Table of Contents

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.

Provider Quick Reference Guide

Administrative Functions

Medical Credentialing
- Verify Provider Information Requirement

Role of the Primary Care Provider (PCP) – (CareFirst BlueChoice only)
- OB/GYNs as PCPs
- Back-up Coverage
- After Hours Care
- Open/Closed Panel

Reduction, Suspension or Termination of Privileges

Quality of Care Terminations

All Other Sanctions or Terminations

Member to be Held Harmless
- Reimbursement

Fee Schedule – Place of Service Code Assignments

Health Insurance Portability and Accountability Act (HIPAA) Compliant Codes

Concierge Services Policy

Administrative Services Policy

Notice of Payment (NOP)/Electronic Remittance Advice
- Reimbursement for Limited Licensed Providers (LLPs)

Physician Assistants
# Table of Contents

**Referrals (BlueChoice only)**

**Electronic Capabilities**
- Electronic Claims
- Electronic Remittance Advice (ERA)
- Electronic Fund Transfer (EFT)

**Paper Claims Submission Process**

**Timely Filing of Claims**
- Reconsideration

**Guidelines for Ancillary Claims Filing**
- Billing DME on a CMS 1500 claim form

**Medicare Crossover Claims Submission**

**Effective Follow-Up for Claims**
- Step-By-Step Instructions for Effective Follow-Up

**Claims Overpayment**

**Collection of Retroactively Denied Claims**

**Inquiries**
- Instructions for Submitting an Inquiry

**Appeals**
- Instructions for Submitting an Appeal
- Expedited or Emergency Appeals Process
- Appeal Resolution

**Member Complaints**

**Coordination with Other Payers**
- Coordination of Benefits

**Subrogation**

**No-Fault Automobile Insurance**

**Workers’ Compensation**

**Office Injectable Drugs**
- Standard Reimbursement Methodology
- Exemptions to Standard Pricing Methodology

**Medical Injectables**

---

**Place of Service Code Assignments**

**Facility Payment Rate**

**Freestanding Ambulatory Surgery Center (ASC) Rate**

**Non-Facility Payment Rate**

**Care Management**

**Quality Improvement (QI) Program**
- QI Program Goals and Objectives
- Quality Improvement Committees

**Performance Data**

**National Committee for Quality Assurance (NCQA)**

**Patient-Centered Medical Home (PCMH) Program**

**Disease Management Programs**
- Respiratory Diseases (Asthma, COPD)
  - COPD Resources/Related Links
- Diabetes
  - Diabetes Resources/Related Links
- Heart Disease
  - Resources/Related Links
- Oncology

**Clinical Resources**

**Medical Record Documentation Standards**

**Complex Case Management**

**Outpatient Pre-Treatment Authorization Plan (OPAP)**

**Coordinated Home Care and Home Hospice Care**

**Hospital Transition of Care (HTC)**

**Comprehensive Medication Review Program (CMR)**
Table of Contents

Behavioral Health and Substance Use Disorder Program (BSD)
Intake, Assessment and Appointment (IAA)
Mandatory Second Surgical Opinion Program (MSSOP)
Utilization Control Program (UCP)/Utilization Control Program Plus (UCP+)

Arranging for Care—BlueChoice Only
Referral Process
  Extended (Long-Standing) Referrals
  Services Requiring a Written Referral
  Services Not Requiring a Written Referral
LabCorp
Specialist
  Entering Referral Information on an Electronic CMS 1500
  Entering Referral Information on Electronic Claims
Authorization
  Services Requiring an Authorization
  Medical Injectables
  Necessary Information
  Services Not Requiring Authorization
Care Management
Emergency Room Services
  In-Area Emergencies
  Referred by PCP or Specialist
  Referred by FirstHelp
  Self-Referral
  Ambulance
Emergency Hospital Admissions
  In-Area Authorization Process
  Out-of-Area Authorization Process

Hospital Services
  Inpatient Hospital Services – Elective
  Authorization Process
  Preoperative Testing Services
  Discharge Planning Process
  Outpatient Hospital Services
  Utilization Management Decisions Are Based on The Following Criteria:

Case Management Referral Process
  A Quick Reference Guide when Arranging for Care

Policies and Procedures
Medical Policy and Technology Assessment
  Medical Policies and Medical Policy Operating Procedures
  Technology Assessments
Confidentiality
  General Policy
  Member Access to Medical Records
  Treatment Setting
  Quality Improvement Measurement
  Notice of Privacy Practice
Reimbursement Policy Statements
  Overview
  Reporting CPT® and HCPCS Codes
  Reporting ICD-10 Diagnosis Codes
  Requests for Clinical Information
Basic Claim Adjudication Policy Concepts
  Unbundled Procedures
  Incidental Procedures
  Integral/Included In Procedures
  Mutually Exclusive Procedures
  Global Allowances
  Add-On Procedures
  Duplicate Services and Multiple Reviews
  Unlisted Procedures
  Fragmented Billing
  Modifier Reimbursement Guidelines
# Table of Contents

## Global Surgical, Anesthesia, and Maternity Reimbursement Guidelines
- Bilateral Procedures Reimbursement Guidelines
- Policy Guidelines for Reporting Bilateral Procedures

## Multiple Surgical and Diagnostic Procedures Reimbursement Guidelines
- General Guidelines
- Multiple Endoscopic Procedures through the Same Scope
- Multiple Endoscopic and Open Surgical Procedures
- Serial Surgery Reimbursement Guidelines

## Multiple Provider Participation in Surgical Procedures
- Surgical Assistant or Assistant-at Surgery
- Team Surgery
- Co-Surgeon

## Multiple Provider Participation in Patient Care
- Consultations
- Concurrent Care
- Standby Services
- Evaluation and Management (E/M) Services
- CPT® Modifier-25
- New Patient Visit Frequency
- Preventive Services
- Preventive Services Under PPACA
- Multiple E/M Services on the Same Date
- Counseling Services
- Care Plan Oversight
- Advance Planning
- Chronic Care Coordination Services
- Transitional Care Management Services
- Online/Internet and Telephone Services
- Telemedicine
- E/M Services During the Global Periods
- CPT® Modifier-57
- E/M Services in Conjunction with Immunizations
- Prolonged Services
- Intensity of Service Auditing

## General and Specialty-Related Claim Adjudication Policies and Reimbursement Guidelines

## Multiple Specialties
- Billing for Services Rendered to Patients
- Reporting Medication Administration
- Reimbursement for Injectable, Vaccines and Administration
- Collecting Copayments/Coinsurance During Global Surgical Periods
- Special Services
- Cerumen Removal
- Critical Care Services
- Handling and Conveyance
- Hot and Cold Packs
- Supervision, Interpretation and/or Guidance for Diagnostic Tests
- Introduction of Intravenous Needles/Catheters
- Hydration, Infusions and Injections
- Pulse Oximetry
- Vital Capacity Measurements
- Supplies and Equipment
- Miscellaneous Services
- Venipuncture
- Visual Acuity Testing
- Medical/Clinical Photography
- Emergency Medicine

## Surgery/Orthopedics
- Anesthesia by Operating Surgeon
- Fracture Care, Strapping/Casting
- Gender Reassignment and Transgender Services
- Lesion Removals and Biopsies
- Lesion Excision and Wound Closures
- Surgical Trays
- Nasal Sinus Endoscopy/Debridement

## Medicine/Oncology
- Allergy Testing/Immunotherapy
- Chemotherapy
- Nutrition Therapy and Counseling
- Sleep Disorders
Table of Contents

Genito-Urinary
  Erectile Dysfunction

Pediatrics/Neonatology
  Normal Newborn
  Neonatal and Pediatric Intensive Care Services

Obstetrics & Gynecology
  Lactation Consultations
  Maternity Services
  Contraceptive Devices

Radiology/Imaging
  Mammography
  Multiple CT, MRI, and MRA Scans, Same Session
  Digital Breast Tomosynthesis
  Diagnostic Ultrasound with Ultrasound (US)
  Guidance Procedures

Invasive and Non-Invasive Diagnostic Tests and Procedures

Benefit Exclusions and Limitations—BlueChoice Only

  Covered Services and Benefit Guidelines
  Abortion
  Allergy
  Ambulance
  Anesthesia
  Away From Home Care®
  Behavioral Health/Substance Use Disorder Services
  Cardiology
  Chemotherapy
  Chiropractic Services
  Dental Care
  Durable Medical Equipment (DME) and Prosthetics
  Immediate Needs
  Emergency Services

Endocrinology

Gastroenterology

Hearing Aid Devices

Hematology/Oncology

Hemodialysis

Home Health Services

Home Infusion Therapy

Hospice Care

House Calls

Laboratory Services
  LabCorp (Available for HMO and PPO members)
  Quest Diagnostics (Available for PPO members only)

Nephrology

Nutritional Services

Obstetrics & Gynecology
  Reporting for Obstetrical Services
  Obstetrical Radiology/Laboratory Services
  Amniocentesis/CVS
  Genetic Testing/Counseling (excludes Amniocentesis)
  Maternal and Child Home Assessment
  Infertility Services
  Gynecologic Services
  Mammograms
  Contraceptive Services

OB/GYN Services Quick Reference Guide

Oral Surgery

Orthopedics

Physical, Occupational and Speech Therapy

Podiatry

Prescription Drugs

Pulmonology

Radiology Services
  Multiple CT Scans, MRIs and MRAs

Rheumatology
# Table of Contents

## Routine Office Visits

## Transplants

## Urgent Care Services

## Urology

## Vision Care
- Medical
- Routine Vision and Eyewear

## Wellness Discount Program

## Procedure Code Exception Charts
- Cardiology
- Chiropractic Services
- Endocrinology
- Gastroenterology
- Hematology
- Infertility Services
- Nephrology Services
- Obstetrics & Gynecology Services
- Ophthalmology
- Oral Surgery
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Specialists & PCPs
- Urology

## Membership Information

### Membership
- Members’ Rights and Responsibilities

### BlueCard®
- Out-of-Area Program – BlueCard®
- BlueCard® Member Identification
- How the BlueCard® Program Works
- BlueCard® Program Claims Submission
- BlueCard® Reimbursement
- BlueCard® and Health Care Exchanges
- Contiguous Areas
- Exclusions
- Ancillary Claim Filing Guidelines
- Utilization Review

### NASCO
- NASCO Member Identification
- NASCO Claim Submission

## Membership Identification Card

## Quick Reference Guide
## Provider Quick Reference Guide

### Products / ID Card Prefixes

<table>
<thead>
<tr>
<th>Products / ID Card Prefixes</th>
<th>Provider Service Phone #</th>
<th>Where to Send Claims</th>
<th>Where to Send Correspondence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueChoice</strong> — Prefixes: XIK, XOR, XIQ, XQG, XQA, XIE, JHZ, XWZ, XIG, QXK</td>
<td>800-842-5975</td>
<td>Mail Administrator P.O. Box 14116 Lexington, KY 40512</td>
<td>Mail Administrator P.O. Box 14114 Lexington, KY 40512</td>
</tr>
<tr>
<td><strong>BluePreferred</strong> — Prefixes: XIL, XWV, JHJ, XII, JHI, XIQ, QXM, XIY, XIU</td>
<td>877-228-7268</td>
<td>Mail Administrator P.O. Box 14115 Lexington, KY 40512</td>
<td>Mail Administrator P.O. Box 14114 Lexington, KY 40512</td>
</tr>
<tr>
<td><strong>HealthyBlue</strong> — Prefixes: JHG, QXF, JHA, JHC, QXB, QXE, XIF, JHD, QXD, JHH, QXI, QXL, QXU, QXR, QXS, QXT, QXC, QXH</td>
<td>Eligibility 800-676-2583, Out of area claims 877-228-7268</td>
<td>Send claims to your local plan: Mail Administrator P.O. Box 14116 Lexington, KY 40512</td>
<td>Mail Administrator P.O. Box 14114 Lexington, KY 40512</td>
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<tr>
<td><strong>Indemnity</strong> — Prefixes: XIJ, XWY</td>
<td>877-228-7268</td>
<td>Mail Administrator P.O. Box 14115 Lexington, KY 40512</td>
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</table>

**NASCO**

All prefixes are unique. CareFirst NASCO IDs begin with an 81 or 83.

