CareFirst
Family of health care plans

Arranging for Care—BlueChoice Only

CareFirst BlueChoice, Inc. (CareFirst BlueChoice) only

This section provides information on Care Management for your CareFirst BlueChoice, Inc. (CareFirst BlueChoice) 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**.

Referral process

Unless stated in member coverage, primary care providers (PCPs) must issue a written referral to a specialist for services rendered in the specialist's office. Verbal referrals are not valid. It is the PCP's responsibility to refer the member to a CareFirst BlueChoice participating specialist for care. The member should not be instructed to call CareFirst BlueChoice for the referral.

If a particular specialist or provider cannot be found, call provider services to determine the participatory status of the specialist or provider.

Please include the following information as specified on the referral form:

- Member's name, date of birth and member identification number
- Your name, phone number and CareFirst BlueChoice provider identification number
- The specialist's name and CareFirst BlueChoice provider identification number
- The date the referral is issued and the valid until date
- The diagnosis or chief complaint (stating follow-up or evaluation is not sufficient)
- The number of visits allowed, limited to a maximum of three visits (if this is left blank or you write as needed, the default number will be three visits)

Retain a copy of the referral for the member's medical record. The member will take a copy to the specialist. A copy should be filed in the PCP medical record.

Remember:

- Care rendered by non-participating practitioners for CareFirst BlueChoice members who do not have an out-of-network option must be approved by Care Management
- Unless otherwise indicated, referrals are valid for 120 days from the date of issuance and are limited to a maximum of three visits. Please see the extended referral information below for exceptions
- Members with the Open Access feature included in their coverage do not need a written referral to see an in-network practitioner

Extended (long-standing) referrals

PCPs may issue an extended, or long-standing, referral for a CareFirst BlueChoice member who requires specialized care over a long period of time. Members are allowed up to one year of unlimited specialist visits through an extended referral if all of the following criteria are met:

- The member has a life-threatening, degenerative, chronic and/or disabling condition or disease requiring specialized medical care
- The member's PCP determines in consultation with the specialist that the member needs continuing specialized care
- The specialist has expertise in treating the member's condition and is a participating practitioner

If necessary, you may modify an extended referral to limit the number of visits or the period of time for which visits are approved. In addition, the referral may require that the specialist communicate regularly with you regarding the treatment and health status of the member.

CareFirst BlueChoice also allows referrals to an allergist, hematologist or oncologist to be valid for up to one year. For any other life-threatening, degenerative, chronic and/or disabling condition or disease requiring specialized medical care, call case management at 410-605-2413 or 888-264-8648 for assistance.

Please confirm that the member understands to whom he or she is being referred, the number of visits allowed and the time limit for seeking specialist services.

Services requiring a written referral

- Most office visits to an in-network specialist/practitioner require a written referral.
- A written referral is not required for members with the Open Access feature included in their coverage.

Services not requiring a written referral

- Ambulatory surgery centers (ASCs)
- Participating OB/GYN care when performed in an office setting
- Routine vision exams by participating Davis Vision optometrists
- In- and outpatient mental health/substance use disorder services (see phone number on member's ID card)
- Visits to an urgent care center
- Services provided by a participating specialist in the hospital during the course of the member's hospitalization. Note: a referral is required for any follow-up care provided in the specialist's office following the discharge from the hospital
- Services provided by an in-network practitioner to members with the Open Access feature included in their coverage

Laboratory Corporation of America (LabCorp)

LabCorp is the only network national lab that BlueChoice (HMO) members can use. Please do not refer HMO members to a lab other than LabCorp. LabCorp requisition forms that include the member's identification number must be used when ordering lab testing or directing members to a drawing station. Some exceptions may apply in Western Maryland and the Eastern Shore.

No written referral is necessary.

Members referred to a participating radiology facility require a written order on the practitioner's letterhead or prescription pad. No written referral form is necessary.

Visit the **carefirst.com/qualityandaffordability** for additional information related to National Laboratories.

Specialist

Specialists should render care to CareFirst BlueChoice members only when they have a written referral from the PCP, except for members with the Open Access.

Entering referral information on an electronic CMS 1500

- Locator 17: Enter the name of the referring provider.
- Locator 17B: Enter the PCP NPI.
- Locator 23: Enter the referral number found on the CareFirst BlueChoice referral form (RE followed by 7 digits). If the PCP used a uniform consultation referral form, enter RE0000001.

Entering referral information on electronic claims

Contact your clearinghouse to confirm your billing process can accommodate entering the referral information as described above. Visit **carefirst.com/electronicclaims** for vendor contact information.

Note: Specialists may only perform services as indicated on the referral form. All other services require additional approval from the PCP.

