PROVIDER MANUAL
Chapter 3: Provider Network Requirements

Administrative Functions
Credentialing

Professional Providers

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

Eligible professional providers

- Medical Doctor
- Osteopath
- Podiatrist
- Chiropractor
- Optometrist
- Nurse Practitioner
- Nurse Midwife
- Nurse Anesthetist
- Registered Nurse Clinical Specialist
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Psychologist
- Lactation Consultant (licensed healthcare practitioner)
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Counselor
- Licensed Alcohol and Drug Counselor
- Licensed/Registered Dietician/Nutritionist
- Licensed Art Therapist (Maryland only)
- Licensed Board-Certified Behavior Analyst (Maryland and Virginia only)
- Naturopath (Maryland and Washington, D.C. only)
- Acupuncturist
Professional provider credentialing

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

How to apply

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

Once you have completed your application (CAQH will email you notification that your application is complete), and you have authorized CareFirst to access your data, go to http://www.carefirst.com/caqhquestionnaire, complete and submit the online form. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

The practitioner’s credentialing information is verified to confirm that our credentialing criteria is met. This includes, but is not limited to:

- Valid, current, unrestricted licensure
- Valid, current, Drug Enforcement Agency and Controlled Dangerous Substance registration, if and as applicable, for each state where the practitioner practices
- Appropriate education and training in a relevant field
- Board certification, if applicable
- Review of work history
- Active, unrestricted, admitting privileges at a participating network hospital, except as otherwise agreed to by CareFirst in its sole discretion
- At least 20 office hours per week to see patients
- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
- Attestation to ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use.
- Current malpractice insurance coverage with minimum limits as indicated below:

<table>
<thead>
<tr>
<th>Malpractice Insurance Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of practitioners in practice</strong></td>
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<tr>
<td>---------------------------------</td>
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<tr>
<td></td>
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</tbody>
</table>
### Malpractice Insurance Coverage

<table>
<thead>
<tr>
<th>1</th>
<th>$1M/$3M Individual</th>
<th>N/A</th>
<th>$.5M/$1.5M Individual</th>
<th>N/A</th>
<th>$1M/$3M Shared (up to 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2–5</td>
<td>$1M/$3M Shared</td>
<td>N/A</td>
<td>$.5M/$1.5M Shared</td>
<td>N/A</td>
<td>$1M/$3M Shared (up to 24)</td>
</tr>
<tr>
<td>6–10</td>
<td>$2M/$6M Shared</td>
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<td>$1M/$3M Shared</td>
<td>N/A</td>
<td>$1M/$3M Shared (up to 24)</td>
</tr>
<tr>
<td>11–24</td>
<td>$2M/$6M Shared</td>
<td>$5M</td>
<td>$1M/$3M Shared</td>
<td>$3.25M Shared</td>
<td>$1M/$3M Shared (up to 24)</td>
</tr>
<tr>
<td></td>
<td>$1M/$3M Shared</td>
<td>$10M</td>
<td>$.5M/$1.5M Shared</td>
<td>$7.5M Shared</td>
<td></td>
</tr>
<tr>
<td>25–50</td>
<td>$2M/$6M Shared</td>
<td>$10M</td>
<td>$1M/$3M Shared</td>
<td>$5M Shared</td>
<td>Individual Consideration</td>
</tr>
<tr>
<td></td>
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<td>$15M</td>
<td>$.5M/$1.5M Shared</td>
<td>$10M Shared</td>
<td></td>
</tr>
<tr>
<td>51+</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
<td>Individual Consideration</td>
</tr>
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</table>

If all credentialing criteria is met, the CareFirst Medical Director refers the practitioner to the Credentialing Advisory Committee (CAC) for a recommendation to approve the application. If credentialing criteria is not met, the Medical Director may deny the application or defer to the CAC for their recommendation. The Medical Director may request additional information from the practitioner. Practitioners will be notified in writing upon approval or denial. If the application is denied, the practitioner is afforded the opportunity to submit a written appeal within 30 days. The decision based on the appeal is final.

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

**Note:** To avoid confusion and unexpected out-of-pocket expenses for members, all providers in the same practice must participate in the same provider networks.
To ensure that CareFirst has obtained correct information to support credentialing applications and made fair credentialing decisions, providers have the right, upon request, to review this information, to correct inaccurate information and obtain the status of the credentialing process. Requests can be made by calling 877-269-9593 or 410-872-3500.

Institutional and Ancillary Providers

CareFirst contracts with the following organizational and ancillary providers who meet CareFirst requirements.

Eligible institutional and ancillary providers

- Medical
  - Birthing Center
  - Freestanding Ambulatory Surgery Center (ASC)
  - Freestanding Dialysis
  - Home Health
  - Hospice
  - Hospital
  - Rehab Hospital
  - Skilled Nursing Facility
  - Lithotripsy
- Behavioral health
  - Ambulatory
  - Residential/Inpatient
- Alcohol Rehabilitation
  - Ambulatory
  - Residential/Inpatient
- Drug Rehabilitation
  - Ambulatory
  - Residential/Inpatient
- Durable Medical Equipment (DME)

Locum Tenens

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

**Recredentialing**

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

**Ongoing Monitoring of Sanctions**

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

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

**Adding a New Practitioner to Your Existing Group Practice**

Practitioners can go directly to CAQH ProView and complete the credentialing application online through the CAQH ProView secure website. If the CAQH ProView application is already complete, make sure it includes the new practice affiliation information. Once complete, go to carefirst.com/provider > click Join Our Networks > click How to Apply > Select the CareFirst Questionnaire. Follow the prompts to add the practitioner to the practice and click submit.

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

**Access and Availability**

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

**Appointment Wait Times – Network Accessibility Standards**

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

<table>
<thead>
<tr>
<th>Appointment type</th>
<th>Time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care (including medical, behavioral health, and substance use disorder services)</td>
<td>72 hours</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>15 calendar days</td>
</tr>
</tbody>
</table>
Network accessibility standards

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Visit/Well Visit</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Non-urgent specialty care</td>
<td>30 calendar days</td>
</tr>
<tr>
<td>Non-urgent behavioral health/substance use disorder services</td>
<td>10 calendar days</td>
</tr>
</tbody>
</table>

Provider Data Accuracy

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

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

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

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

Institutional and Ancillary Provider Credentialing

CareFirst credentials institutional and ancillary providers prior to