CareFirst
Family of health care plans

Administrative Functions

This manual provides information for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) patients.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures contained in this manual, as applicable.

If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify you through **email** and **BlueLink**, our online provider newsletter.

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

Read and print the **Guidelines for Provider Self-Services**.

Institutional credentialing

Institutional and ancillary providers wishing to participate in any CareFirst BlueCross BlueShield or CareFirst BlueChoice (CareFirst) provider networks are required to have a physical location in the CareFirst service area (Maryland, the District of Columbia and Northern Virginia). Providers must also meet all credentialing requirements and submit a **Request for Information (RFI) Application**, a **Facility Data Sheet**, a W-9 and current credentialing documents for every location. These providers include:

- Hospital
- Medical rehabilitation facility
- Ambulatory Surgery Center (ASC)
- Skilled Nursing Facility (SNF)
- Dialysis facility
- Durable Medical Equipment (DME)
- Mental health substance abuse facility*
- Lithotripsy
- Home health agency
- Hospice agency
- Birthing center facility

All required current credentialing documents, **RFI Application** and **Facility Data Sheet** should be submitted, by mail or via fax at 410-505-2765:

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117
Mail Stop CG-51, Fifth Floor
Attention: Jackie Redmond, Institutional Contracting

All requested information and documents must be submitted before a request for participation can be reviewed. Failure to submit all requested completed documents will result in the information being returned.

Home Infusion Therapy (HIT) and Medical Specialty Pharmacy (MSP) providers wishing to participate with CareFirst should contact Ralph Stanley at 410-872-3515.

As required by the Affordable Care Act (ACA) and Centers for Medicare and Medicaid Services (CMS), CareFirst is mandated to collect patient safety initiative documentation from hospitals and/or facilities with more than 50 beds. Your organization must attest to having these initiatives in place each year. CareFirst will send you an email reminder with an attached letter and attestation form on an annual basis. Please sign and return the attestation form to CareFirst by the end of the first quarter, March 31.

To confirm that CareFirst obtained correct information to support credentialing requirements and made fair credentialing decisions, providers have the right, upon request, to review this information, to correct inaccurate information and to obtain the status of the credentialing process. Requests can be made by calling 410-872-3526.

Additional credentialing resources

For more information regarding the credentialing process, visit **carefirst.com/institutionalcredentialing** and read the **Institutional Credentialing FAQs**.

View the Institutional/Ancillary credentialing requirements or the DME credentialing requirements.

*Note: Mental health substance use disorder facilities wishing to participate in the CareFirst BlueChoice behavioral health network should complete the process outlined on the previous page.

Verify provider information requirement

To keep the information we have on file for your practice up to date, CareFirst requires Institutional and Ancillary providers to review and verify practice information once per calendar year.

To view the information we have on file for your practice, log in to the Provider Portal (CareFirst Direct) at **carefirst.com/providerlogin** and follow our step-by-step guide. If the information displayed is correct, click the *Verify Provider Information* button to meet the requirement.

If you need to make changes, use the *Update* links. For changes to information where *Update* links are not available, submit a **Change in Provider Information-Institutional/Ancillary** form. Be sure to include your office letterhead when mailing or faxing the completed form. If the tax identification number is changing, a new W-9 must be included with the written request. If the request is to add a new location, a new RFI must be submitted.

CareFirst Direct & CareFirst on Call

CareFirst offers a variety of benefit plans to meet our members' needs. These plans range from traditional coverage to several managed care programs. Information regarding a member's specific benefit plan should be verified before rendering care through our self-service channels.

CareFirst Direct is available to participating providers and allows registered users to make eligibility, benefit and claims status inquiries for all CareFirst members.

CareFirst on Call and expanded capabilities through our clearinghouse partners are all designed to make it easier for you to conduct business electronically with CareFirst.

Read and print the **Guidelines for Provider Self-Services**.

Inpatient notification and outpatient prior authorizations

Inpatient notification

CareFirst requires notification when a patient has or will be admitted to the hospital as an inpatient. The only exception to this process are routine maternity admissions, meaning those that do not exceed 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. Routine maternity admissions do not require notifications. The admission time of 48 hours or 96 hours does not begin until the baby is delivered.

When a notification is required, it must occur no more than seven days after the admission date.

Admission notification may be done up to 30 days in advance of the admission. CareFirst must receive the authorization request within 48 hours after an emergency admission or on the next business day following the admission, whichever is longer. This includes any medical/surgical or obstetrical admissions.

Notifications are entered in the Provider Portal, at **carefirst.com/providerlogin**. For instructions on how to use the portal, please register for an instructional webinar at **carefirst.com/cpet**.