**Federal Employee Program (FEP)**

"R" prefix

**DC/Metropolitan Area**

- Mail Administrator P.O. Box 14116 Lexington, KY 40512
- Mail Administrator P.O. Box 14114 Lexington, KY 40512

**MD**

- 800-854-5256
- 800-854-5256
- 800-854-5256

**BlueCard®**

Prefixes are unique

- Eligibility 800-676-2583
- Out of area claims 877-228-7268
- Send claims to your local plan: Mail Administrator P.O. Box 14116 Lexington, KY 40512
- Mail Administrator P.O. Box 14114 Lexington, KY 40512

### Resources

<table>
<thead>
<tr>
<th>Resources</th>
<th>Contact Information and Phone #</th>
<th>Link to Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Assistance</td>
<td>CareFirst Help Desk: 877-526-8390</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>CareFirst: 800-245-7013</td>
<td></td>
</tr>
</tbody>
</table>
| Credentialing | **Professional**
Mail Administrator
P.O. Box 14763
Lexington, KY 40512
Phone: 877-269-9593 or 410-872-3500
Fax: 410-872-4107

**Institutional**
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Mail Stop CG-51
Owings Mills, MD 21117
Phone: 410-872-3526
Fax: 410-505-2765

| www.carefirst.com/credentialing | |

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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 trademarks of the Blue Cross and Blue Shield Association.
<table>
<thead>
<tr>
<th>Resource</th>
<th>Contact Information and Phone #</th>
<th>Link to Website</th>
</tr>
</thead>
</table>
| Pre-cert/Pre-auth | Medical: 866-773-2884  
CVS Pharmacy: 855-582-2038  
| Pharmacy     | CVS Caremark: 800-241-3371                                                                    | [www.carefirst.com/rx](http://www.carefirst.com/rx) |
| Lab          | **LabCorp:** 1-888-LabCorp (522-2677)  
Quest Diagnostics: 866-697-8378 (available to PPO members only)  
**Note: BlueChoice members must use LabCorp.** | [www.labcorp.com](http://www.labcorp.com)  
[www.questdiagnostics.com](http://www.questdiagnostics.com) |

<table>
<thead>
<tr>
<th>Resource</th>
<th>Area</th>
<th>Contact Phone #</th>
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</thead>
<tbody>
<tr>
<td>Other Party Liability</td>
<td>CareFirst (Small/Medium Group and Consumer Direct)</td>
<td>866-285-2611</td>
</tr>
<tr>
<td></td>
<td>NASCO (Large Groups, CDH, ASO/self-insured)</td>
<td>877-228-7268</td>
</tr>
<tr>
<td></td>
<td>Workers Comp/Subrogation</td>
<td>443-471-5589 or 443-471-5585</td>
</tr>
<tr>
<td></td>
<td>FEP Workers Comp/Subrogation</td>
<td>800-854-5256</td>
</tr>
<tr>
<td></td>
<td>FEP Coordination of Benefits (COB)</td>
<td><strong>DC</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>MD</strong></td>
</tr>
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<tr>
<td></td>
<td></td>
<td>202-680-7779</td>
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</table>

For additional online resources, view our Provider Link List, available at [www.carefirst.com/providermanualsandguides](http://www.carefirst.com/providermanualsandguides).
Administrative Functions

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

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Read and print the Guidelines for Provider Self-Services.

Medical Credentialing

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

- 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 on the next page:

PM0007-1E (5/18)
### Administrative Functions

<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>
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<td>$1/$3M Individual</td>
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<td>$1/$3M Shared (up to 24)</td>
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</tr>
</tbody>
</table>

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

CareFirst encourages the use of the Council for Affordable Quality Healthcare (CAQH) ProView application. New practitioners can go directly to CAQH ProView and complete the credentialing application online through the [CAQH ProView secure website](https://www.proview.caqh.org). Once you have completed your application (CAQH will email you notification that your application is complete), and you have authorized CareFirst to access your data, go to provider.carefrst.com > click Join Our Networks > Click How to Apply > select the [CAQH Data Sheet](https://www.proview.caqh.org), complete and submit the online form. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

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

If you are a participating primary care provider in CareFirst’s network(s), you also have the opportunity to participate in programs that emphasize primary care and work to improve quality through coordinated care and appropriately aligned incentives like the CareFirst Patient-Centered Medical Home (PCMH) Program.

For more information on our Credentialing process, visit [www.carefrst.com/professionalcredentialing](http://www.carefrst.com/professionalcredentialing).

### Verify Provider Information Requirement

If you are already registered with CAQH ProView, please continue to make regular updates any time your provider information changes (or at least once each quarter). You will be contacted by CAQH each quarter with a reminder to review, update and attest to your provider information.

Role of the Primary Care Provider (PCP) – (CareFirst BlueChoice only)

Providers in the following medical specialties are recognized as PCPs:
- Family practice
- Internal medicine
- Pediatrics
- OB/GYNs (MD only)
- Nurse Practitioners

In a managed care program, a strong patient-PCP relationship is the best way to maintain consistent quality medical care. Your role as the PCP is a “physician manager” who coordinates all aspects of a member’s care.

Each CareFirst BlueChoice member selects a PCP upon enrollment and receives an individual membership identification card with the name of the PCP located on the card.

If a member chooses to change PCPs, the member must call the selected provider’s office to confirm that they still participate with CareFirst BlueChoice and are accepting new patients. The member then notifies Member Services of this change. Notification can also be done online at www.carefirst.com/myaccount.

Requests received on or before the 20th of the month will be effective the first day of the following month. Requests received after the 20th will be effective on the first day of the second month following the request.

For example: Changes received by Jan. 20 will be effective Feb. 1. Changes received on Jan. 21 will be effective March 1. New cards will be issued after the PCP change is processed.

If you no longer wish to be a CareFirst BlueChoice member’s PCP, you must verify that you are the patient’s current PCP, and notify Provider Services in writing prior to notifying the member. Additionally, you must give the patient 30 days notice prior to their release. A Member Services Representative will help the member select a new PCP.

OB/GYNs as PCPs

Only members in Maryland have the opportunity to select obstetrics and gynecology specialists as their PCP. A CareFirst BlueChoice participating OB/GYN who agrees to act as PCP for a female member should give the member a “letter of intent” stating your decision to serve as PCP.

The letter should include your CareFirst BlueChoice provider number and the member’s identification number and should be returned by the member to Member Services.

Note: Nurse practitioners (NPs) must be certified by the relevant approved National Certification Board and meet all licensing/certification guidelines of the state in which the NP practices.

Back-up Coverage

When you are not available to provide service to patients, you must arrange effective coverage through another practitioner who is a PCP in the CareFirst BlueChoice network. The covering practitioner must indicate on the paper claim form "covering for Dr. [provider’s name]" when submitting the claim to CareFirst BlueChoice.

After Hours Care

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week so that you can appropriately respond to members and other providers concerning after hours care. The use of recorded phone messages instructing members to proceed to the emergency room during off-hours is not an acceptable level of care for CareFirst BlueChoice members and should not be used by CareFirst BlueChoice participating physicians.

Open/Closed Panel

As stated in the Physician Participation Agreement, you may close your panel to new members with at least 60 days prior written notice to Provider Information and Credentialing, provided your panel includes at least 200 CareFirst BlueChoice members.

If you wish to accept a new member into a closed panel, you must notify Provider Information and Credentialing in writing. Written notification is also required when you elect to re-open your panel to new members.

Requests for opening and closing a panel can be made via the Provider Self-Service Portal, or faxed on your
Reduction, Suspension or Termination of Privileges

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

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

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

To make final determinations, the medical director seeks advice from the Credentialing Advisory Committee (CAC) and may appoint other practitioners as ad hoc members to the CAC to offer specialized expertise in the medical field that is the subject of the case or issue presented. As part of its investigation, the committee may use information that may include chart review of outpatient and inpatient care, complaint summaries, peer/staff complaints and interviews with the practitioner.

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

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

Quality of Care Terminations

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

The appealing practitioner is notified in writing of the hearing process. Following the hearing, the panel will make a final decision to affirm, amend or reverse the sanction or network termination. The medical director, in consultation with CareFirst legal representative(s), notifies the practitioner of the decision in writing, provides a statement for the basis of the decision and informs the practitioner that the decision is final and not subject to further consideration with CareFirst.

All Other Sanctions or Terminations

The medical director or credentialing manager will reconsider appeals for all other sanctions or terminations on the basis of new information provided by the practitioner. The medical director may seek recommendations from the CAC prior to making a final decision. The medical director notifies the practitioner of the decision in writing and informs the practitioner
that the decision is final and not subject to further consideration with CareFirst.

Member to be Held Harmless

CareFirst will make payments to the provider only for covered services which are rendered to eligible members and are determined by CareFirst to be medically necessary. Any services determined by CareFirst to have not been medically necessary, and ineligible for benefits, will not be charged to the member. The provider may look to the member for payment of deductibles, copayments, and coinsurance or for services not covered under the member’s Health Benefit Plan. Payment may not be sought from the member for any balances remaining after CareFirst’s payment for covered services or for services denied due to the provider’s lack of contracted compliance (i.e., lack of authorization), unless it is to satisfy the deductible, copayment or coinsurance requirements of the member’s Health Benefit Plan. The provider should not specifically charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against members or persons other than CareFirst or a third party payer for covered services provided according to the Participation Agreement.

Note: If a referral is required for a service, and the member does not present one to the provider of care, the member is not liable for any charges not paid due to the missing referral.

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.

CareFirst’s fee schedule is a list of plan allowances that are reviewed regularly. When adjustments to the fee schedule are made, providers will be notified if they will be impacted. They will receive a list of the impacted codes and fees. If the number of adjustments is too great, then a list of the most commonly billed codes (according to specialty) will be sent. Fee schedules for additional codes can also be obtained via CareFirst Direct.

Fee Schedule – Place of Service Code Assignments

Place of Service Code Assignments are used by CareFirst providers when submitting claims for payment. These codes are also located in the Reference Guides tab at www.carefirst.com/providerguides.

Health Insurance Portability and Accountability Act (HIPAA) Compliant Codes

To comply with the requirements of HIPAA, CareFirst will add the HIPAA-compliant codes and plan allowances 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 as needed during the calendar year.

Concierge Services Policy

CareFirst has expectations and requirements of participating providers, including those who choose the concierge practice model. We recognize that it is the member’s choice to receive services from a concierge practice. At the same time, CareFirst has a responsibility to confirm that services covered by the member’s contract, if provided, are appropriately billed.

According to our standard Participation Agreement, contracted providers must:

- Submit claims to CareFirst for all covered services, including preventive services
- Bill members for payment of applicable deductibles, copayments and/or coinsurance

To verify member benefits, use CareFirst Direct.

Please be advised that for the benefit of our members, we will identify “concierge” providers in our provider directories.

If you are considering a transition to a concierge practice model, along with the requirements noted above, CareFirst requires:

- 90-day written notification detailing your intent to transition to a “concierge” practice
The written notice should be forwarded to your professional provider relations representative.

For providers enrolled in the PCMH Program, please visit [www.carefirst.com/pcmhinfo](http://www.carefirst.com/pcmhinfo) to learn more about requirements related to the “concierge” practice model.

“Concierge” is defined as any private fee‑based program, as well as, any type of retainer, charge, and/or payment to receive additional “value added” services from the provider.

**Administrative Services Policy**

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against subscribers or members for covered services, including those that are inherent in the delivery of covered services. The practice of charging for office administration and expense is not in accordance with the Participation Agreement and Participating Provider Manual. Such charges for administrative services would include, by way of example, annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses, malpractice coverage increases, writing new/refill prescriptions with or without an office visit, telephone consultations, copying and faxing, completing referral forms or providing pertinent paperwork related to referrals to other physicians, other expenses related to the overall management of patients and compliance with government laws and regulations, required of health care providers, completion of physical forms, medication forms, pre-op forms and/or CareFirst requested forms.

The provider may look to the subscriber or member for payment of deductibles, copayments or coinsurance, or for providing specific health care services not covered under the member’s Health Benefit Plan as well as fees for some administrative services. Such fees for administrative services may include, by way of example, fees for completion of certain forms including school, work, camp, jury duty, disability forms not connected with the providing of covered services, missed appointment fees, and charges for copies of medical records when the records are being processed for the subscriber or member directly.

Fees or charges for administrative tasks, such as those enumerated above may not be assessed against all members in the form of an office administrative fee, but rather to only those members who utilize the administrative service.

**Notice of Payment (NOP)/Electronic Remittance Advice**

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. A Notice of Payment (NOP) or Electronic Remittance Advice (ERA) is available for each voucher and enables providers to identify members and the claims processed for services rendered to those members. A check may or may not be available depending on whether or there were payments.

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

CareFirst reimburses LLPs at a percentage of the standard physician fee schedule. This reimbursement policy applies to all CareFirst provider contracts.

The following is a list of LLPs typically affected by this reimbursement policy:

<table>
<thead>
<tr>
<th>LLPs Affected and Related Percentages of the Standard Physician Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse midwife</td>
</tr>
<tr>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>Board Certified Behavior Analyst (BCBA)</td>
</tr>
<tr>
<td>Dietician/Nutritionist</td>
</tr>
<tr>
<td>Licensed professional counselor, licensed marriage and family therapist</td>
</tr>
<tr>
<td>Licensed alcohol and drug therapist</td>
</tr>
<tr>
<td>Naturopathic provider</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
</tr>
<tr>
<td>Licensed clinical social worker</td>
</tr>
</tbody>
</table>

**Physician Assistants**

Covered services rendered by physician assistants (PAs) are eligible for reimbursement under the following circumstances:
Administrative Functions

- The PA is under the supervision of a physician as required by local licensing agencies.
- Services rendered by the PA are submitted under the supervising physician's name and provider number.

CareFirst does not contract with PAs. PA services are to be submitted under the supervising physician's name and provider number.

Referrals (BlueChoice only)

Unless otherwise stated, all office services not rendered by a PCP require a written referral, except for OB-GYN services and services rendered for members with the Open Access feature.

A written referral is valid for a maximum of 120 days and limited to three visits except for longstanding referral situations, and in-network services rendered to CareFirst BlueChoice members with the Open Access feature included in their coverage.

Decisions to issue additional referrals rest solely with the PCP.

Additional information about covered services and benefits guidelines is available through the Medical Policy Reference Manual.

Electronic Capabilities

To support our paperless initiative and improve your claims processing experience, CareFirst strongly encourages providers to utilize 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 certain claims require additional documentation from CareFirst and 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
- Medicare Secondary that do not automatically crossover from CMS

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.

