reimbursement.

Multiple Endoscopic and Open Surgical Procedures:
Endoscopic and open surgical procedures performed in the same anatomic area are not usually eligible for separate reimbursement. If an open surgical procedure and an endoscopic procedure accomplish the same result, the more clinically intense procedure is usually reimbursed. The comparable procedure is considered mutually exclusive and is not eligible for reimbursement.

A number of endoscopic-assisted, open surgical procedures are performed on the same anatomic area during the same operative session. In accordance with multiple procedure editing, these procedures are usually eligible for separate reimbursement based on the additional time, skill, and physician resources required when two approaches are used for a surgical procedure.

Serial Surgery Reimbursement Guidelines
Separate or additional reimbursement is not made each time procedures are performed in stages or serially or for procedures identified as “one or more sessions” in the code definition. Global surgical rules apply.

Multiple Provider Participation in Surgical Procedures
Certain procedures may require the participation of more than one provider in order to accomplish the desired outcome. Information outlining policies and reporting guidelines for these situations are as follows:

Surgical Assistant or Assistant-at Surgery
Assistants-at-surgery are distinct from team and co-surgery, as described below. For information on this topic refer to Medical Policy Reference Manual Operating Procedure 10.01.008A, Surgical Assistants. The American College of Surgeons (ACS) is the primary source for determining reimbursement for assistant-at-surgery designations of Always or Never. The ACS utilizes clinical guidelines (as opposed to statistical measures) in determining the appropriateness of assistants-at-surgery. A variety of sources, including expert clinical consultants, specialty organizations (e.g., American Academy of Orthopaedic Surgeons), and CMS, are used to determine reimbursement for assistant-at-surgery ASC designations of Sometimes.

CPT® modifiers –80, –81, or –82 are reported for the services of an MD or DO. HCPCS modifier –AS is reported for the services of the non-physician assistant (e.g., physician assistant, nurse practitioner). CPT® modifiers –80, –81, –82, and HCPCS modifier –AS are currently reimbursed at 20% of the allowance for the procedure(s) for which assistant services are eligible for reimbursement.

All applicable reimbursement policies will apply (e.g., incidental procedures, multiple procedures, bilateral
procedures, global periods) to an assistant-at-surgery the same as it would apply to the primary surgeon.

**Team Surgery**
The term “team surgery” describes circumstances in which two or more surgeons of the same or different specialties are required to perform separate portions of the same procedure at the same time. Examples of these circumstances include procedures performed during organ transplantation or reimplantation of limbs, extremities or digits. In these instances, the surgeons are not acting as an assistant-at-surgery, but rather as team surgeons. To report as team surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT® modifier –66 to the specific procedure code(s) used for reporting the services provided.

Submissions of claims containing CPT® modifier –66 are reviewed by our Medical Review Department, and should be submitted with the complete operative record in order to be appropriately adjudicated. The unique surgical services and level of involvement of each surgeon should be documented in a single operative report that is signed by all participants.

If a surgeon functions as both a team surgeon and an assistant-at-surgery for different portions of the total operative procedure, then CPT® modifier –66 should be appended to the procedure applicable to team surgery, and CPT® modifier –80, –81, or –82, as appropriate, should be appended to the procedure(s) in which the surgeon acted as an assistant.

The percentage of the allowed benefit apportioned to each of the team surgeons will be determined based on several factors, including but not limited to:

- The complexity of the individual surgical services performed
- The amount of involvement in the operating room
- The amount of pre- and post-operative care required
- Whether the procedures performed are related, incidental, or unrelated to each other

All applicable reimbursement policies will apply (e.g., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT® modifier –66.

**Co-Surgeon**
The term “co-surgery” describes circumstances in which the individual skills of two or more surgeons, often of different specialties, are required to perform the same procedure. In these instances, the surgeons are not acting as an assistant-at-surgery, but rather as a co-surgeon. To report as co-surgeons, each surgeon participating in the surgical procedure(s) must file a separate claim and append CPT® modifier –62 to the specific procedure code(s) used for reporting the services each provided.

Submissions of claims containing CPT® modifier –62 are reviewed by our Medical Review Department*, and should be submitted with the complete operative record in order to be appropriately adjudicated. The unique surgical services and level of involvement of each surgeon should be documented in a separate operative report. *(See Modifier Reimbursement Guidelines for revised policy effective January 1, 2012.)*

If a surgeon functions as both a co-surgeon and an assistant-at-surgery for different portions of the total operative procedure, then CPT® modifier –62 should be appended to the procedure(s) applicable to co-surgery, and CPT® modifier –80, –81, or –82, as appropriate, should be appended to the procedure in which the surgeon acted as an assistant.

If additional procedures (including “each additional” procedures) are performed during the same operative session by one of the surgeons, the additional procedure code(s) should be reported by that surgeon only, without CPT® modifier –62 appended.

All applicable reimbursement policies will apply (e.g., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with CPT® modifier –62.

**Multiple Provider Participation in Patient Care**

**Consultations**
Consultation services should be reported using the appropriate consultation E/M codes (office/outpatient, inpatient) according to CPT® reporting guidelines and as follows.

Consultation services are reimbursed according to the terms of the member’s benefit contract and applicable
Policy Statements (continued)

claims adjudication policies. A consultation occurs when the attending physician or other appropriate source asks for the advice or opinion of another physician for the evaluation and/or management of the patient’s specific problem. The need for a consultation must meet medical necessity criteria and be documented in the referring physician’s medical record.

A physician consultant may initiate diagnostic and/or therapeutic services as a part of or during the consultation process. The request for a consultation from the attending physician or other appropriate source and the reason for the consultation must be documented in the patient’s medical record. The consultant’s opinion/recommendation and any services that were ordered or performed must also be documented in the medical record and communicated to the requesting provider.

If the attending physician requests a second or follow-up office or outpatient consultation, an office/outpatient consultation E/M visit may be reported a second time, as there is no follow-up consultation code for this setting.

A consultation initiated by a patient and/or family, and not requested by a physician should not be reported using consultation codes. Report these services using the setting specific non-consultation E/M codes, as appropriate.