Outpatient prior authorizations

CareFirst may require a prior authorization for outpatient services for some products. Check CareFirst Direct to determine if your patient requires a prior authorization. If a prior authorization is needed, enter the request in the Provider Portal, at **carefirst.com/providerlogin**.

Certain medical injectable therapy drugs require prior authorization when administered in outpatient hospital and home or office settings. This requirement applies to both BlueChoice and Indemnity plans. For additional information, refer to the Care Management section of this manual, under Medication Pharmacy Management.

The prior authorization must be completed no more than three days after the date of service, and can be entered 31 days before the outpatient date of service.

Appeals

Appeals should be mailed to:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114

When submitting an appeal, include:

- A cover letter explaining the reason for the notification or prior authorization delay
- A copy of the registration sheet
- The complete medical record

As a reminder, if your appeal is granted, there could still be penalties based on the member's contract. CareFirst must receive the authorization request within 48 hours after an emergency admission or on the next business day following the admission, whichever is longer. This includes any medical/ surgical or obstetrical admissions.

Services requiring an authorization

When the admitting physician schedules an inpatient or outpatient procedure, he/she must provide the hospital with the following information:

- The name and telephone number of the admitting physician or surgeon
- A diagnosis code
- A valid CPT code and/or description of the procedure being performed

The hospital will then request the authorization for the following services pending verification of eligibility requirements and coverage under the member's health benefit plan:

- Any services provided in a setting other than a physician's office, except for lab and radiology facilities and freestanding ambulatory surgery/care centers
- All inpatient hospital admissions and hospital-based outpatient ambulatory care procedures
- All inpatient hospital and residential treatment center admissions for behavioral health and substance use disorder services and the following outpatient services: applied behavioral analysis, complex psychological testing, electroconvulsive therapy and repetitive transcranial magnetic stimulation
- All diagnostic or preoperative testing in a hospital setting
- Chemotherapy or intravenous therapy in a setting other than a practitioner's office and billed by a provider other than the practitioner
- DME for certain procedure codes – view the list of codes requiring prior authorization at **carefirst.com/preauth**
- Follow-up care provided by non-participating practitioner following discharge from the hospital

- Hemodialysis (unless performed in a participating free-standing facility)
- Home health care, home infusion care and hospice care
- Inpatient hospice care
- Nutritional services (except for diabetes diagnosis)
- Prosthetics when billed by an ancillary provider or supply vendor
- Radiation oncology (except when performed at contracted freestanding centers)
- Skilled nursing facility care
- Treatment of infertility
- Attended sleep studies

Note: Authorization from CareFirst is required for the services on the previous page, even if the member has other primary health coverage, such as Medicare or commercial coverage.

For more information on pre-certification or prior authorization, visit **carefirst.com/medicalpolicy**.

Denied room and board charges during the inpatient stay must be properly indicated in the non-covered column (Field 48) of the UB-04 or corresponding electronic field. If CareFirst receives a claim where denied services are not indicated, the claim will be returned and you will be asked for a new UB-04 indicating covered and non-covered charges in the appropriate columns. We will no longer ask for an itemized bill and will manually split the charges.

Note: For Diagnostic Related Group (DRG) facilities, this only applies if there is a high cost outlier and CareFirst is reviewing for medical necessity.

Timely filing of claims

Institutional claims must be submitted within 365 days after:

- The services are rendered for emergency room or outpatient care, or
- The date of discharge for inpatient care

A member cannot be billed by a provider for failure to submit a claim to CareFirst within the guidelines listed above.

Reconsideration

Claims submitted beyond 365 days generally are rejected. If your claim is rejected but you have proof that the claim was submitted to CareFirst within the guidelines, you may request processing reconsideration.

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 necessary to prove timely filing

- **For electronic claims:** Provide confirmation from the **clearinghouse** that CareFirst successfully accepted the claim. Error records are not acceptable documentation
- **For paper claims:** Provide a screen shot 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

How to submit claims with denied charges

Complete the following field locators when submitting electronic or paper claims for admissions with denied days. If you submit claims electronically, contact your vendor to determine the correct format for this data.

- **Statement Covers Period Covered Days (Cov D)** (Paper Form Locator 39, 40 or 41 and value code 80) days of care authorized for coverage. Do not include non-covered days
- **Non-Covered Days (N-C D)** (Paper Form Locator 39, 40 or 41 and value code 81) days of care denied for coverage

- **Total Charges**
  (Paper Form Locator 47) Total charges pertaining to the related revenue code for the current billing periods as entered in the Statement Covers Period
- **Non-Covered Charges**
  (Paper Form Locator 48) To reflect non-covered charges for the primary payer pertaining to the related revenue code

Any claims with denied days that are not submitted in this format will be rejected and the claim should be resubmitted.