To locate a claim, start from the point of initial electronic filing to identify any potential transmission problems. If the claim is not showing on the system, please contact your clearinghouse, or contact the CareFirst EDI Help Desk at 1-877-526-8390, edi@directsubmission.com or edidirectsubmission@carefrst.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 www.carefrst.com/carefrstdirect 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 www.carefrst.com/electronicclaims.

Electronic Remittance Advice (ERA)

If you submit claims electronically, you can receive payment vouchers through an Electronic Remittance Advice (ERA 835), delivered by your clearinghouse and including the payment details, 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. ERA is available online through the portal.

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 Electronic Fund Transfer (EFT), which allows you to get paid faster with secure direct deposits from CareFirst and reduced paperwork. All of our preferred...
Administrative Functions

clearinghouses offer EFT enrollment services. You will no longer receive a paper voucher or check once you are enrolled for EFT.

Paper Claims Submission Process

Paper claims are scanned and a digitized version of the claim is produced and stored electronically. Successful imaging of the claim depends on print darkness. Light print produces unacceptable imaging and your claim may be returned to you. Please make sure to change your printer cartridges regularly so that the print is dark.

Incomplete claims create unnecessary processing and payment delays for all providers. The fields listed below must be completed on all claims submitted to CareFirst. Claims missing information in any of the following fields will be returned:

- Block 1a: Insured’s ID Number*
- Block 2: Patient’s Name
- Block 3: Patient’s Birth Date
- Block 21: ICD-10
- Block 24a: Dates of Service
- Block 24b: Place of Service
- Block 24d: Procedures, Services or Supplies
- Block 24f: Charges
- Block 24g: Days or Units
- Block 24j: Rendering Provider NPI
- Block 25: Federal Tax ID Number
- Block 31: Signature of Provider (including degree or credentials)
- Block 33a: Provider’s Billing National Provider Identifier (NPI) (Required, or it will be returned to the provider).

*The 3-digit prefix must be included if present on the subscriber’s identification card. FEP membership numbers do not have a 3-digit prefix, but begin with an “R” and have 8 numeric digits.

All claims must be submitted on an original (red/white) CMS1500 form (version 02/12). All information must fit properly in the blocks provided.

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

Timely Filing of Claims

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 are generally 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 Notice of Payment (NOP) or Electronic Remittance Advice (ERA). 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 is needed from the vendor/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 12, indicating the original bill creation date

Guidelines for Ancillary Claims Filing

For a full list of claims filing guidelines for Lab, DME, and Specialty Pharmacy, visit www.carefirst.com/ancillaryclaims.

Billing DME on a CMS 1500 claim form

- DME rental periods for a one month rental period should be billed as 1 unit, not 30 units with an RR modifier
- Correct billing of HCPCS codes for Lancets, per box of 100 should only be billed as 1 unit, not 100 units of 100 lancets
- Bill a modifier of NU for purchase of DME
Unlisted CPT and HCPCS codes should only be reported when there is no established code to describe the service.

Submissions of claims containing unlisted procedure codes must be submitted with a complete description of the service or procedure code provided. Any applicable records or reports must be submitted with the claim.

The following services are reimbursed on a daily basis according to the terms of the CareFirst provider contract, and the RR (Rental) modifier must be appended to the claim:

- Enteral Nutrition Infusion Pump – with or without an alarm
- Parental Nutrition Infusion Pump – portable or stationary
- Phototherapy (bilirubin) light with the photometer
- Continuous passive motion exercise therapy device for use on the knee only
- Negative pressure wounds therapy electrical pump, stationary or portable
- Repair or non routine service for DME other than oxygen equipment requiring the skill of a technician
- Repair or non routine service for oxygen equipment requiring the skill of a technician

Medicare Crossover Claims Submission

Check CareFirst Direct or CareFirst on Call to verify if the claim has been received by CareFirst. You may check any time after the receipt of a Medicare Remittance Notice. You do not need to wait 30 days from Medicare's processing date to check CareFirst Direct or CareFirst on Call however, the following rules govern the submission of Medicare Secondary claims:

- Wait 30 days from the Medicare Explanation of Benefits (EOB) date before submitting your secondary claim.
- If you are submitting a secondary claim electronically (professional providers only), you must include the Medicare EOB or remittance advice date.
- Out-of-area member claims for covered services are now rejected by the member’s home plan. When you receive a rejection notification, you must resubmit these claims to CareFirst for processing through BlueCard®.
- Medicare claims billed using a 'GY' modifier can be submitted directly to CareFirst without prior submission to Medicare. These claims are not impacted by the 30 day requirement and do not require the inclusion of a Medicare EOB.

For these requirements and directions on how to submit Medicare Secondary claims, visit www.carefirst.com/electronicclaims > Medicare Secondary page.

Effective Follow-Up for Claims

To follow-up on claims submitted more than 30 days ago, you can check CareFirst Direct or CareFirst on Call to determine the claim status.

Do not resubmit claims without checking CareFirst Direct or CareFirst on Call first. Submitting a duplicate of a claim already in process will generate a rejection, which will cause a backlog of unnecessary claims to be processed.

Step-By-Step Instructions for Effective Follow-Up

Claim Status

The most effective way to accomplish follow-up on submitted claims is to access CareFirst Direct or CareFirst on Call. If there is no record of the claim, the claim must be resubmitted.

If the claim has been pending in the system for less than 30 days, wait until 30 days have elapsed from the processing date given on CareFirst Direct or CareFirst on Call. If processing has not been completed after 30 days, the preferred method for submitting an inquiry is electronically through CareFirst Direct’s inquiry Analysis and Control System (IASH) function.

When you cannot use CareFirst Direct’s IASH function, please use the Provider Inquiry Resolution Form (PIRF) to submit your Inquiry.

Large Volume of Unpaid Claims

- Please be sure that all NOPs or ERAs have been posted.
- Use CareFirst Direct or CareFirst on Call to verify receipt and status of claims.
Administrative Functions

- If you still have questions, please contact the appropriate provider customer service unit for assistance

Claims Overpayment

If a claims overpayment is discovered, please mail the amount to the following address:

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

Please include with your check:
- Membership number
- Patient name
- Claim number
- Reason for the refund

Make the check payable to CareFirst BlueCross BlueShield and 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.

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

Inquiries

Inquiries may include issues pertaining to: authorizations, correct frequency, ICD-10, medical records, procedures/codes and referrals. Prior to submitting an inquiry, consider sending a corrected claim.

Instructions for Submitting an Inquiry

The preferred method for submitting an Inquiry is electronically through CareFirst Direct’s Inquiry Analysis and Control System (IASH) function.

When you cannot use CareFirst Direct, please use the Provider Inquiry Resolution Form (PIRF) to submit your Inquiry.

Helpful Tips when completing a 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
- A copy of the form can be located on the website at [www.carefirst.com/providerforms](http://www.carefirst.com/providerforms)

An Inquiry must be submitted to the appropriate addresses below within 180 days or six months from the date of the Explanation of Benefits. Please allow 30 days for a response.

- Correspondence Address:
  - **Mail Administrator**
  - P.O. Box 14114, 14112, or 14111 (see below)
  - Lexington, KY 40512

  Select the appropriate P.O. Box:
  - 14114 – MD, National Capital Area (NCA), BlueChoice, local BlueCard and NASCO
  - 14112 – Federal Employee Program (FEP) providers in Montgomery & Prince George’s counties, Washington, DC and Northern Virginia
  - 14111 – All other MD FEP Inquiries

  Note: 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

An appeal must be submitted in letter form on your office letterhead describing the reason(s) for the appeal and the clinical justification/rationale. Please be sure to include:
- Patient name and identification number
- Claim number
- Admission and discharge dates (if applicable) or date(s) of service
- A copy of the original claim or Explanation of Benefits (EOB) denial information and/or denial letter/notice
Supporting clinical notes or medical records including: lab reports, X-rays, treatment plans, progress notes, etc.

Written appeals should be mailed to:

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

An appeal must be submitted within 180 days from the date of the Explanation of Benefits or Adverse Decision Notice. All Appeal decisions are answered in writing. Please allow 30 days for a response to an Appeal.

IMPORTANT: Do not use a Provider Inquiry Resolution Form (PIRF) to submit an Appeal. Visit www.carefrst.com/inquiriesandappeals for more information.

Expedited or Emergency Appeals Process
A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the member’s psychological state, or in the opinion of a practitioner with knowledge of the member’s medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

- 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 past 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 is available free of charge, including copies of the benefit provision, guideline, protocol or other 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, and
- Information regarding the next level of appeal, as appropriate

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

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

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

- Send an e-mail to: quality.care.complaints@carefrst.com
- Fax a written complaint to: 301-470-5866
Administrative Functions

- Mail a written complaint to:
  CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
  Quality of Care Department
  P.O. Box 17636
  Baltimore, MD 21298-9375

  Please include the following information when submitting a complaint:
  - Your telephone number and name
  - Your provider number
  - The member's name and ID number
  - Date(s) of service
  - As much detail about the event as possible

Coordination with Other Payers

Coordination of Benefits
Coordination of Benefits (COB) is a cost-containment provision included in most group and member contracts and is designed to avoid duplicate payment for covered services. COB is applied whenever a member 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.

Please note that, the member may 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)

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 wrong doing of another party. Such action will not affect the submission and processing of claims, and all provisions of the participating provider agreement apply.

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 if 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.

Office Injectable Drugs

Medications administered in the provider’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 will need to obtain office administered injectable medications and bill CareFirst directly. Providers cannot write a prescription for a medication and have the member obtain the medication from the pharmacy so the member can deliver the drug to the provider. These medications are not covered by the member’s prescription drug benefit.
Administrative Functions

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

For commercial members, providers may obtain injectable medications from a source of their choice. CareFirst has a contract with CVS Caremark. CVS Caremark can ship single doses of most injectable medications, on an individual patient (prescription) basis, directly to the provider office for administering. This option is available for most office injectables, eliminating the upfront cost of stocking expensive specialty injectables. CVS Caremark obtain eligibility and benefits then bill CareFirst directly. Your practice should continue to bill CareFirst for the administration by following Current Procedural Terminology (CPT®) guidelines and using the appropriate CPT® codes.

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 we make available and is not a guarantee of availability or supply by CareFirst. Not all drugs or individual prescriptions are available using this option.

Note: The arrangement with CVS Caremark does not apply to members whose primary coverage is Medicare.

Standard Reimbursement Methodology
If you obtain office injectable drugs, the following standard reimbursement methodology applies. Injectable drugs are reimbursed at a 6 percent above the Average Sales Price (ASP). Injectable drugs without an ASP are reimbursed at a 15 percent off the lowest Average Wholesale Price (AWP). The ASP is calculated by the Centers for Medicare & Medicaid Services (CMS) and available at www.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 (e.g. 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
Exemption to the Standard Pricing Methodology include:

- Pediatric vaccines are reimbursed at 100 percent of AWP.

Medical Injectables
Certain medical injectables require prior authorization when administered in an outpatient hospital or office settings. Intravenous immune globulin (IVIG) and select autoimmune infusions can be administer 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 www.carefirst.com/pharmacyresources > Pharmacy Prior Authorizations.

You should request prior authorization:

- Online: Log in at www.carefirst.com/providerlogin and click the Pre-Auth/Notifications tab to begin your request.
Place of Service Code Assignments
For Use with CMS-1500

Facility Payment Rate
This rate is applied when a professional provider performs covered services in a facility setting (e.g. hospital or skilled nursing facility) and the practice expenses associated with providing that service are the responsibility of the facility. In this scenario, payments would be made:

- To the professional provider for the professional services
- To the facility where the service was performed for the overhead costs and supplies

For covered services, the following Place of Service codes will be reimbursed at the Facility payment rate:

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Indian Health Service Freestanding Facility</td>
</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-Based Facility</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Freestanding Facility</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-Based Facility</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus – Outpatient Hospital</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>On Campus – Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility-Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>57</td>
<td>Nonresidential Substance Abuse Treatment Facility</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
</tbody>
</table>

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 trademarks of the Blue Cross and Blue Shield Association.

CUT9402-1N (5/18)
### Place of Service Code Assignments

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>End-Stage Renal Disease Treatment Facility</td>
</tr>
</tbody>
</table>

#### Freestanding Ambulatory Surgery Center (ASC) Rate

This rate is applied when the provider performs certain covered services in a Freestanding ASC. This allowance will be higher than the facility allowance but lower than or equal to the non-facility allowance.

For covered services, the following Place of Service code will be reimbursed at the Freestanding ASC payment rate:

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Ambulatory Surgery Center</td>
</tr>
</tbody>
</table>

#### Non-Facility Payment Rate

This rate is applied when the provider performs covered services in a non-facility setting (e.g. office or urgent care facility) and the professional practice incurs the full expense of providing the service such as labor, medical supplies, and medical equipment.

For covered services, the following Place of Service codes will be reimbursed at the Non-Facility payment rate:

<table>
<thead>
<tr>
<th>Place of Service Code</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>02</td>
<td>Telemedicine</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
</tr>
<tr>
<td>09</td>
<td>Prison-Correctional Facility</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
</tr>
<tr>
<td>12</td>
<td>Patient's Home</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
</tr>
<tr>
<td>16</td>
<td>Temporary Lodging</td>
</tr>
<tr>
<td>17</td>
<td>Walk In Retail Health Clinic</td>
</tr>
</tbody>
</table>
Care Management

This section provides information on Care Management Programs available 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.

Quality Improvement (QI) Program

The goal of the Quality Improvement (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 within and across health care organizations, settings and levels of care. CareFirst strives to provide access to health care that meets the Institute of Medicine's aim of being safe, timely, effective, efficient, equitable and patient-centered.