A consultation code is not eligible for reimbursement when an attending physician requests that the second (consulting) physician take over care of the patient. If the attending physician decides to transfer care of the patient to the consultant after the consultation, the consultant may not continue to report a consultation visit. The consultant should begin reporting the appropriate non-consultation E/M codes. (See CPT® E/M Services guidelines regarding concurrent care and transfer of care).

Standby Services
Standby services are not eligible for reimbursement (see Medical Policy Operating Procedures, 10.01.004A, Standby Services), except for attendance at delivery when requested by the obstetrician (see our Medical Policy Reference Manual, Procedure 10.01.002A, Attendance at Delivery).

Evaluation and Management Services
Benefits are available for evaluation and management (E/M) services according to the terms of the subscriber’s benefit contract and applicable claims adjudication policies. Incidental, integral to/included in, mutually exclusive, and global services editing policies apply to all E/M services.

E/M services are reported for the appropriate level of service in accordance with CPT® guidelines and must be supported in the medical record according to the CareFirst Medical Record Documentation Standards, located in Operating Procedure, 10.01.013A, in our Medical Policy Reference Manual.

CPT® Modifier–25
In many instances, E/M services are considered included in or mutually exclusive to other procedures and services reported on the same date, and are therefore not eligible for separate reimbursement.

Per CPT®, modifier –25 is used to describe a “significant, separately identifiable E/M service by the same physician on the same day of a procedure or other service.” CPT® modifier –25 is only valid with E/M codes.

Reporting with a CPT® modifier –25 does not require a different diagnosis as the procedure or other service, but documentation in the medical record must support that a “significant, separately identifiable” E/M service was provided. To be eligible for reimbursement for CPT® modifier –25, the key components of the E/M service (i.e., history, physical, decision-making, as outlined in CPT®) must be performed and documented in the medical record.

There are many instances in which CPT® modifier –25 may be appropriately reported, as described throughout these reimbursement guidelines.
**New Patient Visit Frequency**

According to CPT® guidelines, a “new patient” is one who has not had services from the same physician or group in the same specialty in the past three (3) years. An established patient E/M visit must be reported if the patient is seen, for any reason, by the same physician or member of the group, within the three-year timeframe. This also applies to physicians who are on-call for or covering for another physician. In this case the patient’s E/M service is classified as it would be for the physician who is not available. The covering physician should report the appropriate level E/M service according to the 3-year timeframe as described above. Refer to CPT® reporting guidelines for further instructions.

If a new patient E/M code is reported more than once by the same provider/group within the 3-year timeframe, the code will automatically be replaced with a corresponding “established” E/M code.

**Preventive Services**

Preventive services, also known as health maintenance exams, include preventive physical examinations; related x-ray, laboratory, or other diagnostic tests; and risk factor reduction counseling. Most CareFirst subscriber contracts include a benefit for these preventive examinations, many of which are limited to once per benefit year (i.e., annually). It is important, therefore, that preventive services (CPT® 99381-99397) are only reported when providing the complete health maintenance exam and related tests and immunizations. Routine, age-specific immunizations are reported separately (see “Reimbursement for Injectables, Vaccines, and Administration”). Providers must report the appropriate E/M codes (e.g., CPT® 99201-99215) for other encounters such as preoperative or pre-diagnostic procedure evaluations.

For additional information, refer to CPT® Preventive Medicine Services Guidelines and CareFirst Preventive Services Guidelines in the Providers & Physicians section of the CareFirst Web site, www.carefirst.com.

**Multiple E/M Services on the Same Date**

Multiple E/M services reported by the same provider on the same date of service are usually considered mutually exclusive. The most clinically intense service is usually reimbursed.

There are times however, that a patient may present for health maintenance/preventive medicine service visit, and a condition or symptom is identified that requires significant additional effort to address and treat the condition. If the treatment of the condition or symptom requires the performance of the key components of a problem-oriented service, then it may be appropriate to report the appropriate level E/M code in addition to the preventive care visit code. CPT® modifier –25 must be appended to the E/M code to indicate that a significant separately identifiable E/M service was provided in addition to the preventive service.

CareFirst considers significant additional effort as encompassing all of the following:

- Additional time is required to diagnose and treat the presenting problem; and
- The physician develops and initiates a treatment program for the identified condition by the end of the office visit.

If a physician monitors a chronic condition (e.g., hypertension, diabetes) at the time of the preventive medicine visit, and the condition does not require a significant change in the plan of care, then CareFirst considers this monitoring to be part of the comprehensive system review and assessment. Likewise, if a patient requires problem-focused care (e.g. for a sore throat or viral illness) or needs to be referred to a specialist, this is considered to be included in preventive medicine evaluation and management and is not considered significant additional effort. In both these instances it would not be appropriate to report an E/M service in addition to the preventive visit.

**Counseling Services**

Carefully follow CPT® guidelines when reporting preventive counseling services (i.e., CPT® 99401-99429). Since these guidelines indicate that these codes are “used for persons without a specific illness,” it is inappropriate to report these codes for services such as preoperative counseling.

**Care Plan Oversight**

CareFirst provides a benefit for care plan oversight services (CPT® codes 99374 – 99380) to one (1) physician who provides a supervisory role in the care of a member receiving complex case or disease management services. These services are reported in accordance with CPT® guidelines (e.g., time
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spent per 30 days) and may be reported in addition to direct patient care E/M services as appropriate.

E/M Services During the Global Periods
E/M services reported on the same date as zero day global period procedures are edited as follows:

- Initial/New Patients: the E/M service is eligible for reimbursement in addition to the procedure.
- Follow-Up/Established Patients: only the procedure is eligible for reimbursement unless CPT® modifier -25 is appended to the visit code to indicate that a “significant, separately identifiable” E/M service was provided at the time of the procedure.

E/M services for new or established patients reported on the same date as a 0/10 and 1/90 day global period procedure are not eligible for reimbursement. An exception to this is when CPT® modifier -57 (see below) or CPT® modifier –25 is appended to the visit code to indicate that a “significant, separately identifiable E/M” service was provided in conjunction with the procedure. The E/M service is then eligible for separate reimbursement.

CPT® modifier –24 identifies an unrelated E/M service provided during the global post-operative period. Follow CPT® reporting guidelines for this modifier.

See also Collecting Copayments / Coinsurance During Global Surgical Periods (page 26.)

