CareFirst

Family of health care plans

DENTAL

PROVIDER MANUAL

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Family of health care plans

Chapter 3: Provider Network Requirements

Administrative Functions

Credentialing

Dental

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) contract with independently practicing licensed healthcare practitioners who provide services covered under the member's plan's dental benefits. The practitioner must be licensed in the state where the member receives the service and must be within the CareFirst service area, which includes Maryland, Washington, D.C. and Northern Virginia

Eligible dental providers

- General Dentists
- Endodontists
- Oral Surgeons (Medical)
- Oral Surgeons (Dental)
- Orthodontists
- Pediatric Dentists
- Periodontists
- Prosthodontists

Dental provider credentialing

Providers wishing to participate in CareFirst's provider networks are required to submit a completed credentialing application and copies of credentials.

How to apply

CareFirst encourages the use of the Council for Affordable Quality Healthcare (CAQH) ProView® application. CAQH ProView is an online credentialing application that streamlines data collection by using a standard form. New practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website.

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, access and complete our CAQH Data Sheet and send to dentalcontracting@carefirst.com. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

The practitioner's credentialing 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 and Controlled Dangerous Substance registration, if and as applicable, for each state where the practitioner practices
- 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, if applicable

- 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 ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use
- Current malpractice insurance coverage certification which must include the limits of coverage of $1M/$3M, the expiration date and the name of the provider covered under the policy

If all credentialing criteria are met, the CareFirst Dental Director refers the practitioner to the Dental Advisory Committee (DAC) for a recommendation to approve the application.

If the credentialing criteria is not met, the Dental Director may deny the application or defer to the DAC for their recommendation. The Dental Director may request additional information from the practitioner. Practitioners will be notified in writing upon approval or denial. If the application is denied, the practitioner is afforded the opportunity to submit a written appeal within 30 days. The decision based on the appeal is final.

If the practitioner is part of a group practice, the practice will be notified of the termination of that provider. Since all members of a group practice must be approved for participation, the practice may be terminated if the terminated practitioner remains with the group practice.

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

To ensure 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 obtain the status of the credentialing process. Requests can be made by calling 443-921-0676.

Locum Tenens

A locum tenens practitioner is a healthcare practitioner who is practicing temporarily to substitute for another practitioner. When a locum tenens practitioner is requesting participation with CareFirst, they must apply and be accepted for participation. Refer to the “How to Apply” section for providers listed above.

A locum tenens practitioner can participate in the CareFirst provider networks for six months or less.

Recredentialing

After initial credentialing and contracting, CareFirst recredentials its practitioners every three years. If you keep your CAQH ProView profile up-to-date, you won’t need to do anything for recredentialing.

Ongoing Monitoring of Sanctions

Between recredentialing cycles, CareFirst monitors state licensing boards and other sources for sanctions and disciplinary actions. Reports are reviewed by the CareFirst Dental Director who may request further review by the DAC. The Dental Director may request additional information from the practitioner.

For more information on our credentialing process, visit carefirst.com/dentalcredentialing.

Adding a New Practitioner to Your Existing Group Practice

Practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website. If the CAQH ProView application is already complete, make sure it includes the new practice affiliation information. Once complete, go to www.provider.carefirst.com, hover

over *Join Our Networks*, and under *Dental*, click on *How to Apply.* Access, complete and fax the CAQH Dental Provider Datasheet and a completed Billing Authorization Form to CareFirst at 410-720-5080 or email it to dentalcontracting@carefirst.com. CareFirst will add you to our CAQH ProView roster.

CareFirst will receive your updated information electronically and begin the process to add your new practitioner. You will receive written notification of the practitioner's acceptance, provider number and effective date of participation.

Access and Availability

CareFirst's services are assessed against network availability and network accessibility standards of care. This assessment determines how CareFirst maintains an adequate network of practitioners to provide appropriate access to routine and specialty dental care to meet the needs and preferences of members.

Appointment Wait Times – Network Accessibility Standards

Members should be able to schedule an appointment for the care they need within the specified time frames.

Network accessibility standards	
Appointment type	**Time frame**
Urgent Dental Care	3 calendar days
Routine Dental Services	45 calendar days
Non-Urgent Specialty Care	60 calendar days

Provider Data Accuracy

Accurate provider data is essential to doing business with CareFirst. The information we have for you is displayed in our print and online provider directories. This enables our members, your patients, to find you, determine if you participate with their plan and are accepting new patients, and contact you to schedule an appointment at their preferred office location. If the information we have for you is not correct, your patients may not be able to find you and may consider other providers instead.