Note: This does not apply to the Federal Employee Program (FEP). Please do not use this process when submitting denied claims for FEP members.

Electronic capabilities

Electronic claims

We strongly encourage providers to submit all claims electronically. Electronic submission can help your practice save time, money and eliminate incomplete submissions.

We understand that CareFirst requires additional documentation on certain claims and they cannot be submitted electronically. However, we urge you to take advantage of all the benefits by filing electronically whenever possible, including when submitting the following types of claims:

- Initial
- Corrected (Institutional and Ancillary)
- Late Charge (Institutional only)
- Interim (Institutional only)
- Medicare Secondary that do not automatically crossover from CMS (Institutional and Ancillary)

Your billing **National Provider Identifier (NPI)** must be used to identify your practice when submitting claims.

Throughout the electronic claims submission process you will receive reports from both your clearinghouse and CareFirst that will confirm if a claim has been received or if the claim encountered an error which will require you to correct and resubmit the claim. If a claim encounters an error, you must correct the error and resubmit through your clearinghouse. If not, the claim has not been filed with CareFirst, and may result in a timely filing rejection.

If the claim cannot be found in the CareFirst system, please **contact your clearinghouse**, or contact the CareFirst EDI Help Desk at 1-877-526-8390 or **edidirectsubmission@carefirst.com**.

Claims receipt reports should be filed and kept for an appropriate period of time for follow-up and research activities. CareFirst does not keep copies of these reports.

You can always login at **carefirst.com/carefirstdirect** to check on the status of a claim that has been received but not fully processed. To identify any issues, contact **Provider Services**.

For more information, visit **carefirst.com/electronicclaims**.

Electronic Remittance Advice (ERA)

If you submit claims electronically, you can receive payment vouchers through an ERA-835, delivered by your clearinghouse and including the payment details, Health Insurance Portability and Accountability Act (HIPAA) adjustment reason codes and HIPAA remark codes necessary for you to reconcile your patient accounts. Receiving your payment information electronically allows you to realize claim resolution faster and save money.

For more information and to set-up ERA, please **contact your clearinghouse**.

Electronic Fund Transfer (EFT)

If you are submitting claims electronically and receiving an ERA, you can also take advantage of EFT, which allows you to get paid faster with secure direct deposits from CareFirst and reduced paperwork. These are the **preferred clearinghouses** who offer EFT services.

Special claims submission information

Observation services

Observation services are necessary to evaluate a patient's condition or to determine the need for admission as an inpatient. These services are provided on a hospital's premises and include bed use and periodic monitoring by hospital nurses or other staff. These services are covered only when provided under the order of a provider or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Diagnoses appropriate for observation services may include, but are not limited to:

- Abdominal and pelvic pain, undiagnosed
- Asthma
- Chest pain, undiagnosed after study
- Dehydration
- Dizziness, undiagnosed
- Gastroenteritis
- Nausea and vomiting
- False labor

Guidelines

In Maryland, observation services should be billed on the basis of one unit of service per each clock hour (with partial hours rounded up or down to the nearest full hour) in accordance with Health Services Cost Review Commission guidelines. DC and Virginia DRG hospitals are typically paid an hourly rate or a daily rate (for each date of observation service) for medically necessary observation care, unless these services are considered to be packaged into a payment under another payment methodology (i.e., inpatient DRGs, outpatient ASC Groups or ER case rates), in accordance with the terms and conditions of the hospital's contract (Appendix B). Professional provider services should be billed separately and will be paid in addition to the payment for the hospital's facility services. All observation services require a facility authorization for CareFirst BlueChoice members; no other CareFirst insurance plans require an authorization for observation services.

Mother and baby claims

CareFirst requires the submission of the mother's delivery and the baby's routine newborn charges as a single request for payment. The routine newborn charges will be processed under the mother's name. Should the baby require special care, a separate request for payment will be required for these charges and will be processed under the baby's name. A separate authorization for the baby's stay will be required if the baby stays longer than the mother. Include an itemization to differentiate routine versus non-routine charges. For an itemized chart of routine versus non-routine charges, see **Mother and Baby Claims-Billing Guide**.

Diagnosis Related Group (DRG)

Routine delivery payment:

- The payment follows the standard DRG payment, i.e. DRG weight x base rate for type of coverage
- The baby's payment for routine delivery is a per diem payment based on DRG 795 NORMAL NEWBORN. Follow the formula listed for a per diem substituting the number of nursey days paid on the claim for revenue code 170–179 for APPROVED DAYS in the calculation
- Add mother's DRG payment to the total of the per diem payments for the child and this is combined payment for a routine delivery
- In order for the hospital to receive a separate payment for the baby based on a sick DRG:
  - The hospital must have the baby's stay authorized
  - The hospital must file a separate claim for the baby
  - The primary diagnosis for the claim for a sick baby cannot be ICD-10 codes Z38.00-Z38.8 (live born infant) must be the sick diagnosis resulting in the extended stay

Network claims product

CareFirst jointly administers with third party administrators (TPAs), self-insured employers and health and welfare funds of the network claims

product. This process helps employers access the CareFirst provider networks, design health benefits and share financial responsibilities. CareFirst is actively involved and responsible for collecting claims, pricing claims, training and maintenance of the provider network.