CPT® modifier –57
When an E/M visit results in the initial decision to perform surgery for a “major” (i.e., 1/90 global period) procedure, CPT® modifier –57 should be appended to the E/M service code. The E/M service is then eligible for separate reimbursement. Refer to CPT® reporting guidelines.

CPT® modifier –57 is not eligible for reimbursement in the following circumstances:

- When reported with non-E/M codes;
- When the initial decision to perform surgery is a “minor” surgical procedure (i.e., a procedure with a 0 or 10 day global period), or

- When appended to an E/M visit code when the visit is for the preoperative history and physical exam prior to the surgical procedure.

E/M Services in Conjunction with Immunizations
If an immunization(s) and administration of the drug are reported together, both are eligible for separate reimbursement. Covered E/M services are also eligible for separate reimbursement at the same visit as the immunization, with the exception of CPT® code 99211. If a significant, separately identifiable CPT® code 99211 service is rendered at the time of the immunization/injection, CPT® modifier -25 should be appended.

Prolonged Services
Prolonged physician service codes (CPT® 99354-99359) may be reported when there is patient contact beyond the usual E/M service in either the inpatient or outpatient setting.

Several of these are “add-on” codes and, as such, must be reported in addition to other E/M codes. They are not valid when reported with any other procedure or service. See CPT® guidelines when reporting CPT® 99358-99359 as these may be reported on a different date from the E/M visit under certain circumstances.

Prolonged services codes are not eligible for reimbursement in combination with the following:

- Emergency services (CPT® 99281-99288)
- Observation services (CPT® 99217-99220)
- Observation or inpatient services (CPT® 99234-99236)
- Critical care services (CPT® 99291-99292)

Prolonged services are not eligible for reimbursement for time spent by a non-physician incidental to the physician’s service, e.g., office staff discussing dietary concerns with a patient.

Carefully follow CPT® reporting guidelines when reporting prolonged services, including base codes with which they may be reported. Because these are time-based codes, documentation in the medical record must clearly reflect exact times spent on base and prolonged services in order to verify appropriate use of these codes.
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Intensity of Service Auditing
Effective with claims processed on and after December 3, 2007, CareFirst will no longer automatically reassign or reduce the code level of E/M codes for covered services, except in the case of replacing a new patient visit code with an established patient visit code in accordance with CPT® guidelines. We will evaluate and reduce or reassign code levels if it is determined through review of clinical information that the reported code(s) is not reflective of the service rendered.

General and Specialty-Related Claim Adjudication Policies and Reimbursement Guidelines
The following represent highlights of certain policies, edits, and reimbursement guidelines that may be of interest to many providers in the CareFirst networks. Since there is no way that we can address all editing scenarios in this document, please contact your Provider Services representative with questions of a more specific nature.

Multiple Specialties

Reporting Medication Administration
In all instances, one should only report the actual services provided to the patient, including medications administered in any setting. CareFirst will only reimburse providers for the amount of the medication administered. Providers should schedule patients in such a way as to minimize any waste and utilize medications efficiently. If a specific dose of medication is drawn from a multidose vial, only the amount of medication administered to the patient is to be reported, not the total amount of the drug in the vial.

Reimbursement for Injectables, Vaccines, and Administration:
Covered vaccines and injectables are reimbursed, as is the administration of these medications, according to an established fee schedule. Newly recommended vaccines are eligible for reimbursement as of the effective date of a recommendation made by any of the following:

- The U. S. Preventive Services Task Force;
- The American Academy of Pediatrics; and
- The Advisory Committee on Immunization Practices

Benefits for vaccinations and immunizations are contractually determined. It is advised that providers ensure that benefits are available prior to rendering these services.

See also: E/M Services in Conjunction with Immunizations and Hydrations, Infusions, and Injections. Additional information is available in the Medical Policy Reference Manual (e.g., Medical Policy 5.01.001) and the CareFirst Preventive Services Guidelines, both of which are located on www.carefirst.com.

For information regarding procurement of office administered medications, refer to Injectable Drugs (page 10) in the Administrative Functions section of this manual.

Collecting Copayments / Coinsurance During Global Surgical Periods
- If an E/M service/visit is allowed, regardless if rendered before, during or after a global surgical period, a claim should be submitted, and the applicable copayment / coinsurance may be collected.
- If an E/M service/visit is disallowed and/or bundled into the global surgical allowance, a claim should not be submitted, and a copayment / coinsurance may not be collected.

It is not appropriate to collect a copayment / coinsurance from a subscriber / member and not submit a claim for a service / visit. See also Medical Policy Operating Procedure 10.01.009A, Global Surgical Care Rules, in the Medical Policy Reference Manual.

Special Services
Services rendered during off-hours, on weekends, on holidays, on an emergency basis, and for hospital-mandated on call (e.g. CPT® 99026-99060) are considered incidental or mutually exclusive to other services. Incidental and mutually exclusive services are not eligible for reimbursement.

Exception: Effective Oct. 1, 2010, CPT® 99050 will be eligible for separate reimbursement to primary care providers (PCPs) practicing in the State of Maryland for after hours service. After hours is defined as medical office services rendered after 6 p.m. and before 8 a.m. weekdays; or weekends and national holidays. This code
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may be reported in addition to other services on the claim. The following types of practitioners are considered PCP’s: general practice; family medicine; internal medicine; pediatrics; and geriatrics.

Cerumen Removal
Cerumen (ear wax) removal (CPT® 69210) is designated as a “separate procedure.” As described previously, “separate procedures” are not usually eligible for reimbursement when reported with other procedures to which they are considered integral. A new patient visit (i.e., CPT® 99201-99205) will usually be allowed with CPT® 69210. An established patient visit (i.e., CPT® 99211-99215) will usually not be eligible for separate reimbursement when reported with CPT® 69210 on the same date.

Critical Care Services
CPT® describes reporting guidelines for the time-based, critical care services codes (CPT® 99291-99292) that are consistent with CareFirst policy. These guidelines also define procedures and services that are considered incidental to critical care. Examples of additional procedures that CareFirst considers to be incidental to critical care are as follows:

- Venipuncture, under age 3  
  (CPT® 36400, 36405, 36406)
- Venipuncture (CPT® 36415)
- Insertion of needle/catheter (CPT® 36000)
- Transfusion procedures (CPT® 36430)
- Intravenous fluid administration  
  (e.g., CPT® 96360 - 96379)

Incidental services and procedures are not eligible for reimbursement.

