CareFirst

Family of health care plans

PROVIDER MANUAL

CareFirst
Family of health care plans

Chapter 10: Medicare Advantage

Provider Network Overview

Individual Medicare Advantage

CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. (CareFirst Advantage) are the entities that provide the network and products which service our Medicare Advantage (MA) Members in our MA and integrated Medicare Advantage Prescription Drug (MA-PD) plans.

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

The provider network for CareFirst Advantage is different than our other HMO product, BlueChoice. You must sign a separate agreement to be included in the MA HMO network.

Group Medicare Advantage

The Employer Group Waiver Program through the Centers for Medicare and Medicaid Services (CMS) is a customized Medicare Advantage (MA) program that employers may choose to offer their retirees. Under Group Medicare Advantage arrangements, employers or unions contract with a private insurer to provide Medicare benefits and additional retiree health benefits to their Medicare-eligible retirees. Medicare pays the insurer a fixed amount per enrollee to provide benefits covered by Medicare, and the employer/union and/or retiree pays for any additional benefits.

Our product is known as CareFirst BlueCross BlueShield Group Advantage and is a Preferred Provider Organization (PPO) product.

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

The provider network for CareFirst BlueCross BlueShield Group Advantage is different than our commercial PPO network. You must sign a separate agreement to be included in the MA PPO Group Medicare Advantage network.

Participating Provider Responsibilities

Providers participating in CareFirst BlueCross BlueShield Medicare Advantage HMO and PPO (CareFirst) must comply with the following responsibilities:

- Manage the medical and health care 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 (both in and out-of-network), and maintaining a medical record meeting 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 health care 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 people with hearing loss
- 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 Centers for Medicare and Medicaid Services (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 10 years
- Participate in and cooperate with the CareFirst appeal and grievance procedures
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Support, cooperate and comply with CareFirst's 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 police, 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 & Participation in the PPO network

CareFirst Advantage PPO, Inc. offers eligible providers an opportunity to participate in the CareFirst PPO network, which is utilized for the CareFirst BlueCross BlueShield

Group Advantage product. Network providers provide care to CareFirst BlueCross BlueShield Group Advantage members, and CareFirst reimburses for covered services at the agreed upon payment rate.

Providers must be a Medicare eligible provider and a participating provider in traditional Medicare. 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 Provider Information and Credentialing Department at 410-872-3500 or 877-269-9593. For more information on credentialing, please refer to Chapter 3: Provider Network Requirements.

Non-contracted providers

If you are not contracted with the CareFirst PPO network, you can still see CareFirst BlueCross BlueShield Group Advantage members if you are a Medicare contracted provider. We highly encourage non-contracted providers to see our CareFirst BlueCross BlueShield Group Advantage members to provide continuity of care.

Marketing of Medicare Advantage

MA 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, activities with Health Care Providers or in the Healthcare 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.

Appointment Wait Time Standards

Members should be able to schedule an appointment for the care they need within the specified time frames. For more information, visit the "Appointment Wait Times" page under Legal/Mandates.

Network accessibility standards (Medicare Advantage plans)	
Appointment type	**Time frame**
Urgently needed services or emergency	Immediately
Primary Care services that are not emergency or urgently needed, but the enrollee requires medical attention	Within 7 business days
Behavioral Health services that are not emergency or urgently needed, but the enrollee requires medical attention	Within 7 business days

Primary Care routine and preventive care	Within 30 business days
Non-urgent specialty care	30 calendar days

Product Information

Individual Medicare Advantage (HMO)

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

CareFirst Advantage offers two HMO options for MA:

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

You can find information about the two plans, organized by service area, on our website.

Note: Service Area 1 includes Anne Arundel, Frederick, Carroll, Harford and Howard counties. Service Area 2 includes Baltimore City, Baltimore, Montgomery and Prince George's counties.

Member Identification

The prefix for CareFirst Advantage 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.

Referrals are required for services provided by a specialist.

Members have direct access to:

- Mammography
- Influenza vaccinations
- Women's specialists for routine and preventive services

Members have no copay for influenza and pneumococcal vaccines.

Members do not have coverage outside of the CareFirst BlueCross BlueShield (CareFirst) service area, except for emergency and urgently needed services and renal dialysis for members who are temporarily outside the CareFirst service area.

Group Medicare Advantage (PPO)

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

CareFirst BlueCross BlueShield Group Advantage is a PPO product. While primary care provider (PCP) selection is not required, it is strongly encouraged that members maintain a relationship with a PCP who can manage the member's care. Similarly, PCPs are encouraged to provide referrals to members even though they are not required. Referrals are not required for any service under these plans.

CareFirst is offering a Group Medicare Advantage Plan that includes Part D coverage.

Medicare Covered Benefits

CareFirst BlueCross BlueShield Group Advantage plans cover all Original Medicare-covered benefits including:

- Inpatient hospital
- Podiatry services
- Skilled Nursing Facility
- Outpatient diagnostic procedures of tests
- Cardiac and pulmonary services
- Lab services
- Emergency care / post-stabilization care
- X-ray services
- Urgent care
- Diagnostic and radiological services
- Primary care provider
- Diagnostic therapeutic services
- Specialist visits
- Opioid treatment services
- Psychiatric services
- Mental health specialty services
- Dialysis services
- Outpatient substance abuse
- Chiropractic services
- Outpatient observation
- Occupational, speech pathology, and physical therapy
- DME, medical supplies, prosthetics, diabetes supplies
- Medicare part B drugs
- Medicare-covered preventive services

Non-Medicare Covered Extra Benefits Beyond Medicare

CareFirst BlueCross BlueShield Group Advantage covers additional benefits such as:

- Telehealth (In-network providers with capabilities)
- 24-Hour Nurse Hotline
- In-home assessments
- Fitness Silver Sneakers
- Outpatient blood services
- Routine Hearing Exams
- Hearing aids
- Fitting/evaluation for hearing aids
- Worldwide emergency coverage & urgent coverage
- Preventive and comprehensive dental
- Vision exams and eyewear

