CareFirst

Family of health care plans

DENTAL

PROVIDER MANUAL

CareFirst
Family of health care plans

Chapter 8: Medicare Advantage

Provider Network Overview

CareFirst Advantage, Inc. is the entity that provides the network and products servicing our Medicare Advantage (MA) Members and integrated Medicare Advantage Prescription Drug (MA-PD) plans. CareFirst Advantage PPO, Inc. is the entity that provides the network and products servicing our Group Medicare Advantage (MA) and Group Medicare Advantage Prescription Drug (MAPD) PPO plans.

CareFirst BlueCross BlueShield Medicare Advantage participating providers play an integral role in managing and transforming care for our enrollees. Together, we can provide an integrated system of coordinated, efficient and quality care.

The provider networks for CareFirst's Medicare Advantage plans are different than our commercial dental networks. You must sign a separate agreement to be included in the MA dental networks

Participating Provider Responsibilities

Providers participating in CareFirst must comply with the following responsibilities:

- Manage the medical and healthcare needs of members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers, and maintaining a medical record that meets CareFirst standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members
- Provide all services ethically, legally and in a culturally competent manner, and meet the unique needs of members with special healthcare needs
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members
- Provide hearing interpreter services on request to members who are deaf or hard of hearing.
- Participate in and cooperate with CareFirst in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by CareFirst
- Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 11 years
- Support, cooperate and comply with CareFirst Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- Treat all members with respect and dignity, provide appropriate privacy and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release
- Provide members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their healthcare, except when contraindicated for medical reasons

- Advise members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
- Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary
- When clinically indicated, contact members as quickly as possible for follow up regarding significant problems and/or abnormal laboratory or radiological findings
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection
- Agree to maintain communication with the appropriate agencies such as local policy, social services agencies and poison control centers to provide high-quality patient care
- Document in a prominent place in medical record if individual has executed advance directives

Provider Network Participation

Enrollment and Participation in the Medicare Advantage Networks

CareFirst Advantage, Inc. offers eligible providers an opportunity to participate in the CareFirst MA dental networks, which is utilized for the CareFirst BlueCross BlueShield Medicare Advantage products. Network providers provide care to CareFirst BlueCross BlueShield Medicare Advantage members, and CareFirst reimburses for covered services at the agreed upon payment rate.

Providers who have opted out of or have been excluded or precluded from the Medicare program are not eligible.

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

For questions regarding credentialing or participation, please contact CareFirst's Dental Credentialing Department at (443) 921-0676. For more information on credentialing, please refer to Chapter 3: Network Requirements.

Marketing of Medicare Advantage

Medicare Advantage plan marketing is regulated by CMS. Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V, and the CMS Managed Care Manual, Chapter 3, Medicare Communications and Marketing Guidelines (MCMGs), including, without limitation, materials governing activities with Health Care Providers or in the Health Care Setting.

CMS holds plan sponsors, such as CareFirst, responsible for any marketing materials developed and distributed on their behalf by their contracting Providers. Providers are not authorized to engage in any marketing activity on behalf of CareFirst without the prior express written consent of an authorized CareFirst representative, and then only in strict accordance with such consent.

Product Information

Medicare Advantage, also known as Medicare Part C, is a health plan approved by Medicare and offered by private insurance companies like CareFirst. MA plans bundle Medicare Part A (hospital/facility costs) and Medicare Part B (doctor/labs/other costs) with added benefits and services, including dental.

CareFirst currently offers individual and group Medicare Advantage plans—that is, Medicare Advantage plans which individuals can purchase, as well as Medicare Advantage plans which employer groups can purchase for their retiree populations.

Individual Medicare Advantage (HMO)

Plan Designs

Both individual Medicare Advantage plans include embedded dental coverage. The CareFirst BlueCross BlueShield Advantage Core medical plan includes embedded basic preventive dental care and treatment.

CareFirst offers two HMO options for individual Medicare Advantage enrollees:

- CareFirst BlueCross BlueShield Advantage Core
- CareFirst BlueCross BlueShield Advantage Enhanced

The CareFirst BlueCross BlueShield Advantage Core plan includes preventive care and treatment only.