Handling and Conveyance
Handling and Conveyance (CPT® 99000-99002) is considered integral to most procedures and services including, but not limited to E/M, surgery, surgical pathology. Integral services are not eligible for reimbursement.

Hot and Cold Packs
Hot and cold packs (CPT® 97010) are considered incidental or mutually exclusive to most services, including but not limited to, chiropractic manipulation, therapeutic exercise, therapeutic activity, manual therapy, massage, and whirlpool therapy. Incidental or mutually exclusive services are not eligible for reimbursement.

Supervision, Interpretation and/or Guidance for Diagnostic Tests
Interpretation of diagnostic studies, including but not limited to, laboratory, radiology, electrocardiographic tests, are considered incidental or integral to all E/M services and other services that include evaluation components. Incidental or integral services are not eligible for reimbursement.

Specialty physicians (e.g., radiologists, cardiologists, pathologists) that perform the final interpretation and “separate, distinctly identifiable, signed, written report” (per CPT® guidelines) of a diagnostic service may be eligible to receive reimbursement when the procedure is reported with CPT® modifier –26.

CPT® codes reported for “supervision and interpretation” and “radiologic guidance” (e.g., fluoroscopic, ultrasound or mammographic) are eligible for reimbursement to the extent that the associated procedure code is recognized and eligible for reimbursement, and provided that the associated procedure code does not include supervision and interpretation or radiologic guidance services. For each such procedure (e.g., review of x-ray or biopsy analysis or ultrasound guidance), only one qualified provider/health care professional shall be reimbursed.

Reimbursing more than one provider for the same service represents duplicate procedure payment. Duplicate services are not eligible for reimbursement. (See also: Duplicate Services and Procedures)

Introduction of Intravenous Needles/Catheters
Introduction of a catheter/needle (CPT® 36000) is considered incidental to all anesthesia services, select radiology procedures, critical care E/M services, and all procedures that typically require the patient to have a peripheral IV line. Incidental procedures are not eligible for reimbursement.

Hydration, Infusions, and Injections
Carefully follow CPT® guidelines when reporting hydration, injection and infusion services alone or in conjunction with other infusion/injection procedures and/or chemotherapy. Because a number of factors determine correct code assignment (e.g., reason for encounter; indications for additional procedures; sequencing of
Policy Statements (continued)

initial, subsequent and concurrent procedures; inclusive services; and time) it is imperative that the medical record documentation be accurate and clearly identify all of these pertinent issues in order that reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of infusion/injection procedures. Incidental procedures are not eligible for separate reimbursement.

Routine injections (e.g., CPT® 96372) are usually eligible for separate reimbursement when reported with office E/M services (exception CPT® 99211) and a covered pharmaceutical agent. Carefully follow CPT® guidelines when reporting injection procedures. Injections are considered incidental when reported with services such as, anesthesia, emergency and inpatient E/M, surgery, select radiology, and select therapeutic and diagnostic procedures. Incidental procedures are not eligible for reimbursement.

Hydration, infusion, and injection procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those facilities. It is not appropriate, therefore, for the professional provider (e.g., physician) to report those services unless that provider personally performs the service.

Pulse Oximetry
Non-invasive pulse oximetry determinations (CPT® 94760-94762) are considered incidental when reported with E/M services, anesthesia, and other procedures. Incidental procedures are not eligible for reimbursement. These codes are only eligible for reimbursement when they are reported as stand-alone procedures (i.e., when no other services are provided to the patient on the same date).

Vital Capacity Measurements
This procedure (CPT® 94150) is considered incidental to all other procedures. Incidental procedures are not eligible for reimbursement. This code is only eligible for reimbursement when it is reported as a stand-alone procedure (i.e., when no other services are provided to the patient on the same date.)

Supplies and Equipment
CareFirst follows the Medicare (CMS) guidelines in terms of what is included in the practice expense for each procedure code. A portion of a procedure code’s relative value unit (RVU) and associated reimbursement allowance is “practice expense.” The practice expense portion includes medical and/or surgical supplies and equipment commonly furnished in a practice, and that are a usual part of the surgical, medical, anesthesiology, radiology, or laboratory procedure or service. This includes, but is not limited to:

- Syringes, biopsy and hypodermic needles (e.g., HCPCS A4206-A4209, A4212-A4215)
- IV catheters and tubing (e.g., A4223)
- Gowns/gloves/masks/drapes (e.g., A4927-A4930)
- Scalpels/blades
- Sutures/steri-strips
- Bandages/dressings/tape (e.g., A4450-A4452, A6216-A6221)
- Alcohol/betadine/hydrogen peroxide (e.g., A4244-A4248)
- Sterile water/saline (e.g., A4216-A4218)
- Thermometers (e.g., A4931-A4932)
- Trays and kits (e.g., A4550)
- Oximetry and EKG monitors
- Blood pressure cuffs (e.g., A4660-A4670)

Therefore, additional charges for routine supplies and equipment used for a procedure, service, or office visit, and reported with CPT® 99070, HCPCS code A4649 and any other code that describes these supplies or equipment, are considered incidental to all services and procedures. This is applicable whether or not the supply is reported with other procedures/services or is reported alone. Incidental services are not eligible for reimbursement, and subscribers may not be balance-billed for them.

Note: Supplies and equipment used while treating a patient in an institutional or outpatient facility should not be reported by the professional provider, as these supplies are reported on the facility claim.

See also “Surgical Trays” in the Surgery/Orthopedics section of this guide.
Miscellaneous Services
Educational supplies (CPT® 99071), medical testimony (CPT® 99075), physician educational services (CPT® 99078), special reports (CPT® 99080), unusual travel (CPT® 99082), telephone calls (CPT® 99441-99443), and collection/interpretation/analysis of data stored in computers (CPT® 99090-99091) are considered incidental to all services. CareFirst subscriber contracts do not provide benefits for these services, and therefore they are not eligible for reimbursement.

Venipuncture
Venipuncture procedures (CPT® 36400-36410) which require a physician’s skill are eligible for separate reimbursement when reported with laboratory tests from the CPT® 8xxxx series. Please note that these procedures are not to be used for routine venipuncture. In addition, “separate procedure” rules apply.