Members enrolled can be identified in several ways:

- An identification card with the CareFirst logo and the logo of the employer
- The prefix on the identification card is alpha/numeric and A

Medicare supplemental products

CareFirst offers a variety of Medicare supplemental policies to complement Medicare benefits through group contracts as well as directly to individual subscribers.

- **Claims for FEP members with Medicare Part B only Omnibus Budget Reconciliation Act of 1990 (OBRA '90)**
  OBRA '90 processing applies to federal retirees who are not enrolled in Medicare Part A. In these situations, CareFirst is primary for Part A charges while Medicare is primary for Part B charges. In most cases, the Part B claims will cross over electronically to CareFirst. FEP requires all charges related to an episode of care are paid as one claim.

  The following guidelines will assist you in submitting FEP Medicare Supplemental claims:

  - Submit Part B charges to Medicare
  - Once Medicare has processed, submit all charges as an inpatient claim (Type of Bill XXX7 is helpful) with the Medicare B Summary Notices to FEP
  - Any Part B services originally processed/paid by FEP will be voided (retracted) and all charges will be processed/reprocessed on the inpatient claim
  - For D.C. and Virginia facilities only, a DRG payment is made (Medicare Part B payment is deducted from the full DRG amount and CareFirst pays the difference)

- **The Tax Equity and Fiscal Responsibility Act (TEFRA)**
  TEFRA is legislation enacted by the federal government that states an active employee age 65 and over, or the spouse age 65 and over of an active employee, may enroll in the same group coverage offered to younger employees and their spouses (the Deficit Reduction Act is an amendment to TEFRA which stipulates that spouses fall under TEFRA). If the employee or spouse has elected the group coverage, CareFirst is the primary carrier and Medicare is the secondary carrier. After CareFirst has processed the claim, you must forward the claim to Medicare.
- **Requirements for itemization (CareFirst BlueChoice only)**
  CareFirst BlueChoice requires itemization when billing the following to determine if services are covered under the member's plan:
  - Supplies (Revenue Code 270)
  - Implants (Revenue Code 278)
  - Pharmacy charges if related to blood services (Revenue Code 250)
  - DME
  - Blood processing and storage charges (Revenue Code 390 and 391)
  - Private room charges
  - Educational training
  - Non-covered inpatient days

Note: This itemization is not required if the charges are paid at a DRG or per diem rate inclusive of all services provided.

Federal Employee Program (FEP) coordination of benefits

In order to comply with FEP requirements, ask your FEP patients to complete the **Coordination of Benefits Form** located at **fepblue.org**. The form should be sent to CareFirst prior to the bill for timely processing.

Notification of denial

When CareFirst denies the certification of an admission or continued stay certification and the facility or provider disagrees, the facility or provider may appeal the adverse decision. However, the facility or provider may not issue a denial notification to the member to hold the member harmless.

Non-DRG reimbursement cases (MD only)

A facility may only issue a denial notification to a CareFirst member if:

- The facility, the attending provider and CareFirst agree and document that it is not medically necessary for the member to remain in the facility
- An appropriate discharge plan has been developed
- The member or family member refuses discharge. However, the hospital is strongly encouraged to discuss the case with the attending provider and the member and/or a family member, to ensure that the patient and/or family member understands their financial responsibility before the written denial is issued

Remittance

Refunding erroneous payments

If an overpayment from CareFirst is discovered, the provider should not return the check. This causes a delay in the payment and the initial check must be voided. Claims will be reprocessed and a new check will be issued. In such a situation, the provider should complete the **Provider Refund Submission Form**.

The service representative may initiate a voucher deduction or may instruct the provider to refund the amount of overpayment. If the amount payable cannot be fully recovered on the next remittance schedule, the balance due is carried forward. Deductions are listed and identified on the final summary page of the remittance. To determine the patient account(s) affected by the deduction, a provider must research prior remittance schedules to determine applicable patient(s) and claims(s), identified by a CR in the *Amount Paid* field, that relates to the current deduction.

> Note: The paper remittance schedules should be kept on file by the provider for research purposes to account for deductions or to solve potential posting errors.