QI Program Goals and Objectives

1. 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.

2. Maintain a high-quality network of providers and practitioners to meet the needs of the population we serve.

3. Implement methods, tracking, monitoring, and oversight processes for all TCCI Programs to measure their value and impact for appropriate patients with complex health care needs.

4. All elements of the CareFirst TCCI program will be operating at targeted levels.

5. Establish collaborative partnerships to proactively engage clinicians, providers, and 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.
6. Promote the provision of data and support to clinicians to promote evidence-based clinical practice and informed referral choices and members to use their benefits to their fullest.

7. Maintain a systematic process to continuously identify, measure, assess, monitor and improve the quality, safety and efficiency of clinical care (medical and behavioral health), and quality of service.

8. Assess the race, ethnicity, language, interpreters, cultural competency, 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, improve network adequacy and improve cultural competency in materials and communications.

9. Monitor and oversee the performance of delegated functions especially for high priority partners (CVS/caremark, Healthways/Sharecare and Medtronic).

10. Develop and maintain a high quality network of health care practitioners and providers meeting the needs and preferences of its membership by maintaining a systematic monitoring and evaluation process.

11. 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.

12. Provide insight based on SearchLight data to increase the knowledge base of the medical panels in the evaluation of their outcome measures.

13. Address health needs of all patients along the health care continuum, including those with complex health needs (advanced developmental, chronic physical and/or behavioral illness, or complicated clinical situation).

14. Support quality improvement principles throughout the organization; acting as a resource in process improvement activities.

CareFirst recognizes that large racial and ethnic health disparities exist and that 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.

**Quality Improvement Committees**

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 practitioners, provide input and feedback on quality improvement program activities through participation in the following committees:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Advisory Committee (QIAC)</td>
<td>A multi-specialty committee of practitioners that advises the Plan about standards of medical and behavioral health care</td>
</tr>
<tr>
<td>Quality Improvement Council (QIC)</td>
<td>Evaluates the quality and safety of clinical and behavioral health care and the quality of services provided to members</td>
</tr>
<tr>
<td>Credentialing Advisory Committee (CAC)</td>
<td>Reviews the credentials of practitioners and other providers applying for initial or continued participation in the Plan</td>
</tr>
<tr>
<td>Care Management Committee (CMC)</td>
<td>Monitors and analyzes the care management program and promotes efficient use of health care resources by members and practitioners</td>
</tr>
<tr>
<td>Delegation Oversight</td>
<td>Monitors and analyzes performance of Behavioral Health and Pharmaceutical Services.</td>
</tr>
</tbody>
</table>
Performance Data

A status of performance and evaluation of meeting goals of the QI program can be found at www.carefirst.com. 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.

National Committee for Quality Assurance (NCQA)

All CareFirst's HMO and PPO products are accredited. Accreditation is awarded to plans that meet 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?

Patient-Centered Medical Home (PCMH) Program

CareFirst’s PCMH Program is designed to provide primary care providers – whether physician or nurse practitioner – with a more complete view of their patients’ needs and of the services they receive from other providers so that they can better manage their individual risks, keep them in better health and produce better outcomes. The program requires greater provider-patient engagement and it meaningfully compensates providers for that engagement.

As part of CareFirst’s PCMH Program, the Chronic Care Coordination Program provides coordination of care for patients with multiple chronic illnesses and is carried out according to Care Plans developed under the direction of the PCP. While Care Plans may result from a case management or HTC episode, they also originate from a review of the trailing 12 months of healthcare use by an attributed member who is identified as likely to benefit from a Care Plan.

Care coordination for these patients is carried out through the LCC who is assigned to each provider/practice within a panel. The LCC assists the PCP in coordinating all elements of the patient’s health care and ensuring that all action steps in the plan are followed up and carried out. CareFirst provides online tailored care plan templates that are suitable for the needs of members with various chronic diseases (e.g., diabetes, asthma, COPD, coronary artery disease, congestive heart failure, hypertension, childhood obesity), or for members with condition “clusters” (e.g., a member with diabetes, obesity and congestive heart failure; or a member with coronary artery disease with myocardial infarction and hypertension).

The vast majority of patients for whom care plans are most appropriate have multiple morbidities. Each care plan template is based on the latest evidence-based clinical care guidelines for the condition or cluster.

The PCMH Program has a significant “upside” for the provider, for the patient and for CareFirst as a steward of its members’ health care dollars. For more specific program information, including eligibility and how to get started, visit www.carefirst.com/pcmhinfo.

Disease Management Programs

CareFirst offers Disease Management programs designed to reinforce and support the physician's plan of care. All programs are voluntary and confidential.

CareFirst uses claims data to identify members with the following chronic conditions who are eligible for disease management: asthma, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), heart failure, chronic low back pain, osteoarthritis, atrial fibrillation, irritable bowel syndrome (IBS), and fibromyalgia. 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.

To obtain more information or to enroll patients into one of these programs administered by Healthways, Inc., call 800-783-4582.

Please note: These programs are not currently available to all members. Please verify the member’s benefits.

Respiratory Diseases (Asthma, COPD)
CareFirst offers 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/Sharecare

Enrolled members:
- Can access a nurse by phone 24-hours a day, seven 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, call the Asthma Management Program at 1-800-783-4582.

Diabetes
CareFirst offers a 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/Sharecare

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

To obtain more information or to refer a patient, please call the Diabetes Management Program at 1-800-783-4582.

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

Heart Disease
CareFirst offers a 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:
- 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/Sharecare

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 or to refer a patient, please call the CHF/CAD management program at 1-800-783-4582.

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
- ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults
- AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk
- ACC/AHA Guideline on the Assessment of Cardiovascular Risk

Note: Additional heart health resources and links can be found in the Clinical Guidelines section of provider.carefirst.com.

**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 1-888-264-8648.

**Clinical Resources**
Clinical resources are developed under our QI program and support our providers in treating chronic disease and conditions and providing preventive care. These resources include Clinical Practice Guidelines and Preventive Service Guidelines.

**Medical Record Documentation Standards**
The following resources are developed under our QI program and support our providers in maintaining office operations.
- Medical Record Documentation Standards
- Practitioner Office Standards

**Complex Case Management**
CareFirst has assembled a team of highly qualified registered nurses who work directly with our sickest members to manage the care of their complicated conditions. Using the web-based care management system, case managers have the ability to create a care management plan in our online portal.

Recognizing the need for targeted capabilities for complex conditions, CareFirst has developed specialized case management for the following patient needs:
- Adult Oncology
- Pediatric Oncology
- Complex Medical
- Trauma/Rehabilitation
- Special Needs/Complex Pediatrics
- High Risk Obstetrics
- Hospice/Palliative/End of Life Care

Health care providers, patients, family members, employers or anyone familiar with the case may refer candidates for CCM by calling 888-264-8648.

**Outpatient Pre-Treatment Authorization Plan (OPAP)**
OPAP is a pre-treatment program that applies to outpatient physical, speech and occupational therapy. Providers should use CareFirst Direct the provider portal to enter their pre-treatment authorizations.

**Coordinated Home Care and Home Hospice Care**
The Coordinated Home Care and Home Hospice Care programs allow recovering and terminally ill patients to stay at home and receive care in the most
comfortable and cost-effective setting. To qualify for program benefits, the patient’s physician, hospital or home care coordinator must submit a treatment plan to CareFirst. Authorization requests should be submitted via CareFirst Direct. 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.

Hospital Transition of Care (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 need upon admission and during a hospital stay with 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 that 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.

Comprehensive Medication Review Program (CMR)
The Comprehensive Medication Review Program is offered to members where there are indications of high potential for medication-related issues. The review is performed by a local pharmacist who consults with prescribers. High prescription use, high cost, and high Drug Volatility Score (DVS) members are flagged for a comprehensive medication review by a local pharmacist or specialty pharmacist to assure a member’s drug profile is optimal and to resolve any issues with it. In addition, other cases are identified from data mining for review to reduce problems resulting from dosage or drug interactions.

Behavioral Health and Substance Use Disorder Program (BSD)
CareFirst’s BSD program is designed with a patient-advocacy focus. Our licensed behavioral health professionals provide behavioral health and substance use care coordination to members in need. Services under this program include: BSD care coordination, transition of care services, needs assessment, assistance with locating providers and setting initial appointments. For more information visit www.carefirst.com/pcmhguidelines.

Intake, Assessment and Appointment (IAA)
CareFirst’s IAA department assists members and providers seeking behavioral health and/or substance use disorder 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 www.carefirst.com/pcmhguidelines.

Mandatory Second Surgical Opinion Program (MSSOP)
MSSOP is aimed at containing costs by reducing unnecessary diagnostic and surgical procedures. It also provides reassurance to patients having elective surgery by either confirming the need for the surgery or advising them of other forms of treatment. Some employer groups elect Voluntary Second Surgical Opinion (VSSOP), while others choose MSSOP for certain procedures. If a subscriber’s contract requires MSSOP, a penalty is applied if the VSSOP is not obtained. A practitioner who is qualified to perform the surgery must perform the VSSOP. The program applies to a specific list of diagnostic and surgical procedures when they are performed on an elective, non-emergency basis. The procedures on the MSSOP list vary from account to account.

Utilization Control Program (UCP)/Utilization Control Program Plus (UCP+)
These programs feature pre-admission review, admission review, continued stay review, retrospective review, and discharge planning. A Notification of Admissions to the CareFirst Utilization Management department is required. This notification is done in CareFirst Direct.
Arranging for Care—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, 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 abuse 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.

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 [www.carefirst.com/qualityandaffordability](http://www.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 Primary Care Provider (PCP) used a Uniform Consultation Referral Form, enter RE0000001.

Entering Referral Information on Electronic Claims
Contact your clearinghouse to confirm that your billing process can accommodate entering the referral information as described above. Visit www.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 www.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 www.carefirst.com/medicalpolicy.

Medical Injectables
Certain medical injectables require prior authorization when administered in an outpatient hospital 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 www.carefirst.com/preauth>Medications.
You should request prior authorization:

- Online: Log in at www.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 membership 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 1-800-535-9700.

**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
Arranging for Care—BlueChoice Only

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 Laboratory Corporation of America (LabCorp)* www.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 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
- 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 1-800-367-3387 x7041 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 denials 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

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<th>Care Services</th>
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<tr>
<td>Obtain Benefits</td>
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<tr>
<td>Inpatient/Outpatient Hospital Authorization</td>
<td>Hospital is required to obtain authorization at least five business days prior to admission</td>
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<td>Inpatient Emergency Authorization</td>
<td>Hospital is required to obtain authorization within 48 hours or next business day following the admission, whichever is longer.</td>
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<td>Member’s Customer Service Line</td>
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Policies and Procedures

This section provides information on policies and procedures 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, 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.

Medical Policy and Technology Assessment

Medical Policies and Medical Policy Operating Procedures
CareFirst evidence-based Medical Policies and Medical Policy Operating Procedures can be found in the Medical Policy Reference Manual (MPRM).

This manual is an informational database, which, along with other documentation, is used to assist CareFirst reach 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 medical policy 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).

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 trademarks of the Blue Cross and Blue Shield Association.

PM0010-1E (5/18)
The Medical Policy Reference Manual 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 Medical Policy Reference Manual 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 Medical Policy Reference Manual 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 and 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 in 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 Blue Cross and Blue Shield 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.

Confidentiality
CareFirst has implemented policies and procedures to protect the confidentiality of member information.

General Policy
- All records and other member communications that have 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 (a person who signs a policy with CareFirst) 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.
- CareFirst releases minimum necessary Protected Health Information (PHI) in accordance with the Privacy Rule as outlined in the Health Insurance Portability and Accountability Act (HIPAA) and our Notice of Privacy Practices (NPP).

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

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 reviews practitioner confidentiality processes during pre-contractual site visits for primary care physicians.

Quality Improvement Measurement
Data for quality improvement measures is collected from administrative sources, such as claims and pharmacy data, and/or from member medical records. CareFirst protects member information by requiring that medical records are reviewed in non-public areas and 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 (HIPAA) of 1996, we are required to send our Notice of Privacy Practices to fully insured members. 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.

Reimbursement Policy Statements

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 (i.e., American College of Surgeons, American Academy of Orthopedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Current health care trends
- Medical and technological advances
- Specialty expert consultants

Therefore, our policies and clinical rules are developed through a compilation of information from a variety of sources. The clinical rules we utilize are designed to verify the clinical accuracy of procedure code relationships on professional (non-institutional) claims. CareFirst utilizes McKesson ClaimsXten® software as a part of the overall editing process for claims. The ClaimsXten software is updated quarterly and provides a means for our claims systems to recognize new and/or revised CPT® and HCPCS codes, including any reclassifications of existing CPT® codes. Providers are notified of key policy changes through BlueLink, weekly News You Can Use emails and/or newsflash updates at carefirst.com/providernews. 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-10 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 health care 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-10 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 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.

Claims are edited for:

- Services reported together on the same claim
Policies and Procedures

- 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-10 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 (i.e., 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.