Routine venipuncture procedures (e.g., CPT® 36415 and HCPCS S9529) are considered incidental to all laboratory services. Incidental procedures are not eligible for reimbursement. Venipunctures may be eligible for separate reimbursement when reported with an E/M service or alone.

If a routine venipuncture (as noted above), laboratory test from the CPT® 8xxxx series, and an E/M service are reported on the same claim, same date of service, and from the same provider, the venipuncture will be considered incidental to the laboratory test.

Visual Acuity Testing
Visual acuity screening (CPT® 99173) is considered incidental to new and established office or other outpatient E/M services. Incidental procedures are not eligible for reimbursement. Venipunctures may be eligible for separate reimbursement when reported with a new or established preventive medicine E/M service.

Medical/Clinical Photography
Photographs taken for any purpose are considered the same as the medical documentation for a patient. As with written or typed documentation, photography, regardless of the individual performing the photography, is considered to be an integral part of any service, procedure, or episode of care. Integral services are not eligible for separate reimbursement.

Emergency Medicine
Emergency medicine E/M services (CPT® 99281-99285) are provided in a hospital-based emergency department (see CPT® reporting guidelines).

Many procedures are performed on patients during the emergency care encounter and are provided by personnel employed by the hospital (e.g., nurses, respiratory therapists, phlebotomists, technicians). Procedures performed by hospital personnel are included in the facility charge, and should not be reported on the professional claim unless personally provided by the emergency physician or other qualified provider.

Services personally rendered by other physicians (e.g., consultants) are reported separately by those providers. (See also: Duplicate Services and Procedures)

Procedures including, but not limited to the following, are considered incidental or mutually exclusive to emergency medicine E/M services:

- Inhalation treatment (CPT® 94640)
- Ventilation management (CPT® 94002-94004)
- Ear or pulse oximetry (CPT® 94760-94762)
- Sedation (See Operating Procedure 9.01.003A in the Medical Policy Reference Manual)
- Physician direction of EMS (CPT® 99288)
- Interpretation of diagnostic studies, (page 27)

Certain procedures when personally performed by the emergency physician are usually eligible for separate reimbursement and include:

- Wound repair (CPT® 12001-14350)*
- Endotracheal intubation (CPT® 31500)
- Insertion of central venous catheter* (e.g., CPT® 36555-36571)

* Global surgical rules apply. This means that E/M services are not eligible for separate reimbursement when provided with procedures for which the E/M is considered part of the surgical package. CPT® modifier –25 may be required if there is a significant, separately identifiable E/M service provided on the same date as certain procedures (see “E/M Services During the Global Periods”). Emergency physicians who perform surgical procedures should report these with CPT® modifier –54,
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as appropriate, since they typically provide the surgical component, not the pre-or post-operative component of the surgical package. (See “Global Surgical, Anesthesia, and Maternity Reimbursement Guidelines”)

Physician direction of EMS (CPT® 99288) when reported alone is not eligible for reimbursement.

Surgery/Orthopedics

Anesthesia by Operating Surgeon
Administration of anesthesia by the surgeon, assistant surgeon, nursing staff or any other provider within the same clinical practice (e.g., same tax ID number) during a procedure is considered included in the allowance for the surgical procedure. This includes any method of anesthesia (e.g., general anesthesia, moderate (conscious) sedation, local or regional anesthesia, nerve blocks). Included in procedures are not eligible for reimbursement. See also, Medical Policy Operating Procedure 9.01.001A, Anesthesia Services and 9.01.003A, Sedation With or Without Analgesia Moderate (Conscious) Sedation, in the Medical Policy Reference Manual.

Fracture Care, Strapping, Casting
Carefully follow CPT® guidelines when reporting fracture care and casting/strapping. Fracture care provided by multiple providers on various days, is subject to historical claims auditing.

Certain casting supplies (e.g., HCPCS A4580, A4590) are eligible for separate reimbursement when reported with fracture care, and casting and strapping procedures.

Lesion Removals and Biopsies
Covered, non-cosmetic lesion removals are eligible for separate reimbursement according to the terms of the subscriber contract and applicable medical policies. Follow CPT® guidelines for reporting excision, destruction, and shaving of benign and malignant lesions. Multiple lesion removal procedures reported together with the same CPT® code are usually considered duplicates or mutually exclusive to each other because the claims systems assume same site. CPT® modifier –59 should be appended to lesion removals subsequent to the primary procedure to indicate that they were distinct procedures (e.g., separate sites, separate lesions). Multiple procedure editing rules apply.

Lesion Excision and Wound Closures
Follow CPT® guidelines for reporting single and multiple wound closures. When intermediate, complex, or reconstructive closures are reported with lesion excisions, both procedures may be eligible for separate reimbursement. Simple wound repair procedures (e.g., CPT® 12001) are considered incidental to excision of lesions in the same anatomic site. Incidental procedures are not eligible for separate reimbursement.

Surgical Trays
As discussed in the “Supplies and Equipment” section of this guide, a portion of the RVU is “practice expense.” This also includes trays necessary for surgical procedures performed in the office setting. Therefore, additional charges for trays (i.e., HCPCS code A4550) used for a surgical procedure or during an office visit are considered incidental to all services and procedures. Incidental procedures are not eligible for reimbursement.

Nasal Sinus Endoscopy/Debridement
Nasal sinus endoscopy (CPT® 31237, “separate procedure”) is eligible for separate reimbursement when performed as postoperative care following functional endoscopic sinus surgical (FESS) procedures that have a zero (0) day global period or after a ten (10) day global period. Endoscopic surgical sinus cavity debridement is not eligible for separate reimbursement when performed as a postoperative treatment related to major surgeries (e.g., septoplasty) within a ninety (90) day global period. When the patient is being followed postoperatively for both a 0 or 10 day global AND a major (90 day global) procedure, append CPT® modifier -79 to CPT® 31237 to indicate that the debridement is unrelated to the major procedure. In addition, ensure that medical record documentation and associated ICD-9 diagnosis codes accurately describe for which procedure(s) the endoscopic sinus debridement is being performed. It should be noted that many nasal surgery codes are considered unilateral. Append CPT® modifier –50 as appropriate when a procedure is performed bilaterally. As always, “separate procedure” rules apply, according to CPT® guidelines.