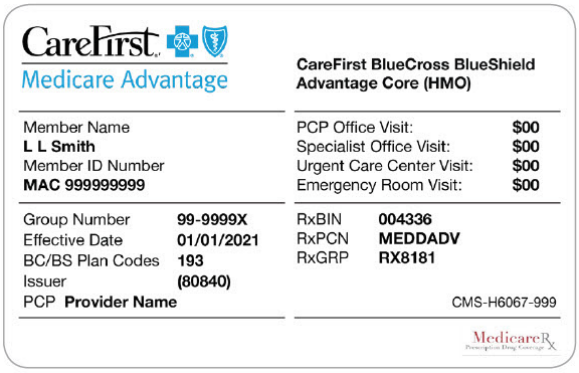
The CareFirst BlueCross BlueShield Advantage Enhanced medical plan includes preventive dental care and treatment, plus some benefits for minor palliative, minor restorative, periodontic and simple extraction services.

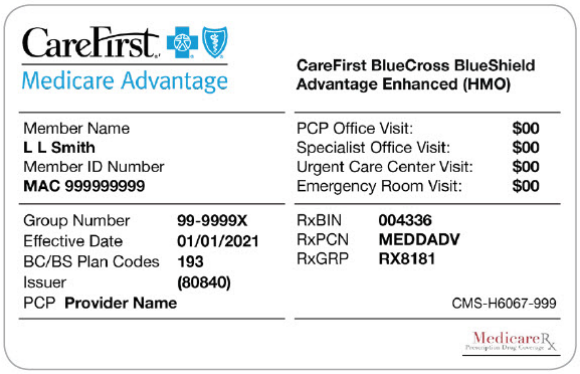
Members who choose the Enhanced plan hold a more comprehensive dental benefit package which includes major restorative and major oral, endodontic, major periodontic, prosthodontic, and non-routine dental care.

Member Identification

The prefix for the CareFirst BlueCross BlueShield Individual MA plan is 'MAC'.

Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. CareFirst On Call is not available for MA inquiries.





The membership ID cards that individual MA members will bring to the office will not contain any typical dental indicators, although all individual MA members' plans include dental coverage. We encourage dental providers to verify eligibility and benefits on CareFirst Direct as you do today for other CareFirst products.

Group Medicare Advantage

Introduction

The Centers for Medicare and Medicaid Services (CMS) allows private insurance carriers, such as CareFirst to develop Employer Group Waiver Plans (EGWP) Medicare Advantage plans. CareFirst customizes the plans for employer groups who offer these plans to their retirees. These plans are known as Group Medicare Advantage plans and offer all the same coverage as Original Medicare, plus additional benefits such as dental, vision, hearing, fitness, and more.

Employer groups can choose if they want to cover additional dental services such as preventive and comprehensive benefits through the Group Medicare Advantage plan.

Dental providers who participate in our Medicare Advantage PPO Dental Provider Network are considered in network for Medicare Advantage PPO members enrolled in any of CareFirst's Medicare Advantage PPO plan offerings.

Plan Designs

CareFirst offers Group Medicare Advantage or Medicare Advantage Prescription Drug plans based directly to Employer Groups for their retirees, spouses, or dependents that are eligible for Medicare (Part A and Part B).

Some groups will have dental coverage and the plan names can be either:

- CareFirst BlueCross BlueShield Group Advantage (PPO)
- CareFirst BlueCross BlueShield Group Advantage without Drugs (PPO)

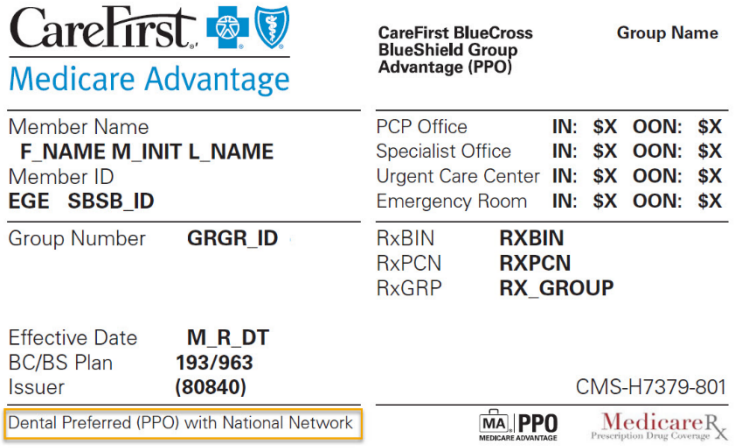
The dental design for the employer groups that have coverage through their Group Medicare Advantage plan is mirrored from their current commercial/retiree benefits with some adjustments. It is key to review the dental benefits for the employer groups that have chosen to obtain coverage with us using CareFirst Direct.