Methods of reimbursement

CareFirst provides several methods of hospital reimbursement:

- Combined per diem or case rate payments
- Predetermined per visit fees
- Percentage of charges (discounted)
- Predetermined flat fees
- Percentage of Medicare Resource Based Relative Value Scale (RBRVS) fee schedule amounts

To determine the method(s) of payment for your facility and for the services in question, refer to your financial department for the payment information contained in the Appendices to the Master Hospital Agreement.

Health Insurance Portability and Accountability Act (HIPAA)

To comply with the requirements of HIPAA, CareFirst will add the HIPAA-compliant codes and corresponding reimbursement rates to your fee schedule when they are released from the **American Medical Association (AMA)** or the **Centers for Medicare and Medicaid Services (CMS)**. These updates are made on a quarterly basis through the calendar year.

Standard reimbursement methodology

If you obtain office injectable drugs, the following standard reimbursement methodology applies. Injectable drugs are reimbursed at a percentage above the Average Sales Price (ASP). Injectable drugs without an ASP may be reimbursed at 15 or 20 percent off the lowest Average Wholesale Price (AWP). The ASP is calculated by CMS and available at **CMS.gov**. The AWP is based on the most cost

effective product and package size as referenced in Truven's Red Book.

Standard reimbursement for all in-office injectable drugs is updated quarterly on the first of February, May, August and November. These updates reflect the industry changes to ASP or AWP. If there are delays in industry changes for certain seasonal injectable drugs (i.e., flu), then standard reimbursements may be updated on the first day of the next month. The specific reimbursement arrangements for participants in the CareFirst Oncology Program are not impacted by the above changes to standard reimbursement.

Exemptions to standard pricing methodology

- Exemptions to the Standard Pricing Methodology exist, including:
- Certain generic oncology drug codes, referred to as MAC codes, are reimbursed at greater than the standard ASP+10%. CareFirst encourages the use of these select generic oncology products where medically appropriate
- Certain high cost oncology, biologic and specialty drugs are reimbursed at ASP +6%
- Pediatric vaccines are reimbursed at 100% of AWP
- Select vaccines are reimbursed at 12% above ASP
- Hyaluronic Acid (HA) derivative drugs, with the exception of Synvisc and Synvisc-One, are reimbursed at ASP + 6%
  - Synvisc and Synvisc-One are reimbursed at ASP+8%

Participating hospitals in Maryland

Maryland general acute and private psychiatric hospitals are reimbursed according to rate structures set by the State of Maryland-Health Services Cost Review Commission.

DRG inpatient payment methodology

In general, participating hospitals which are not located in Maryland are reimbursed for approved inpatient services using a methodology similar to Medicare's DRG payment method. This method uses the principal and secondary diagnoses and the principal and secondary procedures, in addition to the member's age, gender and discharge status to assign a DRG. The diagnoses and procedure codes submitted are valid ICD-10 designated codes. Each DRG is assigned a relative weight.

Using:

- The DRG weight (for the grouper version in use at the time services were rendered)
- The hospital's contracted base rate for the line of business and time period
- A reimbursement description (available on the remittance schedule or through **CareFirst Direct**); this allows you to check individual payment calculations

DRG reimbursement cases

Under no circumstances may a hospital deny a continued inpatient stay that is not medically necessary, due to placement delays or problems in securing alternative financial support needed to move a patient to a lower level of care. The facility may only issue a denial notification for a CareFirst member if:

- The facility, the attending provider, and CareFirst agree, and document that it is not medically necessary for the member to remain in the facility
- An appropriate discharge plan has been developed
- The member or family member refuses discharge
- However, the hospital is strongly encouraged to discuss the case with the attending provider, the member, and/or a family member to ensure the patient and/or family member understands their financial responsibility before the written denial is issued

A copy of the issued denial letter must be forwarded to CareFirst.

Outpatient hospital payment methodology

Outpatient services billed on the UB-04 claim form are paid according to a schedule of fees and are

priced using the current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code that is filed in conjunction with the following services: laboratory, radiology, other diagnostics, physical, occupational and speech therapies and drugs.

Claims for outpatient surgery are paid using a methodology in which each surgical CPT-4 or HCPCS codes is categorized into one of multiple payment categories. The rates for those payment group categories, as well as other payment rules including multiple procedure discounts, are defined in the Ambulatory Surgery Groupings section of the hospital's outpatient financial contractual information. Please remember that this information is based on the date the services were incurred. Refer to the hospital financial information that is relevant to that time period.

Free-standing ASC payment methodology

Services provided in an ASC must be submitted on a UB-04 claim form and are paid according to a schedule of fees and priced using CPT and/or HCPCS codes. However, when Medicare is primary, all claims must be submitted on a CMS-1500 claim form. If the HCPCS or CPT code is not listed on the **standard approved ASC codes list**, then the service is not eligible for reimbursement in an ASC.

