CareFirst Family of health care plans

Care Management

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**.

Care management—indemnity and Health Maintenance Organization (HMO)

Criteria sets are evaluated annually and updated as needed to reflect current patterns of care. Because we recognize that standards of clinical practice may vary, all criteria sets are adopted, reviewed and modified as appropriate with the involvement and approval of practicing providers.

CareFirst employs the following criteria sets to guide our care management review process:

- Modified appropriateness evaluation protocol (AEP) was originally developed at academic institutions in the Northeast
- The Apollo Managed Care criteria are utilized for physical therapy, occupational therapy and rehabilitation
- MCG Care Guidelines

For an updated copy of the modified AEP or how to order the Apollo Managed Care criteria and MCG Care Guidelines call 410-528-7041.

Hospital Transition of Care program (HTC)

HTC monitors admissions of CareFirst members to hospitals anywhere in the country. Locally, it relies on specially trained nurses who are stationed in hospitals throughout the CareFirst region. The HTC program assesses member needs upon admission and during a hospital stay with a focus on post discharge needs. It begins the care plan process for members who will be placed in the complex case management (CCM) or chronic care coordination (CCC) programs. The HTC process also categorizes members based on the level of their severity of need and the nature of their illness or condition so they can be placed in the best possible track for follow-up care coordination services and flags cases that will likely result in high cost to ensure they receive the attention they need to avoid costly breakdowns in care.

Coordinated home care and home hospice care

Coordinated home and home hospice care allows recovering and terminally-ill patients to stay at home and receive care in the most comfortable setting. For the member to qualify for these benefits, the attending provider, hospital or home care coordinator must send a request.

If a prior authorization is needed, enter the request in the CareFirst Provider Portal, which is located at **carefirst.com/providerlogin**. The prior authorization must be done no more than three days after the date of service and can be entered 30 days before the outpatient date of service. For instructions on how to use the portal, please register for an instructional webinar at **carefirst.com/cpet**.

A licensed home health agency or approved hospice facility must render eligible services. Once approved, the home health agency or hospice is responsible for coordinating all services.

Complex case management (CCM)

Members with acute illnesses can voluntarily take advantage of CCM in a variety of specialty areas including acquired immune deficiency syndrome (AIDS), oncology, neonatology, pediatrics, high-risk obstetrics, head injury, spinal cord injury, medicine and surgery. CCM coordinates and supports services that help members attain short-term health objectives and long-term goals.

Health care providers or members may refer candidates for CCM by 866-773-2884.

Behavioral health and substance use disorder program (BSD)

CareFirst's BSD program combines the clinical skills and experience of a professional care management team to guide referrals and serve as a patient's advocate through the entire episode of care. For more information visit **carefirst.com/pcmhguidelines**.

Intake, assessment and appointment (IAA)

CareFirst's IAA department assists members and providers seeking behavioral health and/or substance use support. Services offered includes crisis intervention, needs assessment, program referrals, as well as assistance with locating providers and setting initial appointments. For more information visit **carefirst.com/pcmhguidelines**.

Services requiring prior authorization—CareFirst BlueChoice

A list of services requiring prior authorization can be found at **carefirst.com/preauth**.

Inpatient hospitalization services—indemnity and CareFirst BlueChoice

Pre-admission certification process for elective admissions

- All elective inpatient hospital admissions must be authorized. The participating hospital must request authorization through **CareFirst Direct**. For CareFirst BlueChoice members, all services must be approved by the primary care physician (PCP), who must concur that the proposed treatment plan is clinically appropriate
- You can request prior authorization:
  - Online: Log in at **carefirst.com/providerlogin** and click the *Prior Authorization/Notifications* tab to begin your request

    The prior authorization must be done no more than three days after the date of service and can be entered 31 days before the outpatient date of service. Submit the authorization request to the care management department at least five business days prior to all elective admissions, except when it is not medically feasible due to the member's medical condition. For instructions on how to use the portal, please register for an instructional webinar at **carefirst.com/cpet**.