CareFirst conducts regular audits of the directory to ensure the accuracy of provider information. We are also subject to audits by regulatory agencies. If we are unable to confirm the accuracy of your information in our directory, you may have to pay an administrative fee.

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

If you are not yet registered with CAQH ProView, learn more and register at proview.caqh.org. For details on CAQH ProView, view their Directory Reference Guide, Training Materials and Frequently Asked Questions at proview.caqh.org.

Role of the PGD – BlueChoice and The Dental Network DHMO

General Dentists are recognized as primary care providers (PCPs), also known as Primary General Dentists (PGDs).

In a managed care program, a strong patient-PCP relationship is the best way to maintain consistent quality dental care. Your role as the PGD is a dentist who coordinates all aspects of a member's dental care.

Each CareFirst BlueChoice/The Dental Network (TDN) member selects a PGD upon enrollment and receives an individual member ID card with the name of the PGD on the card.

If a member chooses to change PGDs, the member must call the selected provider's office to confirm they still participate with CareFirst BlueChoice/TDN and that their new PGD is accepting new patients. The member then notifies member services of this change. Notification can also be done online at carefirst.com/myaccount.

Requests received after the first of the month will be effective on the first day of the next month following the request.

If you no longer wish to be a CareFirst BlueChoice/TDN member's PGD, you must verify you are the patient's current PGD and notify provider services in writing prior to notifying the patient. Additionally, you must give the patient 30 days' notice prior to their release. A member services representative will help the member select a new PGD.

Referring to a Dental Specialist

Primary General Dentist Responsibilities (DHMO)

- When the clinical examination reveals that a DHMO member has treatment needs that require a specialist, select an in-network specialist from the Find a Doctor specialist list located on carefirst.com. If a participating specialist is not available in the area, the PGD must contact the DHMO Provider Service Department to obtain authorization to refer to a non-participating specialist. An authorization will only be provided if the member does not have access to an appropriate participating specialist within a 50-mile radius.
- Verify that the procedure is a covered benefit according to the member's plan. Non-covered procedures may be referred to a specialist; however, the member will be responsible for all fees incurred.
- A written referral with a preliminary clinical diagnosis and appropriate radiographs should be sent to the specialist.
- The PGD is responsible for instructing and preparing the member for the appointment with the specialist, including taking the referral and radiographs to the specialist.

Specialist Responsibilities (DHMO)

- Provide treatment for the member as indicated on the referral form
- Collect applicable copayment and submit claim(s) to the payor ID listed on the Dental Claims and Service Reference Guide
- If the specialist has questions concerning the benefit coverage for a non-routine case or treatment, please contact the DHMO Provider Service Department.

Availability

If a PGD needs to be absent from the office for more than 10 days, they are required to contact us to obtain approval of providing acceptable coverage for our members. The dentist will be responsible for the cost of care rendered to their assigned members during his/her absence.

A PGD is required to have a system in place to accommodate emergency appointments and after hour emergencies. Emergency appointments should be granted within 24 hours during normal workdays for members assigned to the practice. If the assigned member is refused or unable to contact the dentist, covering dentist, or office staff member, and must be seen elsewhere, the PGD office will be held accountable for out-of-network fees up to $75.

Specialty Referral Criteria (DHMO)

To be considered for specialty care coverage, the following criteria must be met:

- The member must be eligible in the PGD office when services are rendered
- The referral must be made by the PGD to the appropriate participating specialist after examining the patient
- A participating network specialist must provide the treatment.

Back-up Coverage

If a PGD is not available to provide service to patients, they must arrange effective coverage through another practitioner who is a PGD in the CareFirst BlueChoice/TDN network. The covering practitioner must indicate on the paper claim form that they are covering for a particular provider, and include the doctor's name, when submitting the claim to CareFirst BlueChoice/TDN.

After Hours Care

All PGDs or their covering dentists must provide telephone access 24 hours a day, seven days a week so 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/TDN members and should not be used by CareFirst BlueChoice/TDN participating providers.

Open/Closed Panel

As stated in the Dental Provider Participation Agreement (Participation Agreement), you may close your panel to new members with at least 60 days prior written notice to provider information and credentialing.