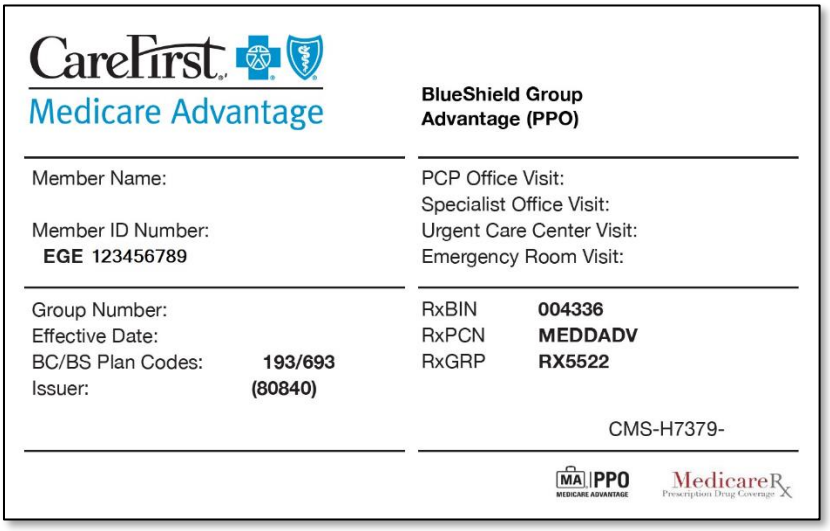
Group Medicare Advantage PPO Service Area

As a CareFirst BlueCross BlueShield PPO participating provider, you may render services to patients who are National Account members of other Blue Plans and who travel or live in CareFirst's service area, which is Maryland, the District of Columbia, and Northern Virginia.

Member Identification

The prefix for CareFirst BlueCross BlueShield Group Advantage is EGE. Just as with commercial members, you should always verify eligibility and benefits through CareFirst Direct. Benefits for MA PPO members are not available through CareFirst on Call.

Sample membership Identification card



Role of Primary Care Physician

- Providers in the following medical specialties are recognized as Primary Care Physicians (PCP)s:
  - Family Medicine
  - General Practice
  - Internal Medicine/Pediatrics
  - Preventive Medicine
  - Nurse Practitioner

In accordance with CMS guidelines in limited and rare circumstances:

- Pediatrician
- Nephrologist
- Geriatric Medicine
- OB/GYN

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.

Choosing a PCP – HMO Only

Each CareFirst member in the HMO selects a PCP upon enrollment and receives an individual member ID card with the name of the PCP on the card.

If a member chooses to change PCPs, the member must call the selected provider's office to confirm they still participate with CareFirst and that their new PCP is accepting new patients. The member then notifies member services of this change. The member may also notify us online at carefirst.com/Medicare.

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 January 20 will be effective February 1. Changes received on January 21 will be effective March 1. New cards will be issued after the PCP change is processed.

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 network. The covering practitioner must indicate on the claim that they are covering for a particular provider, and include the doctor's name, when submitting the claim.

After hours care

All PCPs or their covering physicians 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 members and should not be used by participating physicians.

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 Provider Quick Reference Guide.

Billing & Payment

Billing Process

Collecting deductible, copayments or coinsurance

Providers should collect the applicable cost-sharing from the member at the time of service, when possible. After collecting these amounts, submit the bill for covered services. For additional guidance, refer to Chapter 5: Claims, Billing and Payments.

Balance billing is not allowed

You may only collect applicable cost-sharing from members for covered services and may not otherwise charge or bill them.

Cost-sharing for Qualified Medicare Beneficiaries is not allowed

The Qualified Medicare Beneficiary (QMB) is a Medicaid benefit that pays Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. As mandated by CMS, providers who inappropriately bill individuals enrolled in QMB are potentially subject to sanctions. Any wrongfully collected deductibles should be refunded to the patient. Providers needing to verify a member's QMB status should contact Provider Service.

Refund over-billed members

If you collect more from a member than the applicable cost-share, you must refund the difference to the member.

Coordination of benefits

If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we pay depends on the amount paid by the primary plan. We follow all Medicare secondary-payer laws.

Preclusion

CMS adopted a rule in April 2018 that stipulates providers cannot receive payment from a Medicare plan if they appear on a preclusion list managed by CMS. CMS made the preclusion list available to Part D sponsors and Medicare Advantage plans beginning January 1, 2019.

In addition, under the new rule:

- Part D sponsors are required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the preclusion list.
- Medicare Advantage plans are required to deny payment for a healthcare item or service given by an individual or entity on a preclusion list.

The preclusion list is a list created by CMS of providers and prescribers who cannot receive payment for Medicare Advantage items and services, or Part D drugs furnished or prescribed to Medicare members. CMS created this list to replace the Medicare Advantage and prescriber enrollment requirements, to ensure patient protections, and to protect Medicare funds from providers identified as bad actors. You can find more information on the CMS website.

Provider Inquiries About the HMO and PPO Network

If you have any CareFirst provider-related questions, please call one of the numbers below or visit our Contact Us page.

- 1-855-290-5744 for Individual Medicare Advantage (HMO)
- 1-833-320-2664 for Group Medicare Advantage (PPO)

Filing Claims

Claims for CareFirst members should be filed directly to CareFirst. Do not file claims to Medicare, except for the following:

- Services related to hospice care
- Services related to clinical trials

For more information on claims filing, please refer to Chapter 5: Claims, Billing and Payments.

Appeals and Grievances

Introduction

CareFirst encourages our members to let us know if they have questions, or concerns about covered services or the care they receive. Members are encouraged to first contact Member Services at 855-290-5744.

Federal law guarantees a plan member's right to make complaints about any part of their medical care. The Medicare program has set requirements for filing and processing member complaints.

If a member or authorized representative files a complaint, we must:

- Follow certain processes when we receive it,

- Be fair in how we handle it, and
- Not disenroll or penalize a member for making a complaint.

What are Appeals and Grievances?

When denied coverage for a requested item or service, members have a right to appeal the decision. They can also file a grievance (or complaint) about the health plan.

Appeals

A member can file an appeal to ask CareFirst to review a decision on healthcare services or benefits under Part C or D that they believe they're entitled to receive. This includes a delay in providing, arranging for, or approving the healthcare services or drug coverage.