Importantly: Group MA dental benefits are displayed on CareFirst Direct in the same way it is for commercial dental plans.

Member Identification

The prefix for CareFirst BlueCross BlueShield Group Medicare Advantage is 'EGE.'

Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. CareFirst on Call is not available for MA inquiries.



Reminder: Always check your Group MA patient's member identification card. The **'Dental Preferred (PPO) with National Network'** indicator will be your source of truth regarding whether your patient's MA coverage includes dental benefits.

For more complex inquiries regarding your Individual or Group Medicare Advantage patients, you can contact our dedicated Medicare Advantage Provider Services unit at 833-493-0535.

Claims Submission

We encourage providers to submit claims electronically as you do today for other CareFirst products. We will also accept paper claims which can be submitted to the address found in the Dental Claims and Service Reference Guide.

Appeals and Grievances

Introduction

CareFirst BlueCross BlueShield Medicare Advantage encourages our members to let us know if they have questions, concerns, or problems related to covered services or the care that they receive. Members are encouraged to first contact Member Services at 855-290-5744 for assistance. For information about the rules for making complaints in different situations, please review the information in this section.

Federal law guarantees a member's right to make complaints regarding concerns or problems with any part of their medical care as a plan member. The Medicare program has set forth requirements for the filing and processing of member complaints. If a member or authorized representative files a complain, we are required to follow certain processes when we receive it. We must be fair in how we handle it, and we are not permitted to disenroll or penalize a member in any way for making a complaint.

What are Appeals and Grievances?

Members have a right to request a coverage determination. If the plan denies coverage for the requested item or service, they have the right to appeal and ask us to reconsider the decision. They also have a right to file a grievance (also called a complaint) about the health plan.

Appeal

An appeal can be filed by a member to ask the plan to review a decision made on healthcare services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage. For example, a member may file an appeal if:

- We refuse to cover or pay for services a member thinks we should cover
- We or one of our plan providers refuses to render a service that a member believes should be covered
- We or one of our plan providers reduces or cuts back on services or benefits that a member has been receiving, or
- The member believes that we are stopping coverage of a service or benefit too soon

Grievances

A grievance is any complaint or dispute expressing dissatisfaction with any aspect of our operations, including dissatisfaction with our Medicare plans, Member Services, a provider, or treatment facility that does not involve a coverage determination.

As an example, grievances may be filed if a member is experiencing a problem regarding:

- The quality of care by a plan provider
- Waiting times for appointments or in the waiting room
- Provider behavior or the behavior of the provider's office staff
- Not being able to reach someone by phone to get the information needed, or
- The cleanliness or condition of a provider's facilities

Members can file a grievance within 60 calendar days of the date of the circumstance giving rise to the grievance.

The grievance will be sent to our Appeals and Grievance Department for handling. The plan's response may take 30 days or up to 44 days if more information is needed and an extension is granted.

Submitting a Grievance

Concerns about the plan are important to us. For immediate attention and assistance in resolving their concerns, members can call Member Services to submit a grievance verbally.

Call: 855-290-5744

Members can also fax or mail their grievance in writing to us at:

Fax: 443-753-2298

Mail:
CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

Provider Payment Disputes

Member Appeals vs. Provider Payment Disputes

Contracted providers do not have appeal rights on the provider's behalf. If there is a member liability or for any pre-service denials, a provider can file an appeal on a member's behalf. In these instances, the provider should follow the member appeal process above.

Providers can dispute a payment they believe was paid incorrectly or not paid at all. If a provider receives a service that is denied in part or in whole, with no member liability, and the provider disagrees with the decision then the provider can dispute that payment.

CareFirst BlueCross BlueShield Medicare Advantage has a two-level payment dispute process.