ASC procedures for facility and technical services and supplies include but are not limited to: operating and recovery room services, supplies, anesthesia supplies, drugs, high-cost devices and integral radiology. These allowed amounts do not include the amounts due to providers for their professional services.

With the exception of the codes identified on the provider portal, if a member receives more than one included ambulatory surgery procedure rendered at the ASC on any one day, the allowed amount due to provider shall be equal to the sum of: (a) 100 percent of the allowed amount due to ASC for the procedure that has the highest allowed amount plus (b) 50 percent of the allowed amount(s) that would apply to other included and properly billed outpatient surgery procedures rendered to the member at ASC on that same day.

In addition, procedures performed bilaterally shall be listed on individual lines.

The list of CPT codes eligible for payment in an ASC will be periodically reviewed and updated. Based on the review process, additional CPT codes may be added to the list or deleted from the list.

Ambulatory surgery procedures not on the ASC codes list are not eligible for payment. As new ambulatory surgery procedures are developed, or as established inpatient procedures migrate to the ambulatory setting, CareFirst will review such procedures and add them selectively, on a periodic basis, to the ASC codes list. CareFirst will review written recommendations regarding the addition of such procedures and related requests for payment. The reviews will be based on the available medical literature, relevant industry standards, data submitted by persons making recommendations, and other documentation. Any decisions made by CareFirst to add ambulatory surgery procedures to the standard approved ASC codes list for reimbursement in an ASC will be effective on a prospective basis only. All recommendations should be submitted to the Institutional Contracting Department at the following address:

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Mail Stop: CG-51, Fifth Floor
Owings Mills, Maryland 21117-0825

Hospice reimbursement methodology

Services provided by hospice agencies must be submitted on a UB-04 claim form with revenue codes and are paid according to an all-inclusive per diem schedule of fees including supplies. Exclusions to the all-inclusive rate paid to hospice agencies include but are not limited to DME, infusion medications, non-related hospice laboratory and radiology services, physical, occupational and speech therapy, and ambulance transports. Excluded services must be coordinated with and provided by participating providers, and must receive prior authorization when required.

Miscellaneous payment provisions to the master agreement

Members to be held harmless

Payments shall be made to the hospital by CareFirst only for covered inpatient and outpatient hospital services which are rendered to eligible members, and which are services determined by CareFirst to be medically necessary.

Any services found by CareFirst to have not been medically necessary and ineligible for benefits, will not be charged to the member. Payment may not be sought from the member for any balances remaining after CareFirst payment, unless it is to satisfy the deductible, copayment or coinsurance requirements for services not covered under the member's health benefit plan. The hospital shall not charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against members or persons other than CareFirst for covered services provided according to the Master Hospital Agreement.

Payment period

CareFirst will make its best effort to pay hospitals within the time period specified in the Provider Agreement and pursuant to the current law in the local jurisdiction.

The payment period may be extended if CareFirst requires additional time to investigate whether it is responsible for payment of the billed services, or to determine if the services were medically necessary.

Third party payments

The hospital will collect payment from third party payers following its customary collection procedures, whenever such payers have primary responsibility to provide or pay for covered services in accordance with the coordination of benefits (COB) and third party liability requirements of the member's health benefit plan. If CareFirst is required to pay a portion of the covered services not reimbursed by the primary payer, CareFirst will only pay that amount which, when combined with the other payers and the member's payment responsibility, would equal the amount that would have been paid according to the agreed allowances under the member's health benefit plan up to the Medicare allowable charge. The hospital shall not bill or request any amounts in excess of the agreed upon allowances other than applicable deductibles, copayments, or coinsurance.

Adjustments

The hospital will be entitled to request an adjustment of a payment if it informs the other party of an underpayment or an overpayment within six months following the date of the payment by reason of, but not limited to: duplicate payments for covered services; inappropriate denials of payment for covered services; or failure to pay the full amount due for the services. Except in situations involving third party payment, offset of overpayment, billing errors or incorrect information supplied to the plan, all payments are final unless an adjustment is requested within six months of the payment date.

Off-set of overpayment

If an audit identifies overpayments, the hospital will refund CareFirst the overpayment amount or will allow the deduction of the overpayment from future payments.

The hospital will refund CareFirst any amounts paid in error due to inaccurate or incomplete member information; amounts paid for service for which the member was not entitled; or for primary payments made by CareFirst when a third party or another entity actually has the primary payment responsibility.

The processing of claim adjustments for overpaid claims do not require a signed agreement from the medical provider.