CareFirst will accept appeals made by:

- The member or authorized representative
- The prescribing/treating physician or other prescribers
- A nonparticipating provider involved in the member's care

As an example, a member may file an appeal if:

- We refuse to pay for services a member thinks we should cover.
- We (or a provider) refuse to provide a service a member believes should be covered.
- We (or a provider) reduce services or benefits a member has been receiving.
- The member believes we are stopping coverage of a service or benefit too soon.

Grievances

A grievance is a complaint about with any part of our operations. This includes dissatisfaction with our Medicare plans, Member Services, providers, or treatment facilities. Grievances do not involve decisions about coverage.

As an example, a member may file a grievance if they're experiencing a problem with:

- Quality of care or waiting times for appointments
- The behavior of a provider or their office staff
- Reaching someone by phone to get the information they need
- Cleanliness or condition of a provider's facilities

Acting as an Authorized Representative

A member may appoint an authorized representative to act on their behalf, including:

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

- Healthcare Proxy

To appoint a representative, both the member and their representative must complete either:

- The Centers for Medicare & Medicaid Services (CMS) Appointment of Representative (AOR) form
- Or an equivalent written notice, which includes:
  - Name, address and phone number of the member
  - Name, address and phone number of the authorized representative
  - Member's Medicare Beneficiary Identifier or Plan ID number
  - The authorized representative's professional status or relationship to the member
  - A written explanation of the purpose and scope of the representation
  - A statement the member is authorizing the representative to act on their behalf for the claim(s) at issue
  - A statement authorizing disclosure of individually identifying information to the representative
  - A statement by the authorized representative they accept the appointment

Note: The notice must be signed and dated by both the member and authorized representative

Members must fax (443-753-2298) or mail their form or written notice to:

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

We will:

- Not require information beyond what's in the AOR form.
- Not require information beyond what's outlined above for an equivalent written notice.
- Treat AOR forms as protected information.
- File and make accessible a copy of the signed AOR form or written notice for future grievances, coverage requests or appeals submitted within the compliant timeframe.
- Include a copy of the AOR form or written notice when sending a case file to an **Independent Review Entity (IRE)** or any other entity other than CareFirst.

The AOR form is valid for one year from the date it was signed (unless sooner revoked). If the member wants the same person to serve as their representative after one year, they must submit a new AOR form.

If a grievance, coverage request or appeal is received within one year of the date the AOR form is signed, it will remain valid for the life of the grievance, request or appeal.

Providers as an Authorized Representative

A provider that has administered services or items to a member may represent that member on the appeal; however, the provider may not charge the member a representation fee. Providers who do not have a contract with CareFirst must sign a "Waiver of Liability" statement. This asserts the provider will not require the member to pay for the medical service under review, no matter the outcome of the appeal.

Note: The appeals process will not start until CareFirst receives a valid AOR form. Or, for payment appeals from non-participating providers, a valid Waiver of Liability statement.

Hospital Stay and Discharge Appeals

If a member feels CareFirst coverage for a hospital stay is ending too soon, the member or authorized representative can appeal directly to a Quality Improvement Organization (QIO). QIOs are groups of health professionals paid to handle this type of appeal from Medicare patients. When such an appeal is filed on time, the stay may be covered during the appeal review.

Note: QIOs are assigned regionally by CMS. The QIO for the state of Maryland is Livanta.

Members can find the appeal information on "The Important Message from Medicare" document they receive within two days of admission. It also includes the QIO name and telephone number.

Quality Improvement Organization Review

To request a QIO review for a hospital discharge, the member or authorized representative must contact them no later than the planned discharge date and before leaving the hospital.

If the deadline is met:

The member can stay in the hospital past the planned discharge date without financial liability.

If the QIO reviews the case, they will provide a decision within one calendar day after receiving the request and all the medical information necessary.

- If the QIO decided the planned discharge date is medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision.
- If they decided it's not medically appropriate, we will continue to cover the hospital stay for as long as medically necessary.

If the deadline is missed:

The member or authorized representative may request an expedited appeal.

However, if the member stays in the hospital past the planned discharge date, they may have to pay for services provided beyond that date.

- If the expedited appeal decision is in the member's favor, we will continue to cover the hospital stay for as long as medically necessary.
- If it's not in the member's favor, we will not cover any hospital care provided beyond the planned discharge date (unless and IRE review overturns our decision).

Skilled Nursing Facility, Home Health Agency or Comprehensive Outpatient Rehabilitation Facility Appeals

If a member feels the coverage for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF) service is ending too soon, they can appeal directly a QIO. As with hospital services, these services may be covered during the appeal review if filed on time.

Notice of Medicare Non-Coverage

If CareFirst and/or the provider decide to end coverage for SNF, HHA or CORF, a written Notice of Medicare Non-Coverage (NOMNC) must be delivered to the member at least two calendar days before coverage ends. The member or authorized representative will be asked to sign and date this document. Signing the document does not mean the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in their records.

Beneficiary and Family Centered Care - Quality Improvement Organization Review

For hospital, SNF, HHA, or CORF services, members may ask for an appeal if their coverage was terminated. The member will be issued a notice advising that their coverage for the stay was terminated. The member or authorized representative can ask the QIO to do an independent review of whether terminating coverage is medically appropriate.

The notice will provide the name and phone number of the appropriate QIO agency.

- If the member receives the termination notice two days before coverage is scheduled to end, the member must contact the QIO no later than noon of the day following the day the notice is received.
- If the notice is received more than two days prior to the scheduled end in coverage, the QIO must be contacted no later than noon of the day before the scheduled termination of coverage.

If the QIO reviews the case, they will ask for the member's opinion about why the services should continue. The response is not required in writing. The QIO will look at medical information, talk to the doctor, and review other information that we provide.

Note: The provider must fax all the member's medical records immediately to the QIO for their review. CareFirst will provide the member and the QIO a copy of the explanation for termination of coverage.

The QIO will make a decision within one full day of receiving all the necessary information.

- If they decide the termination of coverage is not medically appropriate, we will continue to cover the stay for as long as medically necessary.
- If they decide it is medically appropriate, the member will be responsible for paying the hospital, SNF, HHA, or CORF charges after the termination date that appears on the advance notice.

Note: Neither Original Medicare nor CareFirst will pay for these services.