First Level Contracted Provider Disputes

When a provider disagrees with a payment amount or with a payment denial with no member liability, the provider may call CareFirst MA provider service for a review of the payment. The provider must give a reason for the payment dispute. Our provider service team will research the issue and follow up with the provider.

- If the response satisfies the provider, the verbal dispute/service case is considered closed.
- If the provider continues to disagree with the payment, they may file a second level provider dispute.

Second Level Provider Disputes

- To submit a provider dispute, contracted providers must make a written request which must be received by the plan within:
    - 180 calendar days of the date of their denial notice denying a post-service claim. When an authorization has been denied, provider must adhere to the 60-day time frame, the 180 days once the claim has denied does not apply.
- When submitting a written request for a payment dispute, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim, the reason for the appeal, and the member's medical records containing all pertinent information regarding the services rendered by the provider.
- All post service payment provider appeal reviews will be completed within 60 days of the date the written request was received.
- The provider will be informed of the decision in writing by mailing notification within 60 days from receipt. If the appeal is approved, payment will be issued within 60 calendar days of notification.

Acting as an Authorized Representative

CareFirst BlueCross BlueShield Medicare Advantage will accept appeals made by the member and/or his/her authorized representative or the prescribing/treating physician or other prescriber or a nonparticipating provider involved in the member's care. CareFirst BlueCross BlueShield Medicare Advantage will accept grievances made by the member and/or his/her authorized representative. The member may appoint:

- A family member
- A friend
- A lawyer
- An unrelated party such as an advocate
- Physician or provider
- Dentist
- Court appointed guardian
- Durable Power of Attorney
- Healthcare Proxy

To appoint a representative, members and their representative must complete the CMS Appointment of Representative (AOR) form and send it to:

Fax: 443-753-2298

Mail:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

CareFirst BlueCross BlueShield Medicare Advantage will not require information beyond what is included in the AOR form of the requirements outlined below for an equivalent written notice. An equivalent written notice includes the following:

- Name, address, and telephone number of the member;
- Name, address, and telephone number of the appointed individual;
- Member's Medicare Beneficiary Identifier, or Plan ID number;
- The appointed Representative's professional status or relationship to the party;
- A written explanation of the purpose and scope of the representation;
- A statement that the member is authorizing the Representative to act on his or her behalf for the claim(s) at issue;
- A statement authorizing disclosure of individually identifying information to the Representative;
- A statement by the individual being appointed that he or she accepts the appointment; and
- Notice is signed and dated by both the Enrollee and the individual being appointed.

CareFirst BlueCross BlueShield Medicare Advantage will accept the AOR form with electronic signatures if the form is submitted through a secure portal or other secure electronic means provided applicable regulatory and CMS website/electronic communication requirements are met. AOR forms contain a Member's Medicare Beneficiary Identifier (MBI) or Plan ID number and will be treated as protected information by CareFirst BlueCross BlueShield Medicare Advantage.

CareFirst BlueCross BlueShield Medicare Advantage will file and make accessible for use a copy of the signed AOR form, or equivalent written notice, for future grievances, coverage requests, or appeals submitted within the complaint timeframe. CareFirst BlueCross BlueShield Medicare Advantage will include a copy of the AOR form, or equivalent written notice, when sending a case file to an Independent Review Entity (IRE), or any other entity other than CareFirst BlueCross BlueShield Medicare Advantage.

The Representative form is valid for one year from the date it has signatures for both the Enrollee and the appointee, unless sooner revoked. If the Enrollee would like the same individual to continue serving as an appointed Representative after one year, the Enrollee must reappoint that person by submitting a new AOR form to CareFirst BlueCross BlueShield Medicare Advantage.

We will keep the form as valid for the life of a grievance, coverage request, or appeal if the grievance, coverage request, or appeal was received within one year of the date a Representative form is signed by both the Enrollee and appointee.

It is important to note that the appeals process will not commence until CareFirst BlueCross BlueShield Medicare Advantage receives a properly executed AOR or for payment appeals from non-participating providers, a properly executed Waiver of Liability statement.

Member Appeals for Coverage or Payment of Other Medical Services

After CareFirst BlueCross BlueShield Medicare Advantage has made a coverage determination to not approve or pay for services a member believes should be covered or provided, the members or their authorized representative may file an appeal.

This would be a standard appeal for benefits (pre-service appeal) or payment of a claim (payment appeal).