Medicine/Oncology

Allergy Testing/Immunotherapy
Allergy services and procedures benefits are often defined by the subscriber contract. For additional information on this topic, refer to Medical Policy 2.01.023, Allergy
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Chemotherapy (Office, Inpatient and Outpatient Settings)
Chemotherapy procedures (CPT® 96401-96549) are considered independent from E/M services. E/M services, when reported with chemotherapy, are not eligible for reimbursement unless CPT® modifier –25 is appended to the E/M code to indicate that a “significant, separately identifiable E/M” service was performed in addition to the chemotherapy.

Carefully follow CPT® guidelines when reporting chemotherapy services alone or in conjunction with other infusion and injection procedures. Because a number of factors determine correct code assignment (e.g., reason for encounter; indications for additional procedures; sequencing of initial, subsequent and concurrent procedures; inclusive services; and time) it is imperative that the medical record documentation be accurate and clearly identify all of these pertinent issues in order that reporting is accurate. Incidental and/or mutually exclusive editing will apply when certain inappropriate code combinations are reported together.

Select intravenous fluids, needles, tubing and other associated supplies are considered incidental to the administration of chemotherapy. Incidental procedures are not eligible for separate reimbursement.

Medically necessary, non-experimental/investigational chemotherapeutic agents and other drugs are usually eligible for separate reimbursement when reported with the appropriate HCPCS code. Refer to applicable policies in the Medical Policy Reference Manual, (e.g., Policy 5.01.01, Off-Label and Orphan Drug Use).

Chemotherapy procedures provided in inpatient and/or outpatient centers are typically provided by personnel in those settings and reported on claims for those centers. It is not appropriate, therefore, for the professional provider (e.g., physician) to report those services unless that provider personally performs the service.

Nutrition Therapy and Counseling
Follow CPT® guidelines for reporting nutritional therapy services. For instance, non-physicians should report these services using CPT® codes 97802-97804. Physician providers are instructed to report these services with an appropriate E/M code. For additional information on nutrition therapy services, refer to the applicable policies in the Medical Policy Reference Manual, (e.g., Operating Procedure 2.01.050A, Professional Nutritional Counseling.)

Genito-Urinary

Pediatrics/Neonatology
Normal Newborn
Benefits for newborn care are defined by the subscriber contract. Carefully follow CPT® guidelines when reporting all aspects of newborn care. For further information, refer to Medical Policy 10.01.006, Care of the Normal Newborn in the Medical Policy Reference Manual.

Neonatal and Pediatric Intensive Care Services
Carefully follow CPT® guidelines for reporting Pediatric Critical Care Transport (CPT® 99466-99467), Inpatient Neonatal and Pediatric Critical Care (CPT® 99468-99476), and Initial and Continuing Intensive Care Services (CPT®
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99477-99480). Note that these represent 24-hour global services (except Pediatric Critical Care Transport), and may only be reported once per day, per patient. These guidelines also define procedures and services that are considered incidental to CPT® 99293-99300.

Incidental services are not eligible for separate reimbursement.

Obstetrics & Gynecology

Maternity Services
Maternity benefits are defined by the subscriber contract. Carefully follow CPT® guidelines for reporting maternity services, including reporting non-global services (e.g., separate antepartum, delivery, and/or postpartum care). Refer to Medical Policy Operating Procedure 4.01.006A, Global Maternity Care in the Medical Policy Reference Manual.


Contraceptive Devices
Family planning services are defined by the subscriber contract. Established patient E/M services reported with insertions and removals of intrauterine devices (IUD) (CPT® 58300-58301) are considered to be included in the surgical package for the procedure, and thus are not eligible for separate reimbursement unless the E/M service is a “significant, separately identifiable” service. In that case, CPT® modifier –25 should be appended to the E/M service.

Diaphragm/cervical cap fitting (CPT® 57170) is considered incidental to all established patient E/M services. Incidental procedures are not eligible for reimbursement.

Radiology/Imaging

Mammography
Mammography benefits are defined by the subscriber contract. Depending on the subscriber contract and related CareFirst Preventive Guidelines, both a screening and/or diagnostic mammogram may be eligible for reimbursement on the same date of service. In this case, the procedure with the higher RVU will be reimbursed at 100% of the allowed benefit, and the procedure with the lesser RVU will be reimbursed at 50% of the allowed benefit.

Multiple CT, MRI, and MRA Scans, Same Session
Follow CPT® guidelines for reporting CT, MRI, and MRA scans (with and without contrast). Adjacent and/or non-adjacent scans reported at the same session are eligible for reimbursement at 100% of the allowed amount.

Diagnostic Ultrasound with Ultrasound (US) Guidance Procedures:

- Limited” Diagnostic Ultrasound Procedures reported with Ultrasound Guidance Procedures: When a “limited” diagnostic ultrasound (e.g., CPT® 76705) and an ultrasonic guidance procedure (e.g., CPT® 76942) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area. Based on CPT® guidelines, an US guidance procedure includes imaging protocols that are comparable to the limited diagnostic US. Therefore, when these two procedures are reported together on the same date, the limited US is considered mutually exclusive to the US guidance. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

- Diagnostic Ultrasound Procedures reported with Ultrasound Guidance Procedures: When an US guidance procedure (e.g., CPT® 76942) and an US procedure (e.g., CPT® 76536) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area. Based on CPT® guidelines an US guidance procedure includes imaging protocols that are comparable to the US procedure. Therefore, when these two procedures are reported together on the same date, the US procedure is considered mutually exclusive to the US guidance. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

- Ultrasound Guidance Procedures reported with Ultrasound Guidance Procedures: When multiple US guidance procedures (e.g., CPT® 76930 and CPT®76942) are reported on the same date, it is assumed by our claims system that both were performed during the same session in the same anatomic area and for similar clinical indications. When these procedures are reported together
on the same date, the code with the lower RVU value will be considered mutually exclusive to the code with the higher RVU value. Mutually exclusive services are not eligible for separate reimbursement. The procedure with the higher RVU value is eligible for reimbursement.

In each of these scenarios there may be particular clinical circumstances in which the procedures are performed on separate anatomic sites, and/or there may be distinct clinical indications for each study. In these circumstances, it will be necessary to append the appropriate modifier(s) to the code(s) to indicate such. Documentation in the medical record must support the reason for multiple reporting of these procedures.