If the member agrees to stop receiving services on or before the date given on the notice, there will be no financial liability.

If the member or authorized representative does not ask for a QIO review in a timely manner, they may request an expedited appeal. However, the member may have to pay for services provided beyond the termination date.

- If the decision is in the member's favor, we will continue to cover the care for as long as medically necessary
- If the decision is not in the member's favor, we will not cover any of the care provided beyond the termination date, and the member may be financially responsible.

Member Appeals for Coverage or Payment of Other Medical Services

If CareFirst does not approve services a member believes should be covered or provided, the member or authorized representative may file an appeal.

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

Filing Standard Payment Appeals

Members can file a standard payment appeal within 60 calendar days of the date of the notice of the initial decision. 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

Filing Standard Pre-Service Appeals

Members can file a standard pre-service appeal within 60 calendar days of the date of the notice of the initial determination. That timeframe may be extended if good cause exists.

All standard pre-service appeals for a service or Part B drug must be submitted in writing to:

Appeals and Grievances Department
10455 Mill Run Circle
Room 11113-A
Owings Mills, MD 21117

Appeal Timeframes and Decisions

Standard Payment Appeals

For payment appeals, we will send a decision within 60 days for payment for a service or Part B drug that was already received. 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.

Standard Pre-Service Appeals

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

Timeframe	Scenario
7 days	For a request for a pre-service Part B drug that the member wants to receive (drug has not yet been provided)
30 days	For a pre-service request for coverage of a benefit or service that the member wants to receive. (Care has not yet been provided)

If additional information is needed to complete the benefit or service appeal review, the timeframe may be extended up to 44 calendar days.

Note: There are no extensions for Part B prescription drug appeals.

Expedited Appeals

Expedited Pre-Service Appeals

If waiting for a decision will seriously harm the member's health, they can request an expedited appeal.

To file an expedited pre-service appeal, members can call Member Services at **855-290-5744.** They can also fax (410-605-2566) or mail it to:

Appeals and Grievances Department
10455 Mill Run Circle
Room 11113-A
Owings Mills, MD 21117

CareFirst has up to 72 hours to decide. We will make it sooner if the member's life, health, or ability to regain maximum function requires it. If we need additional information, the timeframe for review may be extended up to 14 calendar days.

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.

Note: The IRE has a contract with CMS and is not part of CareFirst.

Once a decision is reached, everyone involved in the appeal will be notified. If the decision is a denial, the member or authorized representative will be verbally notified their appeal has been forwarded to the IRE.

Independent Review Entity

CareFirst will automatically forward all adverse reconsideration decisions where the original denial is upheld in part or in full to the IRE. The member may request a copy of the file provided to the IRE for review. The IRE will notify the member of the receipt of the appeal. They will also review the request and decide if we must provide service or payment.

Timeframes for the IRE to issue a decision include:

Appeal Type	Timeframe	Extension
Payment of services already received	60 calendar days	14 calendar days if more information is needed and it's in the member's best interest.
Standard appeals regarding medical care not yet provided	30 calendar days	
Expedited appeals regarding medical care	72 hours	
Part B Prescription drug	7 calendar days	Not applicable

The IRE will issue its decision in writing to the member or authorized representative and CareFirst.

- If the decision is not in the member's favor, the member pursue an administrative law judge review.

Administrative Law Judge Review

The ALJ works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.

Note: The ALJ will not review an appeal if the dollar value of the medical care is less than the minimum requirement and there are no further avenues for this appeal. Refer to The Amount in Controversy, Federal Minimum Requirements for Filing section in this chapter.

During an ALJ review, the member may present evidence. They may also review the record and be represented by an attorney. The ALJ will hear the case, weigh all the evidence, and make a decision as soon as possible.

The ALJ will notify all parties of the decision.

- If the decision is not in the member's favor, they can request a review by the Medicare Appeals Council (MAC)/Departmental Appeal Board. The decision issued by the ALJ will inform the member how to request such a review.

Medicare Appeals Council

The MAC is part of the federal department that runs the Medicare program. It does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review.

- If the MAC decides not to review the case, either party may request a review by a Federal Court Judge.

Federal Court

Members have the right to file the case with Federal Court. The dollar value of the services must meet the minimum requirements. Otherwise, the case will not be reviewed, and the member will have no further right of appeal.

Appeals for Coverage of Part D Drugs

CareFirst encourages its members to contact us through Member Services with any questions or concerns related to prescription drug coverage. As with medical services, we have processes to address various complaints regarding drug benefits.

The member or authorized representative may submit a Part D prescription drug appeal for the following scenarios:

- The member is not able to get a prescription drug that may be covered.
- The member has received a Part D prescription drug that may be covered, but we have refused to pay for the drug.
- We will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary.
- The member disagrees with the copayment amount.
- Coverage of a drug is being reduced or stopped.
- There is a requirement to try other drugs before the prescribed drug is covered.
- There is a limit on the quantity or dose of the drug.

Note: If CareFirst approves a member's exception request for a non-formulary drug, the member may not request an exception to the copayment that applies to that drug.

Submitting Part D Appeals

Providers who feel a member's life or health is in serious jeopardy may start the Part D appeal process by calling **888-970-0917**. Prescribers may also use this number to address process or status questions regarding the Part D appeal process.

All appeals must be filed within 60 calendar days from the date of the coverage determination. If the member's life, health, or ability to regain maximum function is in jeopardy, they may request an expedited appeal. CareFirst will make every effort to gather all the information needed to make a decision about the appeal. Qualified individuals not involved in making the coverage determination will review each request. Members have the right to obtain and provide additional information as part of the appeal. Additional information in support of the member's appeal may be provided in writing to:

CVS Caremark Coverage Determinations/Exceptions
P.O. Box 52000
Phoenix, AZ 85072-2000

You may also provide this information by phone at **1-888-970-0917**.

Members also have the right to ask us for a copy of the information pertaining to their appeal. They can request this information by calling the phone number listed above.

Decisions on Part D appeals

For standard pre-service decisions about a Part D drug:

- We have up to seven calendar days to issue a decision and approve the drug in question. If the member's health condition requires it, we will issue the decision sooner.
- If we do not issue a decision within seven calendar days, the request will automatically be forwarded to the IRE for review.