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 faxed on your letterhead to 410-720-5080 or emailed to dentalcontracting@carefirst.com. Written notifications should be mailed to:

CareFirst BlueCross BlueShield
Attn: Dental Networks Management
Mailstop: RRS-130
10455 Mill Run Cir.
Owings Mills, MD 21117

Changes in Provider Information

Providers who need to change their file information may submit a Dental Change in Provider Information Form, found in the Resources section of www.carefirst.com/providerforms > Dental. This form is also available on CareFirst Direct, our online provider portal, post-login. Any change to a provider's file must be received in writing.

Requests for termination are made effective 90 days from the date of receipt of the written request. Providers are expected to continue to provide services for eligible members until the effective date of the termination. Written notification should be mailed to:

CareFirst BlueCross BlueShield
Dental Provider Networks and Credentialing
Mailstop RRS-130
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-720-5080
Email: dentalcontracting@carefirst.com

Provider files remain active until we are notified of termination, retirement, loss of licensure or death.

If you are not yet registered with CAQH ProView, learn more and register at proview.caqh.org. For details on CAQH ProView, view their Directory Reference Guide, Training Materials and Frequently Asked Questions at proview.caqh.org.

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 dental 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 dental 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
- Closure of PCP panels (CareFirst BlueChoice/TDN 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 dental director seeks advice from the DAC and may appoint other practitioners as ad hoc members to the DAC to offer specialized expertise in the dental specialty 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 patient care, complaint summaries, peer/staff complaints and/or interviews with the practitioner.

The dental director or credentialing manager notifies the practitioner in writing of the reason(s) for the termination and/or sanction, their right to appeal the determination and the appeal process. The

practitioner may appeal the decision by submitting a written notice with relevant materials they consider pertinent to the decision within 30 days of being notified of the decision. The practitioner forfeits their right to appeal if they fail 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, CareFirst complies with the notification requirements.

Quality of Care Termination

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 CareFirst dental director, in consultation with CareFirst legal representative(s), will notify the practitioner of the decision in writing, provides a statement for the basis of the decision and informs the practitioner the decision is final and not subject to further consideration by CareFirst.

All Other Sanctions or Terminations

The CareFirst dental director or credentialing manager will reconsider appeals for all other sanctions or terminations based on new information provided by the practitioner. The dental director may seek recommendations from the DAC prior to making a final decision. The dental director notifies the practitioner of the decision in writing and informs the practitioner 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, except as otherwise provided in the relevant Participation Agreement. The provider may look to the member for payment of deductibles, copayments, and coinsurance or for services 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.

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 may be 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. Fee schedules for additional codes can also be obtained via CareFirst Direct.

American Dental Association Codes

CareFirst will add codes and plan allowances to your standard fee schedule following their release from the American Dental Association (ADA). Fee schedules for these changes can be obtained upon request from the provider or via CareFirst Direct.

Notice of Payment (NOP)

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. An NOP accompanies each check and enables providers to identify members and the claims processed for services rendered to those members. Your office can also elect to receive NOP and payments electronically through ERA and EFT enrollment with your clearinghouse. These can be accessed post-login on CareFirst Direct. Participating providers are reimbursed according to the CareFirst Allowed Benefit as listed on the Dental Fee Schedules.

Capitation (DHMO)

Capitation is paid to participating DHMO general dentists for each member who has selected his/her office as their primary dental site. The Capitation Report is mailed with the capitation check between the 15th and 20th of each month. Capitation may also be deposited electronically in your office's bank account through EFT connectivity with your clearinghouse. Capitation rates for each plan are listed on each Member Copayment Schedule.

Member Copayments (DHMO)

Member copayments are collected by the office at the time of service based on the copayment listed on the Member Copayment Schedule. Some procedures on the schedule list two copayment amounts. The amount on the left is due when the service is rendered by the PGD. The amount on the right is due when the service is rendered by a specialist to whom the member was referred. Copayment schedules are available on CareFirst Direct and can be accessed from the member's benefits and eligibility page.

GRID and GRID+

Participating CareFirst Traditional or PPO Dental providers will be listed in the National Dental GRID and Dental GRID+ directory. The program offers providers access to more patients who hold the Cross and Shield insurance. Participating providers submit claims directly to the member's plan. Providers will also be paid by the member's plan, according to the provider's current CareFirst reimbursement agreement.

Note: A GRID+ indicator means that the member has Traditional coverage benefits available for dental services received from a participating dentist inside the U.S., from a Blues plan. Likewise, a GRID indicator means that the member has PPO coverage benefits available for dental services received from a participating dentist inside the U.S., from a Blues plan. Your reimbursement amounts contracted with CareFirst remain unchanged when you provide dental services for Blues members who have GRID or GRID+ coverage. You will still receive support from your Provider Relations Specialists and from the dedicated customer service teams available to you.