Payment Appeals

A payment appeal is an appeal for a service that has already been received and the initial decision denied payment for the item or service. Members can file a standard payment appeal within 60 calendar days of the date of the notice of our initial determination. That timeframe may be extended if good cause exists.

All standard claims payment appeals must be submitted in writing to:

CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

Standard Pre-Service Appeals

For more information, refer to our Medical Provider Manual.

Standard Appeal Timeframes

If a standard appeal is filed, we will send a decision within:

- 30 days if the appeal is regarding a pre-service request for coverage of a benefit or service that a member wants to receive
- 60 days for an appeal for payment for a service that was already received

Decisions on Appeals

A payment appeal must be decided within 60 days. If the payment is approved upon appeal the payment must be issued within the 60 days. If the payment denial is upheld in full or in part, the case must be forwarded to the IRE for review.

For a standard pre-service review, when care has not yet been provided, CareFirst BlueCross BlueShield Medicare Advantage must finalize the appeal within 30 days or sooner if the member's health condition warrants. If the request is for a Medicare Part B prescription drug not yet received, CareFirst BlueCross BlueShield Medicare Advantage must finalize appeal within 7 calendar days of receipt of an appeal. If additional information is needed to complete the appeal review the timeframe for completion can extend up to 44 calendar days.

For expedited pre-service appeals regarding medical care, CareFirst BlueCross BlueShield Medicare Advantage has up to 72 hours to make a decision, but will make it sooner if the member's life, health, or ability to regain maximum function requires it. All adverse reconsideration decisions are automatically forwarded to the IRE for review. Also, if we do not issue a decision within the standard or expedited timeframes as outlined above, the appeal will be automatically forwarded to the IRE for review. The IRE has a contract with CMS and is not part of CareFirst BlueCross BlueShield Medicare Advantage. The timeframe for a Part C expedited preservice review appeal can be extended up to 17 calendar days if additional information is needed to complete the appeal.

When the appeal is for services that have not been received, if the member requests an extension, or if we find that some information is needed that would be beneficial to the member in this review, an extension of up to 14 calendar days may be granted. The 14-day extension is also an option with an

expedited appeal. If we do not issue a decision by the end of the extended time period, the appeal is automatically forwarded to the IRE for review. CareFirst BlueCross BlueShield Medicare Advantage cannot take extra time when the appeal is for a Part B prescription drug.

Upon completion of the reconsideration, all parties to the appeal will be notified of the outcome. If the decision is a denial, the member or authorized representative will be verbally notified that their appeal has been forwarded to the IRE.

Appeals for Coverage of Part D Drugs

CareFirst BlueCross BlueShield Medicare Advantage encourages its members to contact us through Part D Member Services with any questions concerns or problems related to prescription drug coverage. As with medical services, CareFirst BlueCross BlueShield Medicare Advantage also has processes in place to address various types of complaints that members may have regarding their prescription drug benefits.

Prescribing physicians or other prescribers who feels that an enrollee's life or health is in serious jeopardy may have immediate access to the Part D appeal process by calling 1-888-970-0917. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

For more information, refer to our Medical Provider Manual.

Member Grievances

For more information, refer to our Medical Provider Manual.

Medicare Pharmacy Management

Pharmacy Network

CareFirst BlueCross BlueShield Medicare Advantage has a nationwide network of 60,000+ pharmacies that includes major chains, independents, supermarkets and more. Members are encouraged to use pharmacies that are part of our network. The Pharmacy Directory is available at carefirst.com/Medicare.

Formulary

A formulary is a list of drugs that we cover. CareFirst BlueCross BlueShield Medicare Advantage will have one formulary option for both the Core and Enhanced plans. Members who chose the Enhanced plan will have additional coverage for generic drugs in Tier 1 during the coverage gap. This is denoted by the symbol GC in both the printable and searchable versions of the formulary.