Note: Everyone involved in the appeal will be notified of the decision once it is made.

If we approve the appeal for a Part D drug, we must authorize payment for the drug within 14 calendar days from the date we received the request. The payment must be sent no later than 30 calendar days after the date we received the request.

For expedited appeal regarding Part D drugs that have not been prescribed:

- We have up to 72 hours to issue a decision and approve the requested medication. If the member's health condition requires it, we will issue the decision sooner.
- If we do not comply with the 72-hour timeframe, the case will automatically be forwarded to the IRE for review.

Note: If the appeal is denied, the member may ask for an IRE review. However, a review is not guaranteed since IRE is typically for medical services. Information on requesting an IRE review will be in the member's initial denial notice.

Independent Review Entity

The member or authorized representative must submit a request to the IRE in writing within 60 calendar days of the appeal decision notice. The IRE's name and address will be included in this notice. The IRE will review the request and decide about whether CareFirst must cover or pay for the medication.

Note: The IRE has a contract with CMS and is not part of CareFirst.

An expedited IRE is also available if the member's condition requires it. For an expedited IRE review, the IRE must issue a decision within 72 hours. For a standard IRE review, the IRE has up to seven calendar days to issue the decision.

The IRE will issue its decision in writing, explaining the reasons for the decision. Refer to the CareFirst Actions Based on Review Decisions table below for favorable decision outcomes.

- If the member is not satisfied with the result of the IRE review, they may request an ALJ review.

Administrative Law Judge Review

To request an ALJ review, the value of the drug in question must meet minimum requirements. To calculate the amount in controversy, the dollar value will be projected based on the number of refills prescribed for the requested drug during the plan year. This projected value includes:

- co-payments,
- all expenses incurred after the member's expenses exceed the initial coverage limit, and
- any expenses paid by other entities.

Claims may also be combined to meet the dollar value requirement if:

- the claims involve the delivery of Part D drugs to the member,
- all claims have been reviewed by the IRE,

- each of the combined requests are filed in writing within the 60-day filing limit, and
- the hearing request identifies all the claims to be heard by the ALJ.

An ALJ review must be submitted in writing within 60 calendar days of the date of the IRE decision. The member may request an extension of the deadline for good cause.

During the ALJ review, the member or authorized representative may present evidence. They may also review the record and be represented by counsel.

The ALJ will hear the member's case, weigh all the evidence submitted, and issue a decision as soon as possible.

The ALJ will issue a decision in writing to all parties. Refer to the CareFirst Actions Based on Review Decisions table below for favorable decision outcomes.

- If the ALJ rules against the member, a MAC review may be requested. The ALJ notice will provide instructions on how to request a review.

Medicare Appeals Council

The MAC is part of the federal department that runs the Medicare program. There is no minimum dollar value for the MAC to conduct a review. The MAC does not review every case it receives. When it gets a case, it decides whether to review the case.

If the MAC decides not to review the case, a written notice will be issued. This notice will advise the member if further action can be taken with respect to the request for review. The notice will instruct the member how to request a review by a Federal Court Judge.

If the MAC reviews the case, it will inform all parties of its decision in writing. Refer the CareFirst Actions Based on Review Decisions table below for favorable decision outcomes.

- If the decision is not in the member's favor, they may request a judicial review. But only if the dollar value of the medication meets minimum requirements.

Federal Court

If the member isn't satisfied with the MAC's decision, they can file civil action in a U.S. District Court to request judicial review of the case. The MAC letter will explain how to do this. The dollar value of the drug in question must meet the minimum requirement to go to a Federal Court. The federal judiciary is in control of the timing of any decision.

If the Judge decides in the member's favor, CareFirst must approve or pay for services under the same time constraints outlined above. Otherwise, the decision is final and there is no further right of appeal.

Amount in Controversy, Federal Minimum Requirements for Filing

To view the Amount in Controversy, Federal Minimum Requirements for Filing, visit the CMS website.

CareFirst Actions Based on Review Decisions

The actions we must take depend on the decision from the IRE, ALJ, and MAC reviews.

Timeframe	Scenario	Action
30 calendar days	Decision is in the member's favor. The member has already received and paid for the drug in question	We will reimburse the member within the specified timeframe of receiving the decision.

72 hours	Decision is in the member's favor. The member has not yet received the drug in question	We will approve the medication within the specified timeframe of receiving the decision.
24 hours	Decision is in the member's favor. An expedited review was requested	We will approve the medication within the specified timeframe of receiving the decision.

Note: For IRE reviews, we must send the member confirmation that we have honored their decision for standard appeals.

Member Grievances

Grievances are member complaints. They do not involve coverage or payment for benefits. Concerns about failure to pay for a certain drug or service should be addressed through the appeals processes.

The member grievance process may be used to address other problems related to coverage, such as:

- Problems with waiting on the phone or in the office
- Disrespectful or rude behavior by providers or their staff
- The cleanliness or condition of a provider's office or facility
- If a member disagrees with our decision not to expedite a request for coverage determination
- If CareFirst does not provide a decision within the required timeframe
- If we do not forward a case to an IRE if we do not comply with required timeframes for reconsideration
- If we do not provide the member with required notices

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

The grievance will be sent to our Appeals and Grievance department for handling. A response may take 30 days. Or if more information is needed, up to 44 days.

Members can file an expedited grievance under certain conditions.

Submitting a Grievance

For immediate attention, call **855-290-5744.** Members may also fax (443-753-2298) or mail grievances to:

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

Members are encouraged to contact Member Services first for immediate assistance to resolve their concern. If Member Services cannot resolve the complaint, our Grievance team will review it.

Note: Grievances received verbally will be followed up verbally. Grievances received in writing will be followed up in writing. Grievances regarding quality of care will always receive a written response.

If the member would like to have someone else file a grievance on their behalf, an AOR form must be completed.

Standard Grievances

The member or authorized representative will submit any information, documentation or evidence regarding the grievance. Many grievances are resolved within the original phone call. If the grievance is in writing, our Grievance team will research the grievance and follow up on the findings. We may extend the timeframe by up to 14 calendar days if the member requests the extension. Or, we justify a need for additional information and the delay is in the member's best interest.