Utilization Review (UR) program

The primary objectives of the UR program are to conduct billing audits for participating providers and reporting results through informational/ educational programs. These programs include information on correct claims submission, benefit interpretation and other provider questions. Developed cooperatively with providers and their professional organizations, the programs

encourage clear communication with the health care community in understanding CareFirst policies and procedures.

The UR program is responsible for routinely analyzing paid claims data and profiles information for all providers. The UR program also reviews and responds to individual member/provider issues and internal referrals related to utilization.

Reviews are conducted both on a pre-payment and a post-payment basis. Pre-payment reviews of medical records are conducted before final processing of claims is complete. A review of both individual complaints and pattern cases is performed after payment is made.

The UR program is administered by the medical affairs division under the direction of the senior medical director and is supported by graduate nurse reviewers (senior analysts).

A panel of practicing physicians serves as professional advisors (PA) to this program. Appeals of PA decisions are resolved by a peer review committee. Cases of fraudulent billing are pursued by the Internal Audit Division in cooperation with local, state or federal authorities.

Inquiries and appeals

General inquiries

Inquiries may include issues pertaining to: authorizations, correct frequency, ICD-10 coding, medical records, procedures/codes and referrals.

Instructions for submitting an inquiry

The preferred method for submitting an inquiry is electronically through **CareFirst Direct** using the inquiry analysis and control system (IASH) function.

When you cannot use **CareFirst Direct**, please use the p**rovider inquiry resolution form (PIRF)** to submit an inquiry.

An inquiry must be submitted within 180 days or six months from the date of the explanation of benefits (EOB). Any hospital representative may submit these Inquiries. Please allow 30 days for a response.

Helpful tips when completing a Provider Inquiry Resolution form (PIRF)

- Use a separate form for each patient
- Include the entire subscriber identification number, including the prefix
- Attach a copy of the claim with any additional information that might assist in the review process
- The form can be downloaded at **carefirst.com/providerforms**

For questions about claims that deny because of enrollment, copay/deductible, lack of prior authorization and claims payment, contact Provider Services at 800-842-5975 or 202-479-6560.

Corrected claims

Before sending an inquiry, consider submitting a **corrected claim** that will replace the original claim submitted.

Appeals

An appeal is a formal written request to the plan for reconsideration of a medical or contractual adverse decision.

Instructions for submitting an appeal

Please submit an appeal in letter format on your office letterhead describing the reason(s) for the appeal and the clinical justification/rationale.

Please allow 30 days for a response to an appeal. **Do not use a PIRF to submit an appeal.**

Visit **carefirst.com/inquiriesandappeals** for more information.

Clinical Appeals and Analysis Unit (CAU)

The CAU is responsible for review, preparation, reconciliation and communication, reporting and analysis of all appeals for CareFirst. The CAU is the primary contact for appeals for internal and external auditing agencies.

Clinical appeal checklist

The CAU reviews and responds to clinical appeals. CareFirst has one internal level for the appeals process. Appeals must be submitted within 180 calendar days from the date the adverse decision was received.

The following must be included:

- A letter describing the reason(s) for the appeal and the clinical justification or rationale is required, including the following information, if possible:
  - Member's name and identification number
  - Provider number or tax identification number
  - Admission and discharge date, if applicable, or the date(s) of service
  - Claim number
  - A copy of the original claim or EOB denial information and/or denial letter/notice
  - The treating provider's name
  - The complete inpatient medical record
  - A letter of medical necessity addressing specific related clinical information. Supporting clinical notes or medical records includes pertinent lab reports, X-rays, treatment plans and progress notes
  - If the appeal includes a request for review of ancillary services, the letter of medical necessity should specifically state the medical necessity of the ancillary services on the denied days
- A licensed provider who is a member of the hospital's staff or a nurse working in conjunction with the provider should write the letter of medical necessity
  - A licensed provider who is a member of the hospital staff should include the attending, treating, provider, Utilization Management (UM) director or any provider knowledgeable about the case
  - If a nurse writes the letter of medical necessity, it should indicate the provider(s) involvement in the appeal

Expedited or emergency appeals process

You may request an expedited or emergency appeal after an adverse decision for prior authorization of a service, admission, continued length of stay or awaiting service or treatment.

- An expedited or emergency appeal is defined as one where a delay in receiving the health care service could seriously jeopardize the life or health of the member, or the member's ability to function, or cause the member to be a danger to self or others
- Retrospective or post service denials are not eligible for expedited review
- We will answer an expedited or emergency appeal within 24 hours from the date the appeal is received

Expedited appeals may be faxed to 410-528-7053.