Confidentiality

CareFirst is defined as a 'covered entity' under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA requires CareFirst to ensure the confidentiality, integrity, and availability of all electronic protected health information (PHI) that it creates, receives, maintains or transmits. This means that CareFirst must:

- Protect its customer data against any reasonably anticipated threats or hazards to the security or integrity of the data
- Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under HIPAA
- Ensure its workforce members comply with HIPAA

In 2009, the American Recovery and Reinvestment Act (ARRA) included the Health Information Technology for Economic and Clinical Health (HITECH) Act, which further modified HIPAA.

In 2013, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights issued a final rule that implemented a number of provisions of the HITECH Act to strengthen the privacy and security protections for health information established under HIPAA. HIPAA requires CareFirst to develop procedures to protect the confidentiality, integrity, and availability of electronically PHI. CareFirst has implemented all HIPAA-required security controls, including the ARRA-added requirements that became final with the publication of the HIPAA final rule, and has remained in compliance with these regulation since their original effective date.

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 clinical information that identifies a member 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 clinical management staff.
- The disposal of member information must be done in a way that protects the information from unauthorized disclosure.
- CareFirst releases minimum necessary PHI in accordance with the Privacy Rule as outlined in HIPAA and our notice of privacy practices (NPP).

Member Access to Clinical Records

It is the responsibility of the provider to give member access to their personal clinical record. The member must follow the provider's procedures for accessing dental information from the provider, so long as such procedures are compliant with applicable law. Members may access their dental records by contacting the dental provider's office. If the member contacts CareFirst for a copy of their personal dental records, we will refer the member back to the provider.

Provider Service HIPAA Validation

When calling into Provider Service, all providers will need to validate patient information. Please provide the patient's full name (first and last), along with **three** other pieces of information. This information includes:

- Patient's date of birth
- Patient's address
- Patient zip code
- Patient identification number
- Patient phone number

Treatment Setting

Providers are expected to implement confidentiality policies that address the disclosure of clinical information, patient access to clinical information and the storage/protection of clinical information.

Information Security Policy

CareFirst requires all providers to implement safeguards to protect the confidentiality, integrity and availability of CareFirst information and information assets, where applicable. These safeguards, as defined by the HIPAA Security Rule, require the establishment of policies, procedures and processes in order to comply with HIPAA standards.

CareFirst's confidential PHI, throughout its lifecycle, will be protected in a manner consistent with its sensitivity and criticality to CareFirst. This protection includes an appropriate level of physical and electronic security for the networks, facilities, equipment and software used to process, store, access and/or transmit information. Information used in conducting CareFirst business must have adequate controls to protect the information from accidental or deliberate unauthorized disclosure, damage, misuse or loss. Only those with a "need to know" may view PHI. PHI must be carefully handled and appropriately secured at all times.

Quality Improvement Measurement

Data for quality improvement measures is collected from administrative sources, such as claims and member clinical records.

CareFirst protects member information by requiring that clinical records are reviewed in non-public areas and do not include member-identifiable information.

Notice of Privacy Practices

CareFirst is committed to keeping the confidential information of members private. Under HIPAA, we are required to send our Notice of Privacy Practices (NPPs) 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. Providers must develop and provide their own NPPs to members.

Administrative Services Policy

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against members for covered services. This includes administrative services which are **inherent** in the delivery of covered services. Examples of such charges for administrative services include annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses and

malpractice coverage increases. Additional examples of such services may also include but not be limited to:

- 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 providers
- Completion of physical forms, medication forms, preop forms and/or CareFirst requested forms
- Other expenses related to the overall management of patients and compliance with government laws and regulations required of healthcare providers.

The provider may seek reimbursement from the member for providing specific healthcare services that are not covered under the member's health plan as well as fees for some administrative tasks and services which are **not inherent** in the delivery of covered services. Examples of such fees may include but not be limited to:

- Fees for completion of certain forms including school, work, camp and jury duty
- Disability forms not connected with the providing of covered services
- Charges for copies of clinical records when the records are being processed for the member directly

Fees or charges for administrative tasks and services, such as those listed above may not be assessed against all members in the form of a blanket annual administrative fee, but rather to only those members who utilize the administrative service.

Treatment of Family Members

Treatment of family members or self is not a covered benefit. Providers should not bill CareFirst for services rendered to family members or themselves.