Expedited Grievances

It may be necessary to expedite the review of a grievance because the member's life, health or ability to regain maximum function is in jeopardy. Members may file an expedited grievance if they disagree with instances when we have:

- Extended the timeframe to make an Organization Determination
- Extended the timeframe to resolve an appeal
- Refused to grant their request for an expedited Organization Determination
- Refused to grant their request for an expedited appeal

Note: Expedited grievance review is only available for the circumstances outlined above.

The member or authorized representative will receive a decision within 24 hours of receiving the request. We will notify all affected parties of the decision by phone within 24 hours of filing the grievance. A letter explaining the decision will follow within three days.

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 not paid or paid incorrectly. 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 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 provider service for a review of the payment. The provider must give a reason for the payment dispute. Our customer service team will research the issue and follow up with the provider.

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

Second Level Provider Disputes

Contracted providers must make a written request for a second level provider dispute. We must receive the request within 180 calendar days of the date of the notice denying a post-service claim.

- When an authorization has been denied, the provider must adhere to the 60-day timeframe. The 180 days, once the claim has been denied, does not apply.

To request a second level dispute, the provider must submit all supporting documentation including:

- a copy of the denied claim,
- the reason for the appeal, and
- the member's medical records containing all pertinent information regarding services rendered.

All reviews will be completed within 60 days of the date the written request was received.

Quality Improvement

Overview

As part of CareFirst, providers, and Medicare Advantage plans must adhere to regulations set by CMS. Please note that all providers are responsible for adhering to CMS regulations that are outlined in this manual, as well as CMS policies.

Star Rating Program

CMS uses the Star Rating system to measure MA plan performance. Star Ratings measure the quality of healthcare provided by plans and its providers, including member experience, health and clinical outcomes, and health plan administrative functions for Part C and Part D. Star Ratings range from 1 to 5 Stars, with 1 being the lowest and 5 being the highest. CareFirst has a goal of achieving a 4+ Star Rating to provide the highest quality of care to our members, and partnership with providers is critical to achieving that goal.

The Star Ratings that are impacted by providers are:

- Healthcare Effectiveness Data and Information Set (HEDIS) – Measure that ensure members are receiving preventative care such as screenings and tests, as well as managing chronic conditions.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A survey that asks members to evaluate their health care experiences including obtaining appointments and care quickly, getting needed care, care coordination, and overall rating of healthcare.
- Health Outcomes Survey (HOS) – A survey that asks members to evaluate their health outcomes year over year, including improving or maintaining physical and mental health, monitoring physical assessment, improving bladder control, and reducing the risk of falling.
- Clinical Pharmacy – Measures that focus on measuring member adherence to medication and appropriate medication management.

How are Star ratings derived?

A health plan's rating is based on measures in five categories:

- Staying Healthy Screenings, Tests and Vaccines
- Managing Chronic (Long Term) Conditions
- Member Experience with Health Plan
- Member complaints and Changes in the Health Plan's performance
- Health Plan Customer Service

To learn more about the CMS five start quality rating system, visit CMS's website. You can find more information about Quality Improvement activities outlined in Chapter 7: Care Management of this manual.

Audits

CareFirst conducts audits in accordance with Medicare laws, rules and regulations. Other audits will be conducted as needed, such as diagnosis-related groups validation, site of care, readmission, etc. CareFirst may contract with a vendor as a business associate that is covered by the Health Insurance Portability and Accountability Act to conduct specific audits and/or reviews. Examples of possible reviews include:

- Risk adjustment
- Healthcare Effectiveness Data and Information Set

Medical records may be requested by mail or obtained by on-site imaging at the provider's office and/or facility. The on-site reviewer will have the capability to scan and copy medical records as well as the technology to access electronic medical records. Providers are required to provide medical records for CareFirst to fulfill state and federal regulatory and accreditation obligations. If a reviewer cannot copy records, CareFirst will reimburse providers at a reasonable cost for the duplication of the medical records.

For more information on Audits, refer to the Requests for Charts section in Chapter 3: Provider Network Requirements.

Practice Transformation

What is Practice Transformation?

For more information on Practice Transformation, refer to the Practice Transformation section in Chapter 3: Provider Network Requirements.

Health Systems and Accountable Care Organizations

In 2011, CareFirst began its own PCMH Program to improve health outcomes and value for our members. In 2019, we initiated separate Adult and Pediatric PCMH Programs to meet the needs of these two diverse populations. In 2020, we launched our Total Care Accountable Care Organization (ACO) model; CareFirst offers ACO programs for providers in our MA networks. To participate in CareFirst MA Total Care program, ACOs must operate within the network's geography and provide primary care, multi-specialty, inpatient care, and emergency department access.

Some key elements of the MA Total Care Program:

- Performance-Based Incentives: At the beginning of every month, each ACO will receive a monthly budget for their attributed member population based on CMS' payment to CareFirst. This budget will be compared to the actual total cost of care for attributed members at the end of the year.
    - If an ACO keeps their member costs below the budget, it will receive a portion of the savings as bonuses.
    - If an ACO is over the budget, it must repay a portion of the losses.
- Quality: To ensure that cost savings do not come at the expense of quality, ACOs must meet specific quality performance thresholds to be eligible for shared savings. These thresholds are based on a subset of Star Rating System quality metrics for the MA population. These evidence-based measures focus on addressing health needs across the continuum of care, including preventive screenings, diabetes management, hospital readmissions, and access to behavioral healthcare. In other words, providers are rewarded for keeping their patients healthy and out of the hospital.

ACOs are an integral part of CareFirst's volume to value strategy. They allow CareFirst and providers to be jointly accountable for our members' health and create greater value for those we collectively serve.

In addition, our MA Total Care Program provides PCPs and health systems with significant clinical expertise, analytical resources, and financial incentives to help them transform their system. Each enrolled health system receives the following:

- A care coordinator
- Access to a suite of clinical support programs
- A practice consultant trained to identify and implement transformation opportunities
- Robust performance and quality data available online 24/7

ACO Transformation Opportunities

CareFirst has equipped health systems with additional resources to enable transformation activities. In addition to field-based practice consultants, CareFirst has a team of enterprise managers serving a similar role for leadership of most large, engaged health systems in our network. Regular meetings between CareFirst enterprise managers and health system executives help give leadership a closer view of their MA Total Care ACO progress as well as opportunities to implement transformation strategies that improve their outcomes. Health system executive sponsorship is key to improving access and affordability of healthcare to CareFirst members.