Reporting CPT® and HCPCS Codes

CareFirst does not usually receive claims with procedure codes specific to Medicare and Medicaid, or “Temporary National Codes (Non-Medicare)”. Therefore, unless otherwise directed through BlueLink or other communication means, providers should report services for our members using the standard CPT® codes instead of comparable Level II HCPCS codes. This includes, but is not limited to Medicare temporary G-codes and Q-codes; Hand T-codes which are specific to Medicaid; and non-Medicare S-codes. This policy does not apply to:

- Crossover claims which are reimbursed by CareFirst as secondary to Medicare;
- Claims for Durable Medical Equipment (DME) supplies, 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-10 Diagnosis Codes

Carefully follow coding guidelines outlined in the most current ICD-10 coding book. Guidelines of particular importance include:

- Code to the highest level of specificity, 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.

For additional information, visit [www.carefirst.com/icd10](http://www.carefirst.com/icd10).

Requests for Clinical Information

In order to accurately adjudicate claims and administer subscriber benefits, it is necessary to request medical records. The following is a list of claims categories from which CareFirst 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 specific modifiers are discussed in more detail throughout this manual. These categories include:

- Procedures or services that require pre-certification/pre-authorization
- 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
- Claims involving review of medical records
- Claims involving pre-existing condition issues
- Procedures or services related to case management or coordination of care
Policies and Procedures

- 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 (i.e., data collection as required by accrediting agencies, such as NCQA/HEDIS/Quality Rating System)
- 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. By contract, these records are to be provided without charge.

Basic Claim Adjudication Policy Concepts

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.

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

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 re-bundled 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. 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.

Providers should 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, 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.

**Add-On Procedures**
Procedure codes designated as add-on (or “List separately in addition to the code for primary procedure” for 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 RVUs 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.

**Duplicate Services and Multiple Reviews**
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), 59 (distinct procedural service), 76 (repeat procedure or service by same physician or other qualified health care professional), 91 (repeat clinical diagnostic laboratory test), or CPT® 76140 (consultations on x-ray exams performed at other sites.)

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

**Unlisted Procedures**
In the Federal Register, CMS establishes and publishes RVUs for most CPT® and some HCPCS Level II codes. RVUs are a weighted score used to determine the fee scales for procedures and services performed by professional providers. These RVUs are used to determine allowances for reimbursement. CMS, however, does not assign RVUs 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 (i.e., incidental procedures, multiple procedures, bilateral procedures, global periods) in relation to claims submitted with unlisted codes.

All modifiers will be considered invalid with unlisted codes. Do not report modifiers with any unlisted procedure 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
- 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.

### The following CPT® modifiers may affect reimbursement:

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### The following HCPCS modifiers may affect reimbursement:

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### Examples of modifiers that are used for informational purposes and do not affect reimbursement are:

-23  -33  -90  -22  -32  -63  -99

### The following CPT® modifiers do not affect reimbursement:

-47  -63  -92

### Examples of modifiers that may affect how member benefits are determined and reimbursed:

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CareFirst follows the Center for Medicare and Medicaid Services (CMS) guidelines when determining if particular diagnostic or therapeutic tests and
Policies and Procedures

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.

Submissions of claims containing the following CPT® modifiers are reviewed by our Medical Review Department, and should be submitted with the pertinent medical records (i.e., 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 evaluation and management (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 be made available if requested. 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.
- 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.
- 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.

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)
- 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

Separate benefits are provided for moderate (conscious) sedation whether rendered by the physician performing the diagnostic or therapeutic service that the sedation supports or by another physician. Moderate sedation codes are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care. Refer to Medical Policy Operating Procedures 9.01.001A, 9.01.003A,
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
- Surgical services and related global periods
  - Refer to Global Surgical Procedure Rules, 10.01.009A in our Medical Policy Reference Manual
- Anesthesia Services that are/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 post-operative 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. 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 in the Unit 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 CPT® Modifier-50 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 in the Unit 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 of whether it is performed on one side or both sides. Report the single procedure code with a frequency of one in the Unit 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 colonoscopy 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 (i.e., 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® Modifier-51 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 (i.e., 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 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. As a result of the changes to the Physician Fee Schedule described above, CareFirst will utilize the Transitioned NonFacility Total RVU (Column P) as published by CMS for both new and pre-existing
Policies and Procedures

codes beginning in mid-April 2007 at the time of our next claims software upgrade.

For additional information on this methodology, visit the CMS website at http://www.cms.hhs.gov/PhysicianFeeSched/.

Effective with claims processed on and after January 1, 2013, CareFirst will utilize the Non-Facility Total RVU (Column L) now that the transition period has been completed.

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.

If 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 a procedure is performed in stages 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 10.01.00 8A, 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 (instead of statistical measures) to determine the appropriateness of assistants-at-surgery. A variety of sources, including expert clinical consultants, specialty organizations (i.e., American Academy of Orthopedic Surgeons and CMS) are used to determine reimbursement for assistant-at-surgery ACS 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 (i.e., physician assistant, nurse practitioner).

CPT® Modifiers -80, -81, -82, and HCPCS modifier -AS are currently reimbursed at 16 percent of the allowance for the procedure(s) for which assistant services are eligible for reimbursement.

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

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 re-implantation 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 (i.e., 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.

Effective with claims processed on and after Jan. 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.

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 (i.e., 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 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 the 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.)

Concurrent Care
Reimbursement may be made for multiple providers caring for a patient during an episode of care, according to the terms of the subscriber’s benefit contract and applicable claims adjudication policies. This includes providers of multiple specialties caring for a patient in an inpatient setting on the same date of service. The need for multiple provider participation in the patient’s care must meet medical necessity criteria and be documented in the medical record (see also Consultations above and 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 (E/M) 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.

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 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 three-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 three-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/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 (i.e., CPT® 99201-99215) for other encounters such as preoperative or pre-diagnostic procedure evaluations.

For additional information, refer to the CareFirst Preventive Services Guidelines available in the Resources tab at www.provider.carefirst.com.

Preventive Services Under PPACA
As part of the Patient Protection and Affordable Health Care Act (PPACA), certain preventive services for children and adults must be covered at no cost to the member when using in-network providers.

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

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 be present for health maintenance/preventive medicine service visit, and a condition or symptom is identified that requires significant additional effort to address and treat. 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 (i.e., 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 (i.e. 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® codes 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 physician who provides a supervisory role in the care of a member receiving complex case or disease
Policies and Procedures

management services. These services are reported in accordance with CPT® guidelines (i.e., time spent per 30 days) and may be reported in addition to direct patient care E/M services as appropriate.

Advance Planning
CareFirst provides a benefit for advance care planning (CPT® 99497, 99498). These codes are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. Refer to CPT® guidelines for reporting CPT® 99497 and 99498 separately if performed on the same day as another Evaluation and Management service.

Chronic Care Coordination Services
CareFirst provides a benefit for complex chronic care coordination services (CPT® 99487–99490), effective January 1, 2015. These services are reported in accordance with CPT® guidelines (e.g., time spent per calendar month, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT® code book. Attention should be given to the services that may not be separately reported during the month for which chronic care coordination services are reported, also as outlined in the CPT® code book.

Transitional Care Management Services
CareFirst provides a benefit for transitional care management services (CPT® 99495-99496), effective January 1, 2013. These services are reported in accordance with CPT® guidelines (e.g., calendar days between discharge and a face-to-face visit, who may report these services, etc.) and may be reported in addition to direct patient care E/M services as appropriate, as outlined in the CPT® code book. Attention should be given to the services that may not be separately reported during the timeframes during which transitional care management services are reported, also as outlined in the CPT® code book.

Online/Internet and Telephone Services
CareFirst does not provide benefits for Non-Face-to-Face Services via telephone or internet (CPT® 99441-99443; 99444; 98966-98968; 98969; or effective 1/1/2014, Inter-professional Telephone/Internet Consultations (CPT® 99446-99449). All of these services are considered “integral to/ included in” all other services, whether reported alone or in addition to other services or procedures. “Integral to/ included in” services are not eligible for reimbursement.

Telemedicine
Telemedicine services refers to the use of a combination of interactive audio, video, or other electronic media used by a licensed health care provider for the purpose of diagnosis, consultation, or treatment consistent with the provider’s scope of practice. Use of audio-only telephone, electronic mail message (e-mail), online questionnaires or facsimile transmission (FAX) is not considered a telemedicine service. Services for diagnosis, consultation or treatment provided through telemedicine must meet all the requirements of a face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services. Diagnostic, consultative and treatment telemedicine services should be reported with the appropriate Category I CPT® code and the HCPCS modifier -GT (via interactive audio and video telecommunication systems). Diagnostic consultative and treatment telemedicine services should be reported with the appropriate Category I CPT® code and the HCPCS modifier -GT (via interactive audio and video telecommunication systems) or CPT® modifier -95 (synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system).

CareFirst does provide benefits for telemedicine services under certain circumstances. Refer to Medical Policy 2.01.072, Telemedicine (Unified Communications), in the Medical Policy Reference Manual, for details.

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


Policies and Procedures

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.

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 E/M visit code is used for the preoperative history and physical exam prior to the surgical procedure.

E/M Services in Conjunction with Immunizations
If 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 is rendered at the time of the immunization/injection, CPT® Modifier-25 should be appended.

Prolonged Services
Prolonged physician service codes (CPT® codes 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 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 service 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 (i.e., 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.

Intensity of Service Auditing
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

Billing for Services Rendered to Patients
Except for very limited circumstances (examples: physician assistants or registered nurses administering injections), providers may only report and submit claims for services rendered to patients that the practitioner individually and personally provides. CareFirst contracts with participating providers to perform services for an agreed upon fee. It is that provider, and only that provider, who can submit a claim and receive reimbursement. As outlined in the CareFirst Medical Record Documentation Standards policy, 10.01.013A, participating providers must accurately and completely document the medically necessary services they perform in the appropriate medical record, and sign the document(s) attesting that they performed the service. Attending physicians and other qualified health care professionals who supervise and teach residents or students are allowed to submit claims for those services that the resident or student in training provides, only if the supervising provider also interacts with the patient/family, examines the patient (if applicable), and personally documents their patient encounter in the medical record. Services rendered by residents, associates, graduate students, or others in training, in any discipline, specialty or occupation are not eligible for reimbursement unless these requirements are met.

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 to minimize any waste and utilize medications efficiently. If a specific dose of medication is drawn from a multi-dose 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 and administered 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.

Additional information is available in the Medical Policy Reference Manual (i.e., Medical Policy 5.01.001) and the CareFirst Preventive Services Guidelines, both of which are located on provider.carefirst.com.

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

Collecting Copayments/Coinurance 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 or 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 or 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 (i.e. CPT® 99026-99060) are considered incidental or mutually exclusive to other services. Incidental and mutually exclusive services are not eligible for reimbursement.

Exception: CPT® 99050 is eligible for separate reimbursement to primary care providers (PCPs) for afterhours service. Afterhours is defined as medical
office services rendered after 6 p.m. and before 8 a.m. weekdays; or weekends and national holidays. This code may be reported in addition to other services on the claim. The following types of practitioners are considered PCPs: general practice; family medicine; internal medicine; pediatrics; and geriatrics. CPT® 99050 is not eligible for separate reimbursement at urgent care centers.

Cerumen Removal
Removal impacted cerumen (ear wax) using irrigation/lavage unilateral, CPT® code 69209 (effective 1/1/2016), has been established to report the removal of impacted cerumen by irrigation and/or lavage. Several exclusionary and instructional notes were added to the CPT® guidelines to ensure appropriate reporting of CPT® codes 69209 and 69210. Removal impacted cerumen requiring instrumentation, unilateral. A new code was warranted to differentiate between direct and indirect approaches of removing impacted cerumen performed or supervised by physicians or other qualified health care professionals. Impacted cerumen is typically extremely hard and dry and accompanied by pain and itching, and can lead to hearing loss. CPT® 69210 only captures the direct method of earwax removal utilizing instrumentation such as curettes, hooks, forceps, and suction. Another less invasive method uses a continuous low pressure flow of liquid (eg, saline water) to gently loosen impacted cerumen and flush it out with or without the use of a cerumen softening agent (eg, cerumenolytic) that may be administered days prior to the procedure or at the time of the procedure. CPT® 69209 enables the irrigation or lavage method of impacted cerumen removal to be separately reported, and not mistakenly reported with CPT® 69210. CPT® codes 69209 and 69210 should not be reported together when both services are provided on the same day on the same ear. Only one code (CPT® 69209 or 69210) may be reported for the primary service (most intensive time or skilled procedure) provided on that day on the same ear. Two instructional parenthetical notes have been added following CPT® 69209 and 69210 to exclude from being reported together. If either one of the cerumen removal procedures is done on both ears, modifier 50 should be appended as indicated in the new parenthetical note added following CPT® codes 69209 and 69210. The E/M codes should be reported when non-impacted cerumen is removed according to the section category defined by the site of service (eg, office or other outpatient, hospital care, nursing facility services) as instructed in the parenthetical notes following CPT® 69209 and 69210.

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 (i.e., 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 (i.e., 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” (i.e., 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 procedure (i.e., 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 Multiple Reviews)

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 (i.e., 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 infusion/injection procedures. Incidental procedures are not eligible for separate reimbursement.

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

### 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 (i.e., CPT® 36415) 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. However, this procedure is 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 (i.e., 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 (i.e., consultants) are reported separately by those providers. 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

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* (i.e., 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, as appropriate, since they typically provide the surgical component, not the pre- or post-operative component of the surgical package.

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 (i.e., same tax ID number) during a procedure is considered included in the allowance for the surgical procedure. This includes any method of anesthesia (i.e., general anesthesia, moderate (conscious) sedation, local or regional anesthesia, nerve blocks). Included in procedures are not eligible for reimbursement.