**Invasive and Non-Invasive Diagnostic Tests and Procedures**

Many of these tests and procedures (e.g., cardiac catheterizations, electrophysiological studies, imaging studies) can be reported several ways depending on ownership of equipment, place of service, who is performing the service, and who is supervising and/or interpreting the results of the test. Providers must report these services appropriately in order for the claim to be properly adjudicated. Refer to the Basic Claim Adjudication Policy Concepts section, under “Modifier Reimbursement Guidelines”, regarding reporting global and/or components of these services. (See also: Duplicate Services and Procedures)

**Medical Policy and Technology Assessment**

**Medical Policies and Operating Procedures**

CareFirst evidence-based Medical Policies and Operating Procedures can be found in the *Medical Policy Reference Manual* (MPRM) in the Providers and Physicians section of [www.carefirst.com](http://www.carefirst.com) by clicking on Medical Policies. This manual is an informational database, which, along with other documentation, is used to assist CareFirst in reaching decisions on matters of medical policy and related member/subscriber coverage. These policies and procedures are not intended to certify or authorize coverage availability and do not serve as an explanation of benefits or a contract. Member/subscriber coverage will vary from contract to contract and by line of business, and benefits will only be available upon the satisfaction of all terms and conditions of coverage. Some benefits may be excluded from individual coverage contracts.

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

For specific reporting codes and instructions, refer to the appropriate and current coding manual, such as the CMS Healthcare Common Procedure Coding System (HCPCS, Level II codes), the International Classification of Diseases (ICD), and the American Medical Association’s Current Procedural Terminology (CPT®) (HCPCS Level I codes).

The *Medical Policy Reference Manual* (MPRM) is organized according to specialty, and in some cases, subspecialty, as follows:

- 00 Introduction
- 01 Durable Medical Equipment
- 02 Medicine
- 03 Mental Health
- 04 OB/GYN/Reproduction
- 05 Prescription Drug
- 06 Radiology/Imaging
- 07 Surgery
- 08 Rehabilitation/Therapy
- 09 Anesthesia
- 10 Administrative
- 11 Laboratory/Pathology
- 99 Archived Policies and Procedures

The Introduction to the MPRM should be referenced prior to reviewing the medical policies and procedures. This section describes the medical policy process, format of documents, and definitions and interpretive guidelines of key terms such as “medical necessity,” “cosmetic,” and “experimental/investigational.”

It should be noted that the medical policies and procedures located in the CareFirst MPRM provide guidelines for most local lines of business. Many national accounts, processed through the NASCO system, and subscribers with federal employee (FEP) benefits, may defer to policies promulgated by the Blue
Cross Blue Shield Association. Therefore, there may be differences in medical policy and technology assessment determinations depending on the subscriber contract; and benefits and coverage determinations should be verified prior to providing services.

**Technology Assessments**

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

Technology assessments are presented, with supportive data, to the CareFirst Technology Assessment Committee (TAC) which meets on a regular basis. TAC is comprised of members of the Health Care Policy Department, CareFirst Medical Directors, and specialty consultants, as appropriate. Determinations of the status of the technology (i.e., whether or not the technology is experimental/investigational) are made by consensus of the TAC. TAC determinations are effective on the first day of the month following the meeting.
Vision Care

Some contracts may include a stand-alone vision endorsement. These types of endorsements cover basic routine vision services such as refractions, eyeglasses and contact lenses. Services included in the routine eye exam include but may not be limited to:

- Complete case history
- Complete refraction
- External examination of the eye
- Binocular measure
- Ophthalmoscopic examination
- Tonometry when indicated
- Medication for dilating the pupils and desensitizing the eyes for tonometry
- Summary and findings

Routine vision services should be billed using standard CPT/HCPCS procedure codes.

Services related to the treatment of a medical or surgical condition of the eye, are included under the medical portion of the contract. The appropriate CPT code must be used to bill for these services.

Note: Davis Vision is our contracted vendor for routine vision services, including refractions and eyewear as of 10/01/2004.
Quality Improvement (QI)

QI Program Design
CareFirst implements an annual QI work plan that outlines specific clinical and service-related improvement activities using the Healthcare Effectiveness Data and Information Set (HEDIS®) as a framework.

The QI program provides the framework for the Plan to continuously improve the quality and safety of clinical care and services provided to Plan members.

HEDIS®, developed by the National Committee for Quality Assurance (NCQA), is a set of standard measures used to evaluate health plans on their effectiveness, access and cost of care as well as their use of services and member satisfaction. HEDIS® helps consumers and employer groups compare managed health care plans.

QI Goals and Activities
Ongoing clinical activities include monitoring and evaluation of the following:

- Physician performance against established clinical guidelines
- Effectiveness of care (preventive care and treatment)
- Effectiveness of disease management programs
- Physician performance against medical record documentation standards
- Under and over-utilization
- Continuity and coordination of care

Ongoing service activities include monitoring and evaluation of the following:

- Physician performance against standards for availability and accessibility
- Staff performance against Plan service standards
- Complaints and appeals resolution
- Member and provider satisfaction
- Oversight of delegated functions

CareFirst and CareFirst BlueChoice communicate regularly with providers and practitioners regarding their QI activities through a variety of methods such as newsletters, Internet and special mailings. You may also call the Quality Improvement Department or log on to www.carefirst.com to find the latest information about the following QI activities:

Disease Management Programs
CareFirst offers Disease Management programs designed to reinforce and support the physician’s plan of care. The programs identify members with chronic conditions, who are eligible for disease management. The programs help educate members about their diseases and how to manage them, which will improve medical outcomes and quality of life. Services range from quarterly educational mailings to case management, and access to a support nurse by phone 24-hours a day, seven days a week.

- Asthma
- Cardiovascular
- Diabetes
- Oncology

To obtain more information about, or to enroll patients into the diabetes, coronary artery disease or congestive heart failure programs administered by Healthways, Inc. call 800-783-4582.
Quality Improvement (QI) (continued)

Disease Management
CareFirst offers free Disease Management programs for members with chronic conditions. All programs are voluntary, confidential and designed to reinforce the physician's plan of care.

Services range from educational mailings to case management with 24 hour access to a support nurse by phone.