Examples of transformation strategies for health systems:

- Modify site of service and other cost inefficiencies commonly found in specialist groups and other ambulatory services.
- Leverage robust CareFirst claims data available through the MA Total Care Program to prescribe lower cost medications, close gaps in care, understand cost and utilization, and reduce variance in program performance across providers and practice sites.
- Facilitate collaboration between embedded care coordinators to reduce duplication and strengthen continuity of care.
- Integrate with a two-way data sharing platform to improve quality reporting performance, decrease records requests, and achieve a complete view of existing patients including visits outside of the system.

Medicare Pharmacy Management

Pharmacy Network

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

Formulary

A formulary is a list of drugs that we cover.

CareFirst delegates formulary creation to its Pharmacy Benefits Manager (PBM). 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 the CMS. CareFirst chooses 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 names)
- 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 a PA 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 allows for extended day supplies, meaning up to 90-day fills, at both retail and mail order. We encourage providers to write for these longer fill lengths for members with established histories of chronic medications such as those for hypertension, diabetes, and hypercholesterolemia.

CareFirst also uses CVS Caremark 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 PA and ST criteria at carefirst.com/Medicare.

Exception Requests

Members and their providers may submit the following requests for a drug exception:

- 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
- PA or UM Exception – A request to waive UM criteria such as PA, QL, and ST

Generally, we will only approve a request for an exception if the alternative drugs included on the formulary would not be effective in treating the members' condition, or there is a safety concern.

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 has certain medications that require PA and/or ST. Our PBM handles the initial request while CareFirst is

responsible for appeals. Lists of medications, including those with PA or ST, are available at carefirst.com/Medicare.

Ensuring Appropriate Utilization of Opioids

A topic applicable and relevant for any population, CareFirst has safety edits on top of existing formulary listings and UM. 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 in order to help prevent problematic or habitual use.
- Care coordination edit: When members opioid prescriptions written by three different prescribers and are at or above 90 Morphine Milligram Equivalent (MME), the claim will reject and allow for the pharmacist to review the situation. This helps to ensure communication between providers once high opioid levels are met to help prevent over prescribing.
- High MME edit: When members have opioid prescriptions written by three different prescribers and are at or above 200 MME, the claim will reject and require a coverage determination in order 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 Medicare members can continue to receive medications they may have been taking before joining CareFirst, or for active members who have a history of medication use but now formulary coverage has changed. Below you will find a summary of information on transition.

Description	Transition Fill Days' Supply
New & Renewing Members	
Not in long-term care (LTC)	30 days' supply within the 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.
In LTC	31 days' supply within the 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 are allowed to accommodate fills for amounts less than prescribed/first 90 days.
Non-LTC Resident Level of Care Change	
Member released from LTC facility within the past 30 days	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 member 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 requirement for Medicare Advantage Prescription Drug plans. Pharmacists in various settings work with members to review their current medication regimens in order 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 Health Failure (CHF)
  - Diabetes
  - Depression
  - Asthma
  - Chronic Obstructive Pulmonary Disorder (COPD)
  - Cardiovascular Disorders
  - HIV/AIDS
- Take eight or more chronic medications for the illnesses mentioned above
- Total drug spend annually on medications based on the dollar amounts announced on the CMS Website, which is projected from three months' worth of claims

Qualifying members will be enrolled automatically and can opt-out. 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 medication regimens pursuant to these reviews.

Preservice Review & Compliance/Utilization Management

Healthcare providers may be required to submit requests for prior approval in advance for services such as medical, behavioral health/substance abuse, and pharmacy health care services for our members.

What is a Prior Authorization?

A prior authorization, or prior approval, is a review and assessment of planned services that helps to distinguish the medical necessity and appropriateness to utilize medical costs properly and ethically. Prior authorizations are not a guarantee of payment or benefits.

General Requirements

- Services must be covered under the member's benefit plan
- Services must be medically necessary and appropriate

- Services must be performed in the appropriate setting

Services Requiring Authorization

An authorization is required for the following services pending verification of eligibility requirements and coverage under the member's health benefit plan:

- Any service provided in a setting other than a physician's office, except for lab and radiology facilities, and freestanding Ambulatory Surgery Centers (ASCs)
- 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 hospital
- DME for certain procedure codes –view the list of codes requiring prior authorization at carefirst.com/preauth
- Follow up care provided by a non-participating provider following discharge from the hospital
- Hemodialysis (unless performed in a participating free-standing facility)
- Home healthcare, home infusion care
- Nutritional services (except for diabetes diagnosis)
- Prosthetics when billed by an ancillary provider or supply vendor
- Radiation oncology (except when performed at contracted freestanding centers)
- Skilled nursing facility care
- Treatment of infertility
- Attended sleep studies (for more information on pre-certification or pre-authorization, visit carefirst.com/preauth)
- Medical Injectables
    - Certain medical injectables require prior authorization when administered in an outpatient hospital and home or office settings. Intravenous immune globulin 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 all CareFirst products. The complete list of medications that require prior authorization is available at carefirst.com/preauth > Medications.

Services Not Requiring Authorization

Any service performed at a participating freestanding Ambulatory Surgery Center (ASC) does not require prior authorization. When members are referred appropriately to ASCs, healthcare 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 Doctor or Facility.

How to submit a Prior Authorization Request

Online

Log onto the CareFirst Provider Portal to input requests. Have the following information available to complete the request:

- Member's name, address, and telephone number
- MA Member ID number
- Member's gender and date of birth
- Attending provider'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

Fax

Requests can be faxed to the following numbers:

- Inpatient Services: 443-753-2341
- Outpatient Services: 443-753-2342
- Durable Medical Equipment: 443-753-2343
- Home Care: 443-753-2343
- Outpatient Pre-Treatment Authorization Program (OPAP for outpatient PT/OT/ST): 443-753-2346
- Outpatient Behavioral Health: 443-753-2347

Phone

Requests can be made by phone by calling **866-PRE-AUTH (773-2884)**

Mail

Preservice Review Department
10455 Mill Run Circle
Room 11113-A
Owings Mills, MD 21117

Note: In order to better service our providers and members, please download the appropriate prior authorization form found here. This will help us process the request more efficiently; however, it is not required for CareFirst members.