Authorization

Services requiring an authorization

The admitting physician calls the hospital to schedule 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. The authorization is required 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 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
- Durable medical equipment (DME) for certain procedure codes—view the list of codes requiring prior authorization at **carefirst.com/preauth**
- Follow-up care provided by a non-participating practitioner following discharge from the hospital
- Hemodialysis (unless performed in a participating free-standing facility)
- Home health care, home infusion care and home 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

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

Medical injectables

Certain medical injectables require prior authorization when administered in an outpatient hospital and home or office settings. Intravenous immune globulin (IVIG) and select autoimmune infusions can be administered in the outpatient hospital setting only if medical necessity criteria are met at the time of prior authorization. This requirement applies to both BlueChoice and Indemnity. The complete list of medications that require prior authorization is available at **carefirst.com/preauth** > *Medications*.

You should request prior authorization:

- **Online:** Log in at **carefirst.com/providerlogin** and click the *Pre-Auth/Notifications* tab to begin your request.

Necessary information

The hospital will provide the following information to CareFirst for services requiring authorization:

- Member's name, address and telephone number
- CareFirst BlueChoice member identification number
- Member's gender and date of birth
- Member's relationship to subscriber
- Attending physician's name, ID number, address and telephone number
- Admission date and surgery date, if applicable
- Admitting diagnosis and procedure or treatment plan
- Other health coverage, if applicable

Services not requiring authorization

Any service performed at a participating freestanding ambulatory surgical/care center (ASC) does not require authorization. When members are referred appropriately to ASCs, health care costs can be reduced.

CareFirst offers a wide range of accredited ASCs that are appropriate in various clinical situations.

To find a facility or other network provider, visit **Find a Provider**.

Care management

Care management reviews clinical information regarding health care and/or procedures for appropriateness of care, length of stay and the delivery setting for specific diagnoses.

Care management links health care providers, members and CareFirst in a collaborative relationship to achieve medically-appropriate, cost-effective health care in all delivery settings within the framework of covered benefits.

Emergency room services

In-area emergencies

The covering physician is contractually obligated to be available by telephone 24 hours a day, seven days a week for member inquiries and follow these guidelines:

- For all life-threatening emergencies, call 911
- For 24 hour medical advice and/or the specialist in urgent/urgent situations, call the PCP

CareFirst BlueChoice members may arrive at the emergency room (ER) under one of the following circumstances:

- PCP or specialist referral
- FirstHelp referral
- Self-referral
- Ambulance

Referred by PCP or specialist

Members are encouraged to contact their PCP and/ or specialist to seek guidance in urgent or emergency medical conditions. When a PCP or specialist refers a member, the ER professionals will triage, treat and bill in their customary manner. An authorization number or written referral from the PCP or specialist is not required.

Referred by FirstHelp

When FirstHelp refers a member to the ER, the professionals there will triage, treat and bill in their customary fashion. An authorization number or written referral from FirstHelp is not required.

FirstHelp is available toll-free, 24 hours a day at 800-535-9700.

Self-referral

When a member self-refers, the ER professionals will triage the member. If the condition is deemed emergent, treatment is rendered and billed. An authorization number or written referral is not required. Please remember that all subsequent follow-up care must be provided or coordinated by the member's PCP or authorized by care management.

If the condition is deemed non-emergent, the ER professionals should encourage the member to call his/her PCP, specialist or FirstHelp for advice regarding treatment at the appropriate level of care. Professional services should be billed appropriately.

Ambulance

If a member arrives at the emergency room department via ambulance, the emergency room professionals will triage, treat and bill in their customary manner. An authorization number or written referral is not required for ground transportation.

Emergency hospital admissions

When ER professionals recommend emergency admission for a CareFirst BlueChoice member, they should contact the member's PCP or specialist, as appropriate. The member's physician is then expected to communicate the appropriate treatment for the member. The hospital is required to contact CareFirst by following the Emergency Admission Authorization Process to verify and/or secure authorization.

In-area authorization process

The hospital is responsible for initiating authorization for all emergency admissions.

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.

Medical information for acute hospital care must be received by telephone on the next business day after the request for authorization is made. If the member has been discharged, the hospital has five business days to provide medical information. Failure to provide the requested information may result in a denial of authorization due to lack of information.

Out-of-area authorization process

In the case of an out-of-area emergency admission, it is the hospital's responsibility to obtain the pre-authorization.

Hospital services

Inpatient hospital services—elective authorization process

- Through **CareFirst Direct**, the hospital is responsible for initiating all requests for authorization for an inpatient admission. However, when the admitting physician calls the hospital to schedule an inpatient procedure, they must provide the hospital with the following information:
  - A diagnosis code
  - A valid CPT code and/or description of the procedure being performed
  - The name and telephone number of the admitting physician or surgeon
- The hospital must receive calls from the admitting physician at least **five** business days prior to all elective admissions. An exception to this policy is applied when it is not medically feasible to delay treatment due to the member's medical condition. The admitting physician's office may be contacted by CareFirst BlueChoice if additional information is needed before approving the authorization.
- Failure to notify the hospital within this time frame may result in a delay or denial of the authorization.
- CareFirst will obtain the appropriate information from the hospital and either forward the case to the clinical review nurse specialist (CRNS) or certify an initial length of stay for certain specified elective inpatient surgical procedures. The CRNS must review a request for a preoperative day. The hospital

transition of care (HTC) coordinator nurse monitors admissions of plan members to hospitals anywhere in the country.