- By fax: Visit **carefirst.com/providerforms** to download the appropriate prior authorization form
- By phone: Call 866-PRE-AUTH (773-2884)*

- Unauthorized hospital stays will result in a retrospective review of the admission. Penalties may apply according to your contract
- Authorization decisions are made within two working days of obtaining necessary clinical information. Written authorization denials are issued within one business day of making the decision. Expedited or standard appeal information is included with the denial information
- If the admission dates for an elective admission changes, notify the care management department as soon as possible, and no later than one business day prior to the admission

Emergency admission certification process

- All emergency inpatient hospital admissions must be authorized within 48 hours of the admission or next business day. The hospital must request authorization/notification
- Unauthorized hospital stays result in a retrospective review of the admission

Concurrent review process

- Concurrent review is performed when the inpatient authorization is requested prior to admission or within 48 hours of the admission to the inpatient facility
- The hospital's utilization review (UR) department must provide clinical information to the CareFirst hospital transition of care (HTC) nurse either on-site (at selected hospitals) or by telephone (view t**he Provider Quick Reference Guide**)
- CareFirst's HTC nurse will contact the attending provider or follow agreed hospital protocol if further clarification of the member's status is necessary
- HTC nurses use approved medical criteria to determine medical necessity for acute hospital care
- If the clinical information meets CareFirst's medical criteria, the days/services will be approved
- If the clinical information does not meet the approved medical criteria, the case will be referred to our medical director
- The HTC nurse will notify the attending provider and the facility of our Medical Director's decision
- The attending provider may request an appeal of an adverse decision

Indemnity and HMO retrospective review process

The UR nurse will notify the appropriate hospital department and request medical records when a retrospective review of the clinical record is necessary.

Discharge planning process—indemnity and HMO

The hospital or attending provider must initiate a discharge plan as a component of the member's treatment plan. The hospital, under the direction of the attending provider, should coordinate and discuss an effective and safe discharge plan with us and each patient immediately following admission. Discharge needs should be assessed and a discharge plan developed prior to admission, when possible. Referrals to hospital social workers, long-term care planners, discharge planners, or hospital case managers should be made promptly after admission and coordinated with us.

Outpatient hospitalization services

CareFirst BlueChoice requires prior authorization for most hospital outpatient services via **CareFirst Direct**.

Indemnity prior authorization requirements are dependent on the contract and can be found on the back of the member's identification card.

Case management referral process—indemnity and HMO

Case management is designed to identify patients who require more involved coordination of care due to a catastrophic, chronic, progressive or high-risk acute illness. Case managers coordinate and plan the patient's use of health care benefits and care without compromising quality of care. Patients who would benefit from these services should be referred as soon as they are identified. Please call 800-783-4582 for assistance.

Case management intervention is appropriate for patients:

- With catastrophic, progressive, chronic, or life threatening diseases
- Who will require inpatient or extensive outpatient rehabilitation when medically stable
- Who require continuing care due to a catastrophic event or an acute exacerbation of a chronic illness
- With extended acute care hospitalizations
- With repeat hospital admissions within a limited time period

To maximize the advantages of case management, it is closely aligned with other components of the managed care program such as prior authorization, concurrent review and discharge planning.

Disease management programs

Disease Management provides members with educational resources and reminders necessary for managing their chronic conditions in conjunction with their provider's plan of care, reducing the disease's effect through lifestyle changes and treatment compliance.

Disease management programs are offered to members for:

- Behavioral Health
- Respiratory Diseases (i.e., asthma, COPD)
- Diabetes
- Heart Disease
- Oncology

For more information on our program offerings, visit the **disease management** section of **carefirst.com/providers**.

Preventive services under the Affordable Care Act (ACA)

As part of the ACA, certain preventive services for children and adults must be covered at no cost to the member when using in-network providers. View the **Comprehensive Summary of Preventive Services.**

As a reminder, providers should use the proper diagnosis screening code and current procedural terminology (CPT) code in order to be reimbursed.

Medication pharmacy management

Certain high-cost medical injectable therapy drugs require prior authorization when administered in an outpatient hospital and home or office settings. This requirement applies to both BlueChoice and Indemnity. Information on all medications that require prior authorization including these therapy drugs is available at **carefirst.com/preauth** > *Medications*.

Failure to obtain prior authorization for these medications may result in a denial of the claim payment.

Details about how to submit and review your prior authorization requests online is available by viewing the training video at **carefirst.com/learninglibrary** > *Pharmacy*. **Frequently asked questions** and a **step-by-step user guide** are available.

For questions related to a prior authorization that was submitted for these medications, please call CVS Caremark 888-877-0518.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc.,The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). ®The Blue Cross and Blue Shield Names and Symbols are registered service marks of the Blue Cross and Blue Shield Association.

PM0004-1E (3/19)