CareFirst BlueCross BlueShield Medicare Advantage delegates formulary creation to its Pharmacy Benefits Manager (PBM), CVS Caremark®. The formulary is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other healthcare professionals who make sure the drugs on the formulary are safe and clinically effective. The Medicare formulary is also reviewed and approved by CMS. CareFirst BlueCross BlueShield Medicare Advantage chose the 5-tier generic strategy formulary. This means that there are generic options available on each tier, but also multiple tiers that have varying copays. These include:

Tier 1	Preferred Generics (lowest copay)
Tier 2	Generics (more expensive)

Tier 3	Preferred Brand (lowest copay for brand name)
Tier 4	Non-preferred Brand (more expensive brands and generics)
Tier 5	Specialty Tier (highest copay)

To ensure members are receiving the most appropriate medication for their condition(s), certain medications on the formulary may be subject to utilization management (UM). Below are some descriptions of the types of UM used in the formulary:

- Prior Authorization (PA) – We require providers to submit clinical information to ensure the medications written are appropriate for the situation. There is prior authorization on Part B and Part D drugs. This information may include diagnosis, lab results, your medical specialty and use of prior medications.
- Quantity Limit (QL) – For certain drugs, we limit the amount of the drug that a member can have. This may include the amount of medication that may be obtained per day or the amount of medication that can be obtained over a length of time. Quantity limits can apply to formulary and non-formulary drugs.
- Step Therapy (ST) – In some cases, we require members to try certain drugs before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, we may then cover Drug B.

CareFirst BlueCross BlueShield Medicare Advantage allows for extended day supplies, meaning up to 90-day fills, at both retail and mail order. We encourage you to write for these longer fill lengths for members with established histories of chronic medications such as those for hypertension, diabetes and hypercholesterolemia.

CareFirst BlueCross BlueShield Medicare Advantage also uses our PBM for mail order pharmacy. There are lower copays for members who use mail order to obtain 90-day supplies of their medications. The exception is drugs on tier 5, of which only 30-day supplies are available via the mail. Certain drugs are not available via mail order, and those are indicated on the formulary by the initials NM.

You can find the searchable and printable formularies, as well as Prior Authorization and Step Therapy criteria at carefirst.com/Medicare.

Exception Requests

Members and their doctors may submit a request for a drug exception for the following types:

- Non-Formulary Drug Exception – A request to cover a medication that is not on the formulary (drug must be Part D eligible)
- Tier Exception – A request to cover a medication that is on the formulary under a lower cost-sharing tier.

- Prior Authorization or UM Exception – A request to waive UM criteria such as prior authorization, quantity limit and step therapy

Requirements for Part B Drugs

Part B drugs include drugs that are administered in a provider's office, diabetes monitoring supplies, some vaccines and others. Just like Part D drugs, Part B medications may be governed by UM. CareFirst BlueCross BlueShield Medicare Advantage has certain medications that require Prior Authorization and/or Step Therapy. Our PBM handles initial requests, while CareFirst BlueCross BlueShield Medicare Advantage is responsible for appeals. Lists of medications, including those with PA or ST, are available at carefirst.com/Medicare.

Ensuring Appropriate Utilization of Opioids

CareFirst BlueCross BlueShield Medicare Advantage has safety edits for opioids on top of existing formulary listings and utilization management.

While those are posted in documents on carefirst.com/Medicare, these edits occur at the point of claim adjudication in three scenarios:

- Opioid naïve edit: Using a lookback period of 108 days, if a member is opioid naïve, their initial opioid prescription will be limited to a 7-day supply. The intent is to limit members who have not been exposed to opioids to help prevent problematic or habitual use
- Care coordination edit: When a member has opioid prescriptions written by three different prescribers and are at or above 90 Morphine Milligram Equivalent (MME), the claim will be rejected and allow for the pharmacist to review the situation. This ensures communication between providers, once high opioid levels are met, to prevent over prescribing
- High MME edit: When a member has opioid prescriptions written by three different prescribers and are at or above 200 MME, the claim will reject and require a coverage determination to process.

There are situations that override these edits (i.e. cancer diagnosis, multiple prescribers are all part of the same practice), but the intent is to help keep our members safe.

Transition Fills

Transition is a process to help ensure that Medicare beneficiaries can continue to receive medications they may have been taking before joining CareFirst BlueCross BlueShield Medicare Advantage, or for active members who have a history of medication use, but now the formulary coverage has changed. Below is a summary of transition information.