- If the admission date for an elective admission changes, CareFirst must be notified by the hospital as soon as possible, but no later than one business day prior to the admission. Lack of notification may result in a denial of authorization.

Preoperative testing services

Preoperative laboratory services authorized in the hospital setting are as follows:

- Type and cross matching of blood
- Laboratory services for children under the age of eight

All other preoperative testing must be processed by LabCorp* **labcorp.com** or performed at participating freestanding radiology** centers.

* Some exceptions may apply in Western Maryland.
** Some exceptions may apply on the Eastern Shore.

Discharge planning process

The hospital or attending physician is responsible for initiating a discharge plan as a component of the member's treatment plan. The hospital, under the direction of the attending physician, should coordinate and discuss an effective and safe discharge plan with the hospital transition coordinator (HTC). The HTC program assesses discharge needs on admission and during the hospital stay with the focus on initiating referrals to the appropriate TCCI program upon discharge. Referrals to hospital social workers, long-term care planners, discharge planners or hospital case managers should be made promptly after admission and coordinated with the HTC.

An appropriate discharge plan should include:

- Full assessment of the member's clinical condition and psychosocial status
- Level, frequency and type of skilled service care needs
- Verification of member's contractual health care benefits
- Referral to a CareFirst BlueChoice participating provider, if needed
- Alternative financial or support arrangements, if benefits are not available

Outpatient hospital services

CareFirst BlueChoice requires authorization for all outpatient services, including laboratory* and radiology**, performed in a hospital setting.

- The hospital is responsible for initiating all requests for authorization for outpatient services (i.e., surgery, false-labor/observation stays)
- If authorization criteria are met, authorization will be issued. In addition, the caller will be instructed whether the member is accessing an in or out-of-network benefit. There will be instances in which the member will be directed to a more appropriate network provider for certain services (i.e., laboratory, radiological services)
- If the admission date for an outpatient elective procedure changes, care management must be notified by the hospital as soon as possible, but no later than one business day prior to the procedure. Lack of notification may result in a denial of the claim

Note: All pre-operative services must be performed by or arranged by the member's PCP/ specialist.

* Some exceptions may apply in Western Maryland.
** Some exceptions may apply on the Eastern Shore.

Utilization Management (UM) decisions are based on the following criteria

- Modified appropriateness evaluation protocol (AEP) criteria
- Apollo managed care physical therapy, occupational therapy, rehabilitation care and pain management criteria
- CareFirst Medical Policy reference manual
- The MCG care guidelines
- The Dental Criteria Guidelines (care management staff are trained in procedures for applying criteria. The criteria are not absolute but designed to be used in conjunction with the assessment of individual patient needs)

- CareFirst makes physician reviewers available to discuss utilization management (UM) decisions. Physicians may call 410-528-7041 or 800-367-3387, ext. 7041 to speak with a physician reviewer or to obtain a copy of any of the above-mentioned criteria. All cases are reviewed on an individual basis

Important note: CareFirst affirms that all UM decision-making is based only on appropriateness of care and service. Practitioners and/or other individuals are not rewarded for conducting utilization review for denials of coverage or service. Additionally, financial incentives for UM decision makers do not encourage underutilization of coverage or service.

Case management referral process

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, as early as possible. Case management also coordinates the use of health care benefits to create a plan of care that maximizes benefits effectively without compromising the quality of care. PCPs should refer members who would benefit from these services as soon as they are identified.

Case management intervention is appropriate for members:

- With catastrophic, progressive, chronic or life-threatening diseases
- 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

The case manager prepares and coordinates a care plan in collaboration with the member, his/her PCP, other providers and family. The case manager will ensure that the care plan is within the member's existing benefits.

If you are interested in case management services or to obtain more information or to refer a member, please contact CareFirst at 888-264-8648.

A quick reference guide when arranging for care

Care Services	
Service	**CareFirst BlueChoice**
Obtain benefits	CareFirst Direct
Inpatient/outpatient hospital authorization	Hospital is required to obtain authorization at least five business days prior to admission
Inpatient emergency authorization	Hospital is required to obtain authorization within 48 hours or next business day following the admission, whichever is longer.
Authorization may be obtained by	CareFirst Direct
Care management referral line	410-605-2623 888-264-8648
Member's customer service line	Refer to member's ID card

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