The American Dental Association Principles of Ethics and Code of Professional Conduct (ADA Code) includes a similar standard of practice, indicating that "dentists should avoid interpersonal relationships that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient."

Family members include spouses, parents, children, and siblings of a provider, and may also include other family members, in accordance with the applicable benefit contract.

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 also 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@carefirst.com
- Fax a written complaint to 301-470-5866
- 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 (Tax Identification Number)
- The member's name and ID number
- Date(s) of service
- As much detail about the event as possible

Requests for Charts

Affordable Care Act Risk Adjustment

Risk Adjustment (RA) is a program within the commercial insurance market implemented under the Affordable Care Act (ACA).

Background

The RA Program relies on complete and accurate annual documentation and coding of all conditions to determine members' health status to assign a health plan risk score. Medical record documentation plays a critical role in determining member health status.

The purpose is twofold: to help stabilize premiums by mitigating the impact of adverse selection in the ACA marketplace and to ensure that CareFirst accurately and completely collects and submits medical diagnosis information to the U.S. Department of HHS.

Outreach to encourage patient visits or request clinical records may occur at various times during the benefit year if gaps in care or coding are suspected. Gaps in care and coding can occur for several reasons. A few common reasons are described below:

- Members with chronic conditions who do not visit the doctor during a benefit year.
- Medical diagnoses documented in the medical record were not submitted on the claim.
- The medical record does not reflect the patient's medical condition

Clinical outreach

Patients with chronic conditions that may not have been evaluated or received recommended care during the benefit year may be identified. A patient list will be provided.

If you receive this list, we are asking that you review your patient list and encourage these patients to schedule a visit. During their visit, you should document all existing conditions in the medical record and confirm that all applicable diagnoses are included on the submitted claim.

Both you and your patients will benefit from this additional outreach and follow up care. Full documentation of a patient's conditions will lead to more timely and accurate payments for your practice. Patients will benefit from the additional evaluation, management and/or treatment of their conditions.

Medical record retrieval

Immediately following the close of the benefit year, CareFirst may identify gaps in coding and will request clinical records to supplement the claims data to be submitted to CMS for the RA Program.

One or more of your patients' clinical records may be identified for further review. If this is the case, CareFirst's contracted third-party retrieval vendor will work with you to retrieve the necessary clinical records.

If your patients are identified, staff from the CareFirst designated third-party vendor will contact your office to determine a method of retrieval (e.g., mail, fax, electronic transmission or on-site collection).

Best practices in medical record documentation

The following are best practices you should follow when documenting clinical records:

- Diagnoses need to be clearly documented in the medical record.
- Chronic conditions need to be evaluated and reported on a regular basis (at least annually).
- Clinical records need to be legible, signed, credentialed and dated by the practitioner.
- Patient's name and date of service need to appear on all pages of the record.
- Treatment and reason for level of care needs to be documented; chronic conditions that potentially affect treatment choices considered should be documented.
- CareFirst requests that all providers comply with CMS guidelines on implementing ICD-10.

Common errors to watch for when documenting a patient's visit

Make sure to avoid common errors:

- Incomplete medical record documentation
  - Lack of condition specificity where required
  - Key condition statuses (e.g., transplant, amputation)
- Missing provider signature and/or credentials
  - Missing provider signature on clinical records
  - Missing provider credentials on clinical records
- Short-hand documentation of medical record
  - Use of symbols or other medical terminology that cannot be translated into diagnosis codes
  - Lack of condition specificity where possible

- Other common errors
  - Name on medical record does not match other documents
  - Pages from the medical record are missing

These types of errors may increase the likelihood of a medical record review and other types of follow-up from CareFirst.

HHS Risk Adjustment Data Validation

CMS requires CareFirst to annually validate the accuracy of an ACA member status each benefit year.

Background

The member status is validated specifically for risk adjustment plans in the individual and small group markets through the validation of clinical records. This process is known as the HHS Risk Adjustment Data Validation program.

The purpose of this audit is to provide CMS with a better understanding of the data that they receive regarding disease prevalence, coding interpretation and variances across the country. This audit is not specific to you or your practice and is not designed to monitor your practice, or your billing or coding patterns.

Provider outreach

One or more of your patients' clinical records may be identified for further review. If this is the case, CareFirst's contracted third-party vendor will work with you to receive the necessary clinical records.

If your patients are identified, staff from the CareFirst designated third-party vendor will contact your office to determine a method of retrieval (e.g., mail, fax, electronic transmission or on-site collection).