Description	Transition Fill Days' Supply
New and Renewing Beneficiaries	
■ Not in long-term care (LTC) ■ In LTC	■ 30 days' supply within first 90 days in the plan; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed ■ 31 days' supply within first 90 days in the plan, oral brand solids are limited to 14 days' supply with exceptions as required by CMS guidance, multiple fills for a cumulative applicable month's supply

Description	Transition Fill Days' Supply
	are allowed to accommodate fills for amounts less than prescribed/first 90 days.
Non-LTC Resident Level of Care Change	
■ Beneficiary released from LTC facility within past 30 days	■ Non-LTC: 30 days' supply; multiple fills up to a cumulative applicable month's supply are allowed to accommodate fills for amounts less than prescribed.

The transition supply allows you time to talk to your patient about pursuing other options available within our formulary or for you to submit the necessary information to obtain an exception or coverage determination.

Medication Therapy Management Program

A medication therapy management (MTM) program is a CMS requirement for MA-PD plans. Pharmacists in various settings work with members to review their current medication regiments to:

- Ensure optimum therapeutic outcomes through improved medication use
- Reduce the risk of adverse events
- Help identify issues where medications may not work well together and address these issues with providers.

Members qualify for the program by having:

- Three or more of the following chronic illnesses: osteoporosis, chronic heart failure (CHF), diabetes, depression, asthma, chronic obstructive pulmonary disorder (COPD), cardiovascular disorders, HIV/AIDS
- Eight or more chronic medications for these illnesses
- Total drug spend of at least $4,376 annually on medications, which is projected from three months' worth of claims

Qualified members will be enrolled automatically and can opt-out.

CareFirst BlueCross BlueShield Medicare Advantage MTM members will receive a comprehensive annual review of medications, as well as outreach for potential targeted medication reviews. You may receive letters requesting changes to your patient's medication regimens pursuant to these reviews.

Medication Reconciliation Post-Discharge

Medication reconciliation is a critical part of post-discharge care coordination for all members. CareFirst BlueCross BlueShield Medicare Advantage will perform outreach to members who have been recently discharged from the hospital and review their medications. CareFirst BlueCross BlueShield Medicare Advantage may send providers documents detailing our discussions with them and may ask for certain changes to the medication regimen discussed.

Pre-Treatment Estimate Submission Process

Dental providers and/or members who wish to obtain a clinical review for dental treatment prior to services being rendered may request a Pre-Treatment Estimate (PTE). CareFirst BlueCross BlueShield Medicare Advantage strongly encourages providers to submit PTEs and required attachments electronically through your clearing house and NEA. Hard copy PTEs should be submitted on a completed American Dental Association® (ADA) claim form. Check the box for "Dentist's pre-treatment estimate" and leave the date of service blank. Include the following information on the form:

- ADA Current Dental Terminology® (CDT) procedure code(s)
- Appropriate supporting documentation for the service(s) to be rendered (see Reference Guide for Required Attachments). Providers with electronic capabilities are encouraged to submit attachments via one of our preferred trading partners.

The PTE process is an optional service limited to procedures which are subject to Utilization Review and listed in the Reference Guide for Required Attachments. The PTE is not a guarantee of payment or a prior authorization.

In the PTE process, benefits will be considered based on current eligibility and clinical guidelines. Providers will be notified on the Estimate of Eligible Benefits (EEB) form indicating approval or denial. Upon completion of treatment, the EEB form should be used to request reimbursement by completing the date of service, signing and submitting the EEB to the appropriate claim submission address indicated on the form. Resubmitting supporting documentation is not necessary when submitting for reimbursement. Payment will be considered based on the following conditions:

- PTE was approved less than 270 days prior to the date service was completed
- The Member was eligible on the date service was completed
- Frequency and annual maximums have not been exceeded
- The service must be a covered benefit at the time the service was rendered.
- Services rendered are consistent with those indicated on the PTE

Note: If CareFirst BlueCross BlueShield Medicare Advantage receives a claim form for previously approved services instead of the EEB form, we will request supporting documentation. Therefore, it is best to submit your approved EEB form in lieu of the claim form.

Providers and/or members who choose not to request a PTE must continue to submit claims with the required attachments (radiographs, periodontal charting, etc.) for services requiring clinical documentation. You can check CareFirst Direct to verify if the claim has been received by CareFirst BlueCross BlueShield Medicare Advantage.