Appeal resolution

Once the internal appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the appeal decision
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based
- A statement regarding the availability of all documents, records or other information relevant to the appeal decision, free of charge including copies of the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based
- Notification that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided free of charge upon request
- Contact information regarding a state consumer assistance program
- Information regarding the next level of appeal, as appropriate

Appeal contact information

Submit clinical appeals to the following address:

Clinical Appeals and Analysis Unit
CareFirst Blue Cross BlueShield
P.O. Box 17636
Baltimore, Maryland 21298-9375

Other party liability

Subrogation

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

Personal Injury Protection (PIP)—no fault automobile insurance

PIP is an automobile insurance provision that covers medical expenses and lost wages experienced by the insured or passengers as a result of an automobile accident, and may be required by automobile insurance laws to provide benefits for accident related expenses without determination of fault. While Maryland law requires this coverage for passengers and family members under the age of 16, many insured members choose to continue to carry other passengers under this provision in their automobile insurance contracts.

CareFirst contracts may contain a provision that requires coordination with PIP, and may only provide benefits for covered medical expenses not reimbursed by the automobile insurer. A copy of the record of payment from the automobile insurer must be attached to the claim form submitted to CareFirst for any additional payment due.

Workers' compensation

Health benefit programs administered by CareFirst exclude benefits for services or supplies for injuries/ illnesses arising out of or in the course of employment to the extent that the member obtained or could have obtained benefits under a Workers' Compensation Act, the Longshoreman's Act, or similar law. In the event that CareFirst benefits are inadvertently or mistakenly paid despite this exclusion, CareFirst will exercise its right to recover its payments.

Workers' compensation replaces health insurance. A participating provider cannot balance bill CareFirst or the subscriber for any amount not covered under workers' compensation unless it is determined that the charges are non-compensable under workers' compensation. If workers' compensation determines that the charges are non-compensable, attach a copy of the denial from the workers' compensation carrier to the claim.

Maryland's Workers' Compensation Act excludes sole proprietors, partners and officers of closed corporations from mandatory coverage under the act, giving them the option to elect coverage. Verification from the subscriber of this waiver may be required by CareFirst in order to process claims.

Quality Improvement (QI)

The goal of CareFirst's QI program is to continuously improve the quality and safety of clinical care, including behavioral health care, and the quality of services provided to plan members/enrollees within and across healthcare organizations, settings, and levels of care. CareFirst strives to provide access to health care that meets The Institute of Medicine's aims of being safe, timely, effective, efficient, equitable and patient-centered.

The quality process supports ongoing efforts to improve clinical care and services through activities such as:

- Assessment and improvement of clinical care
- Safe clinical practices
- Measuring quality of services and satisfaction
- Efficient use of resources

The QI program's objectives are to:

- Support and promote all aspects of the CareFirst Patient-Centered Medical Home (PCMH) program and the Total Care and Cost Improvement (TCCI) programs as a means to improve quality of care, safety, access, efficiency, coordination and service
- Establish collaborative partnerships to proactively engage clinicians, providers, community hospitals, and organizations to implement interventions that address the identified medical and behavioral health and service needs of our membership throughout

the entire continuum of care and those that are likely to improve desired health outcomes

- Promote the provision of data and support to clinicians to promote evidence-based clinical practice, informed referral choices and assisting members with using their benefits to the fullest
- Maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety and efficiency of clinical care and quality of service
- Assess the race, ethnicity, language, interpreters, cultural competence, gender identity and sexual orientation needs of our diverse populations while considering such diversity in the analysis of data and implementation of interventions to reduce health care disparities in order to meet the needs and preferences of its membership
- Monitor and oversee the performance of delegated functions, especially for high priority partners
- Develop and maintain a high quality network of health care practitioners and providers who meet the needs and preferences of its membership by maintaining a systematic monitoring and evaluation process
- Operate a QI program that is compliant with and responsive to federal, state and local public health goals, and requirements of plan sponsors, regulators and accrediting bodies
- Address health needs of all patients along the health care continuum including those with advanced developmental, chronic physical and/or behavioral illnesses, or other complicated clinical situations
- Support quality improvement principles throughout CareFirst, acting as a resource in process improvement activities

CareFirst recognizes that large racial and ethnic health disparities exist and communities are becoming more diverse. Racial, ethnic and cultural background influence a member's view of health care and its results. CareFirst uses member race, ethnic and language data to find where disparities exist, and we use the information in quality improvement efforts.

All participating provider offices are contractually obligated to provide copies of member medical records at no charge to CareFirst and/or its designee, for quality improvement activities. If you fail to comply with this request, you will be in violation of your provider contract.

Performance data

CareFirst and CareFirst BlueChoice retain the right, at their discretion, to use all provider and/or practitioner performance data for QI activities including but not limited to, activities to increase the quality and efficiency to members (or employer groups), public reporting to consumers, and member cost sharing.