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

Gender Reassignment and Transgender Services
Gender reassignment and transgender services are often defined by the subscriber contract. For additional information on this topic, including authorization requirements, refer to Medical Policy 7.01.123 Gender Reassignment Services and 7.01.017 Cosmetic and Reconstructive Surgery with Attached Companion Table in the Medical Policy Reference Manual.

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 assumes same site. CPT® Modifier-59 should be appended to lesion removals subsequent to the primary procedure to indicate that they were distinct procedures (i.e., 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 (i.e., 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 day global period or after a ten day global period. Endoscopic surgical sinus cavity debridement is not eligible for separate reimbursement when performed as a postoperative treatment related to major surgeries (i.e., septoplasty) within a 90-day global period. When the patient is being followed postoperatively for both a zero or ten 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-10 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 Testing, Medical Policy 2.01.017, Allergy Immunotherapy, and other applicable policies in the Medical Policy Reference Manual.

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 (i.e., 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.

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 (i.e., 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.

Sleep Disorders
CareFirst provides benefits for the diagnosis and management of sleep disorders, including oral appliances. Most sleep disorder services can be provided in the home setting. Refer to Medical Policy...
Policies and Procedures

2.01.018 in the Medical Policy Reference Manual for details and authorization requirements.

Genito-Urinary

Erectile Dysfunction

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 and 99485-99486), Inpatient Neonatal and Pediatric Critical Care (CPT® 99468-99474), and Initial and Continuing Intensive Care Services (CPT® 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® 99468-99480.

Incidental services are not eligible for separate reimbursement.

Obstetrics & Gynecology

Lactation Consultations
Lactation consultation refers to the educational services provided to women who plan to breast-feed but encounter difficulties due to anatomic variations, complications, and feeding problems with newborns by providing lactation support and counseling. Refer to Medical Policy 4.01.005, Lactation Consultations in the Medical Policy Reference Manual.

Maternity Services
Maternity benefits are defined by the subscriber contract. Carefully follow CPT® guidelines for reporting maternity services, including reporting non-global services (i.e., 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 Services 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 percent of the allowed benefit, and the procedure with the lesser RVU will be reimbursed at 50 percent 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 nonadjacent scans reported at the same session are eligible for reimbursement at 100 percent of the allowed amount.

Digital Breast Tomosynthesis
CPT® codes 77061 Digital breast tomosynthesis; unilateral, 77062 Digital breast tomosynthesis; bilateral, and +77063 Screening digital breast tomosynthesis, bilateral were added effective 1/1/2015. These codes were established to report diagnostic and screening breast tomosynthesis,
unilateral and bilateral procedure. The digital breast tomosynthesis images, and if acquired, the conventional mammography images, are utilized for interpretation for screening and diagnostic mammograms. The addition of digital breast tomosynthesis to conventional mammography has been shown to be more sensitive and specific for breast-cancer screening.

Instructional parenthetical notes have been added to ensure appropriate reporting of breast tomosynthesis imaging procedures. It is appropriate to report CPT® 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT® 77055 and 77056 (conventional diagnostic mammography). It is appropriate to report CPT® 77063 (bilateral screening breast tomosynthesis) in conjunction with CPT® 77057 (conventional bilateral screening mammography).

Exclusionary parenthetical notes have been added to further clarify the reporting of breast tomosynthesis imaging procedures. It would not be appropriate to report add-on CPT® code +77063 (screening breast tomosynthesis) in conjunction with CPT® codes 77055 and 77056 (conventional diagnostic mammography) or CPT® 76376 or 76377 (three-dimensional reconstruction). It would not be appropriate to report CPT® 77061 and 77062 (diagnostic breast tomosynthesis) in conjunction with CPT® 77057 (conventional screening mammography) or CPT® 76376 or 76377 (three-dimensional reconstruction).

**Diagnostic Ultrasound with Ultrasound (US) Guidance Procedures**

- **Limited Diagnostic Ultrasound Procedures reported with Ultrasound Guidance Procedures**
  - When a “limited” diagnostic ultrasound (i.e., CPT® 76705) and an ultrasonic guidance procedure (i.e., 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 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 (i.e., 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.
Policies and Procedures

Invasive and Non-Invasive Diagnostic Tests and Procedures

Many of these tests and procedures (i.e., 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 Multiple Reviews)
Benefit Exclusions and Limitations—BlueChoice Only
CareFirst BlueChoice, Inc. (CareFirst BlueChoice) only

This section provides information on Exclusions and Limitations 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, 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.

Covered Services and Benefit Guidelines
It is the expectation that providers who perform laboratory or imaging tests, at any site, will obtain and/or maintain the appropriate federal, state, and local licenses and certifications; training; quality controls; and safety standards pertinent to the tests performed.

You should always obtain verification of benefits. Information regarding a member’s specific benefit plan can be verified by calling CareFirst on Call or by visiting CareFirst Direct.

The information in this guide includes exclusion and limitation information related to the following products:

- BlueChoice
- BlueChoice HMO (Referral-based)
- BlueChoice HMO Open Access
- BlueChoice HMO HSA/HRA (Referral-based)
- BlueChoice HMO Open Access HSA/HRA
- BlueChoice Open Enrollment
- BlueChoice Opt-Out Plus Open Access HSA/HRA
- BlueChoice Opt-Out (Referral-based)
- BlueChoice Opt-Out Open Access
- BlueChoice Opt-Out Open Access HSA/HRA
- BlueChoice Plus
- BlueChoice HSA
- BlueChoice Saver
- HealthyBlue
- BlueChoice Advantage
- BlueChoice Advantage HSA/HRA
Unless otherwise stated, all office services not rendered by a PCP require a written referral, except for OB-GYN services and services rendered for members with the Open Access feature. Unless otherwise indicated, a written referral is valid for a maximum of 120 days and limited to three visits except for long-standing referral situations, and covered services rendered to CareFirst BlueChoice members with the Open Access feature.

Decisions to issue additional referrals rest solely with the PCP. Please refer to the Administrative Functions guide for additional referral information. The hospital must obtain prior authorization for inpatient hospital admissions, except in emergencies.

Additional information about covered services and benefits guidelines are available through the Medical Policy Reference Manual. If you have additional questions, contact Provider Services at 800-842-5975.

Abortion

An authorization is required to perform an abortion in a hospital setting. Authorization is not required if performed in a provider's office.

Note: Benefits for abortions are not available under all programs.

Allergy

Allergy services require a written referral from a Primary Care Provider (PCP). A PCP may issue a long-standing referral for allergy services. Allergy consultation, injections, testing and serum are generally covered.

PCPs may administer allergy injections and must maintain appropriate emergency drugs and equipment on site.

Ambulance

Ambulance services involve the use of specially designed and equipped vehicles to transport ill or injured members. Benefits for ambulance services are provided for medically necessary ambulance transport. Services must be authorized, except for emergency situations.

Emergency ambulance services are considered medically necessary when the member's condition is such that any other form of transportation would medically conflict and would endanger the member's health. For more information, please refer to the Medical Policy Reference Manual.

Anesthesia

CareFirst BlueChoice provides benefits for anesthesia charges related to covered surgical procedures and for pain management. Authorization for anesthesia during surgery is included in the authorization for the surgery. For pain management services rendered in a provider’s office, a referral from the PCP is required.

For more information about reporting anesthesia services, refer to the Medical Policy Reference Manual.

Away From Home Care®

The Away From Home Care® program is sponsored by the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, and allows CareFirst BlueChoice members and their covered dependents to receive care from any Blue Cross and Blue Shield HMO while away from home for at least 90 consecutive days or more.

Members from other Blue Cross and Blue Shield HMOs can enroll in CareFirst BlueChoice, select a PCP and receive a standard ID card. Benefits may vary; it is important to contact Provider Services at 800-842-5975 or visit CareFirst Direct to verify coverage in the state. This program does not change CareFirst BlueChoice providers’ normal office procedures.

Behavioral Health/Substance Use Disorder Services

CareFirst members may self-refer for services by calling the number on the back of their membership ID card. CareFirst BlueChoice members who choose to see a non-participating specialist still must contact CareFirst at 800-245-7013 to authorize services.

Visit the Disease Management section of www.provider.carefirst.com for more information on Behavioral Health Services.
Benefit Exclusions and Limitations—BlueChoice Only

Cardiology
Radiological services covered under the member’s medical benefit and performed in the cardiologist’s office setting are limited to certain procedures. All other procedures must be performed by a CareFirst BlueChoice contracted radiology facility. Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply. See Procedure Code Exception Charts.

Chemotherapy
Chemotherapy services rendered in a specialist’s office require a written referral from the PCP. The PCP may issue a long-standing referral. Services rendered in a hospital setting must be authorized by CareFirst.

Chiropractic Services
Chiropractic services require a written referral from the PCP, except when rendered to CareFirst BlueChoice members with the Open Access feature included in their coverage. Benefits may be limited to spinal manipulation for acute musculoskeletal conditions of the spine for individuals over the age of 12 years. Refer to the Spinal Manipulation and Related Services, policy 8.01.003, in the Medical Policy Reference Manual on our website. Copayments for specialty office visits apply and there are limitations on number of visits, which vary by contract. See Procedure Code Exception Charts.

Dental Care
Discount Dental is a free discount program offered to all CareFirst BlueChoice Medical HMO members at no additional cost. Members have access to any provider who participates in the CHMO Discount Dental Program and can receive discounts on dental services through this program. Because it is a discount program and not a covered benefit, there are no claim forms, referrals or paperwork to complete. Members must show their CareFirst BlueChoice membership card and pay the discounted fee at the time of service to save.

Durable Medical Equipment (DME) and Prosthetics
Authorization is required for services related to prosthetics and certain other DME items. Authorization is also required when the contracted provider supplies all DME equipment and supplies for diagnoses other than asthma and diabetes. For members with asthma and/or diabetes, the attending provider is responsible only for a written prescription to the participating DME provider. Visit www.carefirst.com/preauth for a full list of codes requiring prior authorization.

Immediate Needs
CareFirst BlueChoice PCPs, physical therapists, podiatrists, orthopedists and chiropractors can provide certain medical supplies in their office when these supplies/devices are rendered in conjunction with an office visit. No separate authorization is needed; however, member benefits must be verified prior to providing supplies, as medical benefit limitations, policies and procedures still apply.

To view a list of immediate needs supplies, visit in the Medical Policy Reference Manual on our website. Search Medical Policies by typing the words “immediate needs” in the subject or word box. The policies that have immediate needs items will be displayed. Choose the applicable policy and view the “Provider Guidelines” section of the policy for detailed information for supplying an immediate need.

If you choose not to supply an “immediate need” item to a member, then you must refer the member to a contracted DME supplier. Contracted DME providers must distribute all other supplies not considered an “immediate need.” Find a list of current DME suppliers in our online Provider Directory.
Emergency Services

CareFirst defines a medical emergency as a serious illness or injury that in the absence of immediate medical attention could reasonably be expected by a prudent layperson (one who possesses an average knowledge of health and medicine) to result in any of the following:

- Placing the member's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any body part or organ

Members should call 911 for all life-threatening emergencies. CareFirst members may contact their PCP or FirstHelp for instructions or medical advice. If the member's medical condition seems less serious, the provider may elect to direct the member to receive care at one of the following locations:

- The PCP's office
- Another participating provider's office (written referral may be required)
- An urgent care center

Copayments are generally required for emergency services; however, the copayment is waived if the member is admitted to the hospital.

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Endocrinology

Radiological services covered under a member's medical benefit and performed in the endocrinologist's office setting are limited to certain procedures.

All other radiological procedures must be performed by a CareFirst contracted radiology facility. See Procedure Code Exception Charts.

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Gastroenterology

Laboratory services covered under a member's medical benefit and performed in the gastroenterologist's office setting are limited to certain procedures. All other laboratory services must be performed by LabCorp. See Procedure Code Exception Charts.

Hearing Aid Devices

In general, CareFirst's payment for hearing aids is limited to the Hearing Aid Allowed Benefit, or, the dollar amount CareFirst allows for the particular hearing device in effect on the date that the service is rendered. Due to the wide variation in hearing aid device technology, the Hearing Aid Allowed Benefit amount does not always cover the full cost of the hearing aid device(s) the Member selects. If the Member selects a hearing aid device(s) where the full cost is not covered by the Hearing Aid Allowed Benefit, the Member will be fully responsible for paying the remaining balance for the hearing aid device(s) up to the provider's charge.

Hematology/Oncology

Intravenous therapy or chemotherapy services administered in a provider's office will be reimbursed directly to the provider. The PCP may issue a long standing referral. Laboratory services covered under a member's medical benefit and performed in the hematologist's/oncologist's office setting are limited to certain procedures. All other laboratory services must be performed by LabCorp. See Procedure Code Exception Charts.

Hemodialysis

Authorization from Care Management is required for inpatient, outpatient or home hemodialysis services, unless the services are performed in a contracted, freestanding facility. If hemodialysis services are rendered in a contracted, freestanding facility, the attending provider is responsible for a written prescription or order.
Benefit Exclusions and Limitations—BlueChoice Only

Home Health Services
Care Management coordinates directly with the provider and/or hospital discharge planning personnel and will authorize and initiate requests for home health services when appropriate.

Home Infusion Therapy
CareFirst has contracted with designated intravenous therapy providers. These services require authorization from Care Management.

Hospice Care
Members with life expectancies of six months or less may be eligible for hospice care. Prior authorization should be requested via CareFirst Direct.