Emergency Hospital Admissions

When ER professionals recommend emergency admission for a 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 authorization process outlined below.

When to Submit Prior Authorization Requests

We advise that you submit advance notification requests with supporting clinical documentation as soon as possible, but at least two weeks before the planned service. After a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.

It may take up to 15 calendar days (14 calendar days for standard MA requests and 72 hours for expedited requests) for us to make a decision. We may be required to extend this time if additional

information is needed. Submitting requests through the Guiding Care Utilization Management Authorization system assists in timely decisions.

We prioritize case reviews based on:

- Case details
- Completeness of the information received
- CMS requirements
- State or federal requirements

If you require an expedited review, please call the number listed on the back of the member's ID card. You must explain the clinical urgency. You will need to provide required clinical information the same day as your request.

We expedite reviews upon request when the member's condition:

- Could, in a short period of time, put their life or health at risk
- Could impact their ability to regain maximum function
- Causes severe, disabling pain (as confirmed by a physician)

Durable Medical Equipment

Durable Medical Equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to service a medical purpose
- Not useful to a person in the absence of illness, disability, or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

Criteria for Utilization Management Decisions

CareFirst uses the MCG Medicare Compliance Guidelines, MCG Medical/Inpatient/Surgical, Ambulatory Care, Home Health Care Guidelines 24th edition, The MCG Behavioral Health Care Guidelines 24th edition, and the American Society of Addiction Medicine (ASAM) criteria.

MCG Behavioral Health Guidelines: Evidence-based criteria guidelines are used to determine the appropriate course of treatment and level of care for behavioral health diagnoses including recommended clinical pathways such as recovery course with expanded recovery milestones, continued stay through discharge criteria to ensure proactive management and support delivery of quality managed health care to members.

MCG Medical/Inpatient/Surgical, Ambulatory Care, Home Health Care Guidelines: Evidence-based criteria guidelines are used to determine the appropriate course of treatment and level of care for medical diagnoses, inpatient hospital, surgical procedures, outpatient, and home health services to apply the recommended medically necessary clinical pathways to ensure proactive management and support delivery of quality managed health care to members.

MCG Medicare Compliance Guidelines: The Medicare Compliance Guidelines are based on the Center for Medicaid and Medicare Services (CMS) Medicare coverage clinical policies for Medicare beneficiaries to facilitate the use and apply the guidelines determined by CMS to provide guidance on the justification of necessary or not necessary services in a variety of circumstances and settings using the 3 types in Medicare Compliance: National Coverage Analysis guidelines (NCA), National Coverage Determinations guidelines (NCD) and Local Coverage Determinations (LCD) guidelines to ensure efficient use, proactive management and support delivery of quality managed health care to members.

The ASAM criteria are evidenced based criteria and guidelines used in making substance use disorder medical necessity determinations and includes guidelines for placement, continued stay, transfers and discharges of patients with addiction and substance use disorders

CareFirst's Dental Clinical Criteria have been developed, revised, and updated periodically and reviewed and approved by the CareFirst Dental Advisory Committee (DAC) and/or the Oral and Maxillofacial Surgery Advisory Committee (OMSFAC). The DAC is comprised of the Dental Director who acts as chairperson for the committee and 12 practicing network dentists. The OMSFAC is comprised of the Dental Director who acts as chairperson for the committee and six network oral surgeons.

The criteria are derived from reviews of the current dental literature, subject textbooks, other insurance companies, and

- Practice Parameters, American Association of Periodontology (www.perio.org)
- Parameters of Care, American Association of Oral and Maxillofacial Surgery (www.aaoms.org)
- Oral Health Policies and Clinical Guidelines, American Academy of Pediatric Dentistry (www.aapd.org)
- Position Statements, American Association of Dental Consultants (www.aadc.org)
- Dental Practice Parameters, American Dental Association (www.ada.org)

Dental Clinical Criteria is posted on carefirst.com under the Providers tab in the Programs/Services section.

CareFirst physician reviews are available to discuss UM decisions. Providers may call **833-707-2287** to speak with a physician reviewer or to obtain a copy of any of the above-mentioned criteria free of charge. 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 and existence of coverage. CareFirst does not specifically reward practitioners or other individuals for issuing denials of coverage, care, or service. Additionally, financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to coverage, care, or service.

Coordinating and Arranging Care

Note: For any requests, there must be a referral from the PCP *in addition* to the servicing/rendering provider.

When an admitting physician calls the hospital to schedule an inpatient or outpatient procedure, they must provide the hospital with the following information:

- The name and telephone number of the admitting physician or surgeon
- A diagnosis code
- A valid Current Procedural Terminology (CPT®) code and/or description of the procedure being performed. The hospital will then request the authorization from CareFirst.

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

Electronic Provider Access along with general pre-certification/pre-authorization for out-of-area providers can be found in Chapter 2: Product Descriptions.

Hospital Services Inpatient Hospital Series – Elective Authorization Process

The hospital is responsible for initiating all requests for authorization for an inpatient admission through CareFirst Direct. However, when the admitting physician calls the hospital to schedule an inpatient procedure, they must provide the hospital with the following information:

- A valid ICD-10 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 a call from the admitting physician at least five business days prior to any 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 if additional information is needed before approving the authorization.

Important note: 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 utilization management specialist 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.

Prior Authorization Requests from Out-of-Network Providers

CareFirst members are not required to request pre-certification/pre-authorization when visiting an out-of-network (OON) provider. However, OON providers are encouraged to submit a pre-certification/pre-authorization or encourage the member to do the same, as we have the right to deny claims if the service is deemed not medically necessary during review.

Out-of-Network Reimbursement Guidance

If an OON provider sees a CareFirst member, the provider will be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e. the provider would get paid at the same rate if the member was enrolled in Traditional Medicare).

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 and/or performed by in-network freestanding providers.

Clinical Programs for Medicare Advantage Members

For specific information regarding care management, refer to Chapter 7: Care Management