Respiratory Diseases (asthma, COPD)
CareFirst offers free, comprehensive disease management programs for members with asthma and chronic obstructive pulmonary disease (COPD). These confidential, voluntary programs:

- Help members learn how to self-manage their condition
- Reinforce the physician’s plan of care
- Are administered by Healthways, Inc.

Enrolled members:

- Can access a nurse by phone 24 hours a day, 7 days a week
- Are assigned a nurse care manager, if disease is severe
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information, refer a patient or if you are a member and want to self-refer, please call the Asthma Management Program at 800-783-4582.

COPD Resources/Related Links
CareFirst and CareFirst BlueChoice follow the COPD guidelines established by National Heart Lung and Blood Institute and World Health Organization.

The COPD Guidelines can be obtained from www.goldcopd.com.

- Stepwise Approach for Managing Asthma
- Asthma Guidelines for Care Flow Sheet
- COPD Guidelines for Care Flow Sheet

Additional respiratory information can be found on www.carefirst.com.

Diabetes
CareFirst offers a free, comprehensive disease management program for members with diabetes. This confidential, voluntary program:

- Provides routine updates to keep physicians informed about patients’ progress and adherence to the plan of care
- Reinforces the physician’s plan of care
- Is administered by Healthways, Inc.

Enrolled members:

- Can access a nurse by phone 24 hours a day, 7 days a week
- Are assigned a nurse care manager
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information, refer a patient or if you are a member and want to self-refer, please call the Diabetes Management Program at 800-783-4582.

Diabetes Resources/Related Links
The following information/journals can be found at http://care.diabetesjournals.org.

- Standards of Medical Care in Diabetes
- Nutritional Recommendations and Interventions for Diabetes

The following diabetes information can be found on www.carefirst.com.

- Diabetes Condition Center for Patients
- Disease Management Home
- Diabetes Annual Standards Flow Sheet

Heart Disease
CareFirst offers a free, comprehensive disease management program for members who have or are at risk for congestive heart failure (CHF) and coronary artery disease (CAD). This confidential, voluntary program:
Quality Improvement (QI) (continued)

- Provides routine updates to keep physicians informed about patients’ progress and adherence to the plan of care
- Takes note of the high rate of heart disease among persons with diabetes
- Reinforces the physician’s plan of care
- Is administered by Healthways, Inc.

Eligible members:

- Can reach a nurse by phone 24 hours a day
- Are assigned a nurse care manager (if greater disease severity exists)
- Receive educational materials, including condition-specific workbooks, action plans and newsletters.

To obtain more information, refer a patient or if you are a member and want to self-refer, please call the CHF/CAD management program at 800-783-4582.

CareFirst supports the American Heart Association Clinical Guidelines. You may obtain a copy of these guidelines at www.americanheart.org.

Resources/Related Links

- Clinical Guidelines for the Management of Heart Failure
- AHA/ACC Guidelines for Preventing Heart Attack and Death in Patients with Atherosclerotic Cardiovascular Disease
- AHA/ACC Guidelines for Secondary Prevention for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2006 Update
- Cardiac Guidelines for Care Flow Sheet

Note: Additional Heart Health Condition Center for Patients and disease management information can be found on the Disease Management link of our website.
Specialty Resources

Oncology
CareFirst’s cancer management program seeks to ensure the best possible outcomes for members with cancer.

Enrolled members are assigned to an experienced oncology Care Manager, who:

- Monitors their progress in conjunction with the physician’s plan of care
- Provides educational and emotional support
- Is available by calling 888-264-8648 Monday - Friday from 8:30 a.m. to 4:30 p.m.

Providers may refer a member to the oncology program by calling 888-264-8648.

Resources/Related Links
Additional oncology information can be found on the Disease Management link of our website.

Great Beginnings
The Great Beginnings program is designed to support the prenatal care and education expectant mothers receive from their physicians.

When a member enrolls in Great Beginnings, a case manager contacts the expectant member to review her medical history and to identify any other conditions that may affect her pregnancy. The case manager continues to contact the member during each trimester of her pregnancy to see how she is feeling and to answer any questions. If the expectant mother has not chosen a pediatrician, the case manager may assist the member in finding a pediatrician close to her home.

If there are any complications during pregnancy, the case manager works closely with the physician to coordinate necessary services and provide additional support and information to the member.

Case managers are available to answer questions Monday - Friday, 8:30 a.m. - 4:30 p.m. For more information about the program, call 888-264-8648.

Quality Improvement Advisory Committees (QIAC)
CareFirst’s multi-disciplinary committees and teams work closely with community physicians to develop and implement the QI Program.

Clinical practitioners, including designated behavioral health care practitioner(s), provide input and feedback on quality improvement program activities through participation on the following committees:

- Quality Improvement Committee (QIC) evaluates the quality and safety of clinical and behavioral health care and the quality of services provided to members
- Credentialing Advisory Committee (CAC) reviews the credentials of practitioners and other providers applying for initial or continued participation in the Plan.
- Care Management Committee (CMC) monitors and analyzes the care management program and promotes efficient use of health care resources by members and practitioners
- Pharmacy and Therapeutics Committee (P&T) advises the Plan on the development of the pharmacy services program and the CareFirst formulary.
- Ad hoc committees or work groups

National Committee for Quality Assurance (NCQA)
In January 2002, CareFirst BlueChoice, CareFirst’s HMO, and BluePreferred, a CareFirst PPO, received the National Committee for Quality Assurance’s (NCQA) highest accreditations. BlueChoice earned Excellent, the highest level of HMO accreditation. BluePreferred was granted Full accreditation, the highest level for PPOs.

These accreditation levels are awarded to plans that meet or exceed NCQA’s rigorous requirements for consumer protection and quality improvement.
NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. NCQA’s Accreditation standards are publicly reported in five categories:

- Access and Service: Do health plan members have access to the care and service they need?
- Qualified Providers: Does the health plan assess each doctor’s qualifications and what health plan members say about its providers?
- Staying Healthy: Does the health plan help members maintain good health and detect illness early?
- Getting Better: How well does the health plan care for members when they become sick?
- Living with Illness: How well does the health plan care for members when they have chronic conditions?

**Medical Record Documentation Standards**

Medical Record Documentation Standards
Practitioner Office Standards