House Calls
When a provider determines that a house call is necessary for treating a CareFirst member, a copayment is required from the member. Based on provider’s specialty, collect the appropriate copayment listed on the membership ID card. A referral from the PCP is required for a specialist to visit the home for CareFirst BlueChoice members.

Laboratory Services
LabCorp and Quest Diagnostics are the national laboratories for CareFirst and are a cost-effective choice when referring patients. Members can easily schedule appointments online through LabCorp and Quest Diagnostics websites.

LabCorp (Available for HMO and PPO members)
LabCorp is the only network national lab that BlueChoice (HMO) members can use. Please do not refer HMO members to Quest Diagnostics.

The required laboratory requisition forms must accompany lab specimens collected in the provider’s office. The requisition form must include the membership ID number exactly as it appears on the ID card. Also, indicate the member’s insurance company as CareFirst BlueChoice. Members may also be referred to designated drawing sites with the required laboratory requisition forms, which can be obtained by contacting LabCorp.

Providers who perform laboratory services in their office should maintain the appropriate level of Clinical Laboratory Improvement Amendment (CLIA) certification.

Note: Specialists in CareFirst BlueCross BlueShield networks are required to use LabCorp for outpatient laboratory services that are not included in the appropriate Procedure Code Exception Charts.

Nephrology
Laboratory services covered under a member’s medical benefit and performed in the nephrologist’s office setting are limited to certain procedures. All other laboratory services must be performed by LabCorp.

Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply. See Procedure Code Exception Charts.

Nutritional Services
Professional Nutritional Counseling is defined as individualized advice and guidance given to people at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, and about options and methods for improving nutritional status. This counseling is provided by a registered licensed dietitian or other health professional functioning within their legal scope of practice.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the person’s overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Refer to Medical Policy Operating Procedure 2.01.050A for additional information on Professional Nutritional Counseling and Medical Nutritional Therapy (CPT® 97802 – 97804).

For additional information on preventive medicine counseling services to address issues such as diet and exercise, refer to the the CareFirst Preventive Services Guidelines.
Obstetrics & Gynecology

Obstetrical care may be provided by a participating OB/GYN without a written referral from a PCP. The hospital must contact Care Management the day of delivery or the next business day to obtain the necessary authorization for the facility.

Note: Any admission for pre-term labor or other obstetrical complications requires an additional authorization. If the newborn requires additional services or an extended stay due to prematurity or any complications of birth, a separate authorization will be required.

Reporting for Obstetrical Services

For additional information about reporting maternity services, visit our Medical Policy Reference Manual and search “Global Maternity Care” (4.01.06A).

Obstetrical Radiology/Laboratory Services

Obstetrical ultrasounds covered by the member’s medical benefit and performed in the OB/GYN’s office setting are limited to:

- One baseline fetal ultrasound for diagnosis codes V22-V22.2 or 650 and,
- Any medically necessary diagnostic fetal ultrasound

Other radiology, laboratory and other noted services covered under the member’s medical benefit and performed in the OB/GYN’s office setting are limited to certain procedures. See Procedure Code Exception Charts.

Amniocentesis/CVS

An authorization from CareFirst is required if the amniocentesis is performed in a hospital setting. If the amniocentesis is performed in the office setting, Care Management authorization is not necessary. All specimens must be submitted to LabCorp for processing for BlueChoice members. Some exceptions may apply on the Eastern Shore.

Chorionic Villus Sampling (CVS) procedures require an authorization from Care Management, whether performed in a hospital or in your office. All specimens must be submitted to LabCorp for processing, unless procedure is performed in a hospital setting. Some exceptions may apply in Western Maryland or a CareFirst BlueChoice contracted radiology facility.

Genetic Testing/Counseling (excludes Amniocentesis)

Genetic testing and counseling performed in a specialist’s office requires a written referral from the PCP, unless the specialist is an OB/GYN. Genetic testing and counseling performed in a setting other than a participating provider’s office will require an authorization from Care Management. All lab work must go to LabCorp for processing. Some exceptions may apply on the Eastern Shore. Please contact CareFirst on Call or visit CareFirst Direct to verify a member’s level of coverage.

Maternal and Child Home Assessment

A postpartum home visit is available for a maternal and child home assessment by a home health nurse. The home visit may be performed as follows:

- In less than 48 hours following an uncomplicated vaginal delivery
- In less than 96 hours following an uncomplicated C-Section
- Upon provider request

CareFirst must authorize the postpartum home visit. The postpartum home visit will consist of a complete assessment of the mother and baby. Tests for phenylketonuria (PKU) or bilirubin levels are also included if ordered by the provider. If more visits are medically indicated, an additional authorization from Care Management will be required.

Infertility Services

Tests that relate to establishing the diagnosis of infertility (i.e., semen analysis, endometrial biopsy, post-coital and hysterosalpingogram (HSG)) do not require an authorization from Care Management when performed in an office setting. All specimens must go to LabCorp for processing. Always schedule these tests with LabCorp prior to rendering these services.

Treatment of infertility, including artificial insemination and In-Vitro Fertilization (IVF), requires authorization from CareFirst in all settings. Treatment of infertility when performed in a specialist’s office requires a written referral from the PCP. Some
members may not have infertility benefits (for either diagnosis or treatment) as part of their health coverage. Contact CareFirst on Call or visit CareFirst Direct to verify a member’s coverage.

Prior authorization may be required for all infertility/IVF prescription medications. CVS/Caremark administers this process and creates a central point of contact for providers, members and pharmacies. To begin the authorization process, call 855-582-2038.

Laboratory, radiology and other noted services covered under a member’s medical benefit and performed in the office setting are limited to certain procedures. See Procedure Code Exception Charts.

All other laboratory and radiology services must be performed by LabCorp.

**Gynecologic Services**
CareFirst BlueChoice members may self-refer to participating OB/GYNs for services performed in an office setting. A written referral is not required from the PCP. If a nurse practitioner is a part of the OB/GYN practice, a written referral is not required if the diagnosis and procedure is related to OB/GYN services. Care Management authorization may be required for gynecologic services performed outside the office setting.

**Mammograms**
All mammograms must be performed in a CareFirst BlueChoice contracted, freestanding radiological center. Some exceptions apply on the Eastern Shore. The PCP or attending provider is responsible for written prescription/order for the radiological center. Refer to the Provider Directory for facilities.

**Contraceptive Services**

**IUD/Diaphragm**
Member benefits generally cover provider services in connection with the insertion of an IUD or fitting of a diaphragm. The IUD or diaphragm itself might not be a covered benefit for some members, and the member may be financially responsible for this component of the service.

If covered, the IUD charges can be submitted to CareFirst BlueChoice. The diaphragm can be obtained by the member at a participating pharmacy with a prescription from the provider. The diaphragm is a covered benefit only for members with prescription drug benefits whose benefits do not include contraceptive limitations.

**Depo-Provera®**
Depo-Provera® is generally covered for the prevention of pregnancy when administered in the provider’s office. Depo-Provera® can be obtained at a participating pharmacy with a prescription from the provider. DepoProvera® is a covered benefit only for members with prescription drug benefits, whose benefits do not include contraceptive limitations. Refer to the following chart for a quick reference regarding OB/GYN services.
## Benefit Exclusions and Limitations—BlueChoice Only

### OB/GYN Services Quick Reference Guide

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<th>Comments</th>
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<td>Yes, if performed in a hospital setting. No, if performed in office or freestanding radiology center. Must verify member’s benefits.</td>
<td>Not covered by all plans, must verify the member’s benefits.</td>
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<tr>
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<td>Yes, if performed in a hospital setting.</td>
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<tr>
<td>Chorionic Villus Sampling (CVS)</td>
<td>Yes, in any setting.</td>
<td>Lab work must go to LabCorp*, unless performed in a hospital setting.</td>
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<td>Depo-Provera®</td>
<td>No.</td>
<td>Must be administered in the physician's office. Medication is available for eligible members through a prescription drug benefit.</td>
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<tr>
<td>Genetic Testing</td>
<td>Yes, if performed in a hospital setting. No, if performed in the office.</td>
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<tr>
<td>Gynecologic Surgical Procedures</td>
<td>Yes, if performed in a hospital setting.</td>
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<tr>
<td>Hysterosalpingogram (HSG)</td>
<td>No.</td>
<td>Must be performed at a contracted free-standing radiology center.</td>
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<tr>
<td>Infertility Testing</td>
<td>Yes, if performed in a hospital setting.</td>
<td>Must verify the member’s benefits.</td>
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<tr>
<td>IUD/Diaphragm Insertion</td>
<td>No.</td>
<td>Cost of IUD/diaphragm may be member’s financial obligation. Diaphragm is available for eligible members through a prescription drug benefit.</td>
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<tr>
<td>Maternity Services</td>
<td>Yes, if performed in a hospital setting.</td>
<td>Must call to authorize and to notify of actual admission date.</td>
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<tr>
<td>Mammograms</td>
<td>No.</td>
<td>Must be performed at a contracted free-standing radiology** center.</td>
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*Some exceptions apply in western Maryland.
**Some exceptions apply on the Eastern Shore.
Benefit Exclusions and Limitations—BlueChoice Only

**Oral Surgery**

Radiological services covered under a member's medical benefit and performed in the oral surgeon’s office setting are limited to certain procedures. See Procedure Code Exception Charts. All other radiology services must be performed by a CareFirst BlueChoice contracted radiology facility.

**Orthopedics**

*(Includes hand and pediatric orthopedics)*

Radiological services covered under a member’s medical benefit and performed in the orthopedist’s office setting are limited to certain procedures. See Procedure Code Exception Charts. All other radiology services must be performed by a CareFirst BlueChoice contracted radiology facility.

**Physical, Occupational and Speech Therapy**

A PCP, neurologist, neurosurgeon, orthopedist or physiatrist must issue a written referral to a participating therapist for up to three visits for rehabilitative physical therapy (PT), occupational therapy (OT) or speech therapy (ST). After the first visit, the therapist should submit their findings from the evaluation and a treatment plan to the referring provider.

*Note: A written referral is not required for members with the Open Access feature included in their BlueChoice coverage.*

- Coverage for rehabilitative PT, OT and/or ST services is provided to enable a member to regain a physical, speech or daily living skill lost as a result of injury or disease
- Coverage for habilitative PT, OT and/or ST services is provided to enable a member to develop or gain a physical, speech or daily living skill that would not have developed without therapy
- Effective 1/1/2018: Habilitative Services should be reported using the appropriate Category I CPT® Code appended with the CPT® modifier 96 (habilitative services).
- When applicable, habilitative PT, OT and ST may require OPAP authorization. Contact CareFirst on Call or visit CareFirst Direct to identify members that require authorization for habilitative services

**Podiatry**

The PCP must provide a written referral to the specialist for podiatric services. Benefits will only be provided for routine foot care services when it is determined that medical attention is needed because of a medical condition affecting the feet, such as diabetes. Radiological services covered under a member’s benefit and performed in the podiatrist’s office setting are limited to certain procedures. See Procedure Code Exception Charts. All other radiology services must be performed by a CareFirst BlueChoice contracted radiology facility.

*Note: A written referral is not required for members with the Open Access feature included in their BlueChoice coverage.*

**Prescription Drugs**

CVS Caremark works with CareFirst to administer prescription drug benefits. The company maintains member drug records, processes paperwork and pays claims related to pharmaceutical needs. Call Caremark at 888-877-0518 if you cannot find a particular drug or have drug-related questions.

CareFirst's online formulary is updated regularly. Drugs are placed on the formulary based on their quality, effectiveness, safety and cost. To access the online formulary, visit www.carefirst.com/rx and click on Drug Search.

Members can use the formulary to determine out-of-pocket expenses for medication. The formulary is divided into three tiers, or levels, of drugs. The tier that a prescription drug is on determines the level of copay:

- Tier 1 (lowest copay) – Generic drugs
- Tier 2 (higher copay) – Preferred brand name drugs
Benefit Exclusions and Limitations—BlueChoice Only

- Tier 3 (highest copay) – Non-preferred brand name drugs

Some drugs require prior authorization under the CareFirst BlueChoice Prescription Program. Call Caremark at 888-877-0518 to obtain an authorization form or download the form from our online drug formulary.

Rheumatology

Radiological services covered under a member's medical benefit and performed in the rheumatologist's office setting are limited to certain procedures. See Procedure Code Exception Charts. All other radiological procedures must be performed by a CareFirst BlueChoice contracted radiology facility.

Routine Office Visits

Annual health examinations, well-child visits and other services for the prevention and detection of disease are covered benefits. CareFirst BlueChoice promotes preventive health services and has adopted preventive health recommendations applicable to our members. Examinations solely for the purposes of employment, insurance coverage, school entry and sports or camp admission are generally not covered and should be charged in full to the member. Immunizations required solely for foreign travel are generally not covered.

Radiology Services

Outpatient radiology procedures rendered at a participating freestanding radiology facility do not require a written referral from the PCP. Providers must provide the member with a prescription or order.

Rheumatology

Radiological services covered under a member's medical benefit and performed in the pulmonologist's office setting are limited to certain procedures. See Procedure Code Exception Charts. All other laboratory services should be performed by LabCorp.

Pulmonology

Laboratory services covered under a member’s medical benefit and performed in the pulmonologist's office setting are limited to certain procedures. See Procedure Code Exception Charts. All other laboratory services should be performed by LabCorp.

Radiological services and other noted codes covered under a member's medical benefit and performed in the PCP's or specialist's office are limited to the following procedures. All other radiology services must be performed by CareFirst BlueChoice contracted radiology facility.

Routine Office Visits

It is the expectation of CareFirst and CareFirst BlueChoice that all providers who perform laboratory or imaging tests, at any site, obtain and/or maintain the appropriate federal, state, and local licenses and certifications; training; quality controls; and safety standards pertinent to the tests performed.

Radiology Services

Multiple medically necessary CT Scans, MRIs and MRAs performed by professional providers at a participating outpatient facility (free-standing or hospital-based) will be reimbursed at 100 percent of the allowed amount, minus applicable copayments, deductibles and/or coinsurance paid by the member.

Multiple CT Scans, MRIs and MRAs

This applies to multiple CT Scans, MRIs and MRAs rendered to the same patient on the same date of service.

Routine Office Visits

Urgent Care Services

A member may require services for urgent, but nonemergency, conditions. Direct the member to an urgent care center; a written referral is not required.

Transplants

Transplants and related services must be coordinated and authorized by Care Management, depending on the member's contract. Coverage for related medications may be available under either the prescription drug program or medical benefits.

Urology

Radiology, laboratory services and other noted codes covered under a member's medical benefit and performed in the urologist's office setting are limited to certain procedures. See Procedure Code Exception Charts. All other radiology and laboratory services must be performed by a CareFirst BlueChoice contracted radiology facility or LabCorp.

Vision Care

Medical

With CareFirst BlueChoice, a written referral from the member's PCP is required for ophthalmologic and
Benefit Exclusions and Limitations—BlueChoice Only

Optometric services related to medical diagnoses. Vision services covered under the member’s medical benefit and performed in the ophthalmologist’s or optometrist’s office are limited to the following procedures.

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 sued to bill for these services. See Procedure Code Exception Charts.

Note: A written referral is not required for members with the Open Access feature included in their coverage.

Wellness Discount Program
Blue365 is a program that offers health and wellness discounts from top national and local retailers on fitness gear, gym memberships, family activities, healthy eating options and much more. This program is not a part of the member’s benefits.

Members can visit www.carefirst.com/wellnessdiscounts for more information.

Routine Vision and Eyewear
Davis Vision is our contracted vendor for routine vision care. Routine vision services, including refractions and eyewear, performed by Davis Vision contracted providers do not require a written referral from the PCP.

Some contracts may include a standalone 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.
# Procedure Code Exception Charts

CareFirst BlueChoice, Inc. (CareFirst BlueChoice) only

The procedure codes listed below show the effective dates for codes in 17 specialty areas. Certain services covered under the member’s medical benefit and performed in a specialist’s office setting are limited to the codes listed. Please refer to your current CPT® or HCPCS code book for specific code descriptions. All other procedures must be performed by a CareFirst BlueChoice contracted facility. Be sure to verify member eligibility and coverage prior to rendering services, as benefit limitations and medical policy requirements still apply.

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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 trademarks of the Blue Cross and Blue Shield Association.

PM0012-1E (5/18)
## Procedure Code Exception Charts

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* Limited to obstetrical services such as normal delivery, abortion, ectopic pregnancy, miscarriage and infertility.

** Limited to infertility and medical services

*** Limited to obstetrical services such as normal delivery, abortion, ectopic pregnancy, miscarriage, infertility and medical services

**** Limited to infertility only

***** Limited to obstetrical services such as normal delivery, abortion, ectopic pregnancy and marriage

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**Special Note:** *For ages 21 years old or younger*
## Procedure Code Exception Charts

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Membership Information

This section provides Membership 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, 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.

Membership

Members’ Rights and Responsibilities

Members have a right to:

- Be treated with respect and recognition of their dignity and right to privacy
- Receive information about the Health Plan, its services, its practitioners and providers, and members’ rights and responsibilities
- Participate with practitioners in making decisions regarding their health care
- Discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Make recommendations regarding the organization’s members’ rights and responsibilities policies
- Voice complaints or appeals about the Health Plan or the care provided
- Communicate with health care providers in confidence and to have the confidentiality of their individually identifiable health care information protected. Members also have the right to review and copy their own medical records and request amendments to their records

Members have a responsibility to:

- Provide, to the extent possible, information that the Health Plan and its practitioners and providers need in order to care for them
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Follow the plans and instructions for care that they have agreed on with their practitioners
Membership Information

- Pay member copayments or coinsurance at the time of service
- Be on time for appointments and to notify practitioners/providers when an appointment must be canceled
- Become knowledgeable about coverage and health plan options, including covered benefits, limitations and exclusions, rules regarding use of network providers, coverage and referral rules, appropriate processes to secure additional information, and the process to appeal coverage decisions
- Show respect for other patients and health workers
- Report wrongdoing and fraud to appropriate resources or legal authorities

BlueCard®

Out-of-Area Program – BlueCard®
The BlueCard® Program allows members to seek care from health care providers participating in any Blues Plan across the country and abroad. The program allows participating providers to submit claims for out-of-area members to their local Blues Plan.

BlueCard® Member Identification
To identify Blue Card® members, look on the member’s identification card for an empty suitcase, or for PPO members, a “PPO” in a suitcase. BlueCard® members also have alpha prefixes on their membership number so that the processing Plan can identify the Plan to which the member belongs.

If you see a member’s ID card without an alpha prefix, call the member’s home Plan. The phone number will be on the back of the ID card.

How the BlueCard® Program Works
If you participate with CareFirst only and the member has a contract with another Blues Plan, submit claims to CareFirst.

CareFirst will be your contact for claims submission, claims payments, adjustments, services and inquiries. Call 800-676-BLUE or log on to CareFirst Direct for eligibility information on out-of-area members.

BlueCard® Program Claims Submission
Submit BlueCard® claims and correspondence to:

- BlueCard® Claims
  Mail Administrator
  P.O. Box 14116
  Lexington, KY 40512-4116
- BlueCard® Correspondence
  Mail Administrator
  P.O. Box 14114
  Lexington, KY 40512-4114

BlueCard® Reimbursement
Once CareFirst receives the claim, it electronically routes the claim to the member’s Blue Cross and Blue Shield Home Plan. After the member’s home Plan processes the claim and approves the payment, you will receive payment from CareFirst.

Payment may not be sought from the member for any balances remaining after CareFirst’s payment, unless it is to satisfy the member’s deductible, copayment or coinsurance, or for services not covered under the member’s Plan.

In some cases, a member’s Plan suspends a claim because medical review or additional information is necessary. When resolution of claim suspension requires additional information from you, CareFirst may ask you for information or give the member’s Plan permission to contact you directly.

BlueCard® and Health Care Exchanges
CareFirst members enrolled through the Exchanges will still have access to the BlueCard program.

The PPO Basic Network is a combination of BlueCard PPO networks and new Exchange networks created by certain plans. The PPO Basic Network does not affect local providers since the PPO Basic network includes all doctors and facilities that are included in the entire regional provider network.

ID cards for public Exchange members with access to the PPO Basic network will include the new “PPO B” suitcase logo, below.

![PPO B logo]

The standard BlueCard PPO network is used in all but the following states where the Exchange network (PPO Basic) will be used for 2016: Alaska, Arizona,
Florida, Kansas, Kentucky, Minnesota, Missouri, Ohio, Washington and Wyoming.

Contiguous Areas
In some cases, your office or facility may be located in an area where two Blue Cross and Blue Shield Plans share a county. Outlined below are processes for filing claims under these circumstances:

- If you provide care to a member from a county bordering CareFirst's service area (MD, DC, and Northern VA), you do not contract with that member's Blues Plan, submit the claim to CareFirst
- If you provide care to a member of a Blues' Plan in a county bordering CareFirst's service area and you contract with both CareFirst and the Plan in the bordering area, submit the claim to the Plan in the bordering area

Exclusions
The Program excludes Federal Employee Health Benefit Plan (FEHBP) member claims and routine vision exam, vision correction material, dental and prescription drug coverage.

Ancillary Claim Filing Guidelines
All Blues plans are mandated by the Blue Cross and Blue Shield Association (BCBSA) to use the following guidelines when submitting ancillary claims for Independent Clinical Lab, Durable/Home Medical Equipment and Supplies (DME), and Specialty Pharmacy providers. For specific information and a chart of claims filing examples, visit [www.carefirst.com/ancillaryclaims](http://www.carefirst.com/ancillaryclaims).

Utilization Review
Out-of-area members are responsible for obtaining pre-authorization for their services from their Blue Cross and Blue Shield Plan. Providers may choose to contact the member's Plan on behalf of the member. If you choose to do so, refer to the phone number on the back of the member’s ID card.

NASCO
The National Account Service Company (NASCO) is exclusively available through Blue Cross Blue Shield (BCBS) Plans nationwide. NASCO offers solutions for administering traditional, point-of-service, preferred provider, HMO, dental, vision, prescription drug and other health services to national, regional and local employers. It allows national account customers to meet their market requirements for processing and administering health care benefits consistently for employees at numerous locations.

NASCO Member Identification
- Member identification cards issued by CareFirst have the CareFirst logo and “National Accounts” on the card
- The membership number has a unique three character alpha/numeric prefix, RAS

NASCO Claim Submission
- Submit claims following the instructions on the reverse side of the member's identification card
- Submit the alpha/numeric prefix and the CareFirst provider number on all claims to help expedite processing
- Medical policy and claims processing guidelines may differ from CareFirst “local” business
- Many accounts follow Blue Cross and Blue Shield Association (BCBSA) “national” medical policy, which may influence claims processing edits
- If no BCBSA medical policy exists, may default to “local” policy
- Claims processing edits and rules are approved by all Plans in the NASCO network
Membership Identification Card Quick Reference Guide

Membership identification cards contain important membership and coverage information that help you correctly route your claims. Be sure to verify eligibility using CareFirst Direct or CareFirst on Call prior to rendering care.

Front of Card

The front of the member ID card contains information about the member, the primary care provider (PCP), copayments/coinsurance and some member benefits.

1. Member Name
2. Member ID Number
3. Group Number
4. Product Name
5. Primary Care Provider's Name
6. Copayments/Coinsurance:
   - D – Deductible
   - CD – Combined Medical and Prescription Drug Deductible
   - P – PCP
   - S – Specialist
   - OV – Office Visit
   - CC – Convenience Care
   - UC – Urgent Care
   - ER – Emergency Room
7. Prescription Drug Program:
   - RX – Formulary 1
   - RX2 – Formulary 2
8. Dental or vision coverage, if applicable
   - DT – Dental Traditional
   - DP – Dental Preferred (PPO)
   - DH – HMO Dental
   - PD – Pediatric Dental
   - AV – Adult Vision
   - PV – Pediatric Vision
   - VC – BlueVision
   - VU – BlueVision Plus
9. Type of out-of-area coverage

Back of Card

The back of the member ID card includes medical emergency assistance and mental health/substance abuse telephone numbers, as well as instructions and an address for filing claims and sending correspondence.

CareFirst BlueChoice BlueShield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

www.carefirst.com
Customer Service: 800-313-2223
Provider Service: 800-313-2223
Pharmacy: 800-241-3371
Vision: 800-763-5602
24hr FirstHelp (Nurse): 800-535-9700
Mental Health/Substance Abuse: 800-783-5602
Prior Auth/Case Management: 800-773-5602
Locate Out of Area Providers: 800-810-2583

CareFirst BlueChoice, Inc. and CareFirst BlueChoice BlueShield are both independent licensees of the Blue Cross and Blue Shield Association.

CUT0491-1E (5/18)
Member ID cards may include one of several logos identifying the type of coverage the member has and/or indicating the provider's reimbursement level.

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<th>Products</th>
<th>Prefixes</th>
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| **Health Maintenance Organization (HMO)** | • BlueChoice HMO  
• BlueChoice HMO Open Access | XIK, XIR, XIB, QXG, QXA, XIE, JHZ, XWZ, XIG, QXK, XIC, XIH |
| **Point of Service (POS)** | • BlueChoice Opt-Out  
• BlueChoice Opt-Out Plus Open Access*  
• BlueChoice Opt-Out Open Access*  
• BlueChoice Advantage  
• BlueChoice Plus  
*Open Access—no referral needed if the provider is in the BlueChoice Network | XIK, XIR, XIB, QXG, QXA, XIE, JHZ, XWZ, XIG, QXK, XIC, XIH |
| **Preferred Provider Organization (PPO)** | • BluePreferred PPO | XIL, XWV, JHJ, XI, JHI, XIQ, QXM, XIY, XIU |
| **Federal Employee Program (FEP)** | • FEP Basic Option  
• FEP Standard Option | R |
| **HealthyBlue** | • HealthyBlue Advantage  
• HealthyBlue 2.0 Open Access  
• HealthyBlue Plus Open Access  
• HealthyBlue PPO  
• HealthyBlue HMO | JHG, QXF, JHA, JHC, QXB, QXE, XIF, JHD, QXD, JHH, QXI, QXL, QXU, QXR, QXS, QXT, QXC, QXH |
| **Maryland Point of Service (MPOS)** | • Maryland Point of Service | Varies |
| **National Account Service Company (NASCO)** | • All products, except FEP | Unique |
| **MedPlus** | • Medigap Plan A, B, F, G, L, M, N  
• Medigap Plan High Ded F | XWC |

### Out-of-Area Coverage (BlueCard®)

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<td>A suitcase icon with “PPO” inside</td>
<td><img src="image" alt="PPO Icon" /></td>
<td>• Member has PPO or EPO benefits available for medical services received inside or outside of the U.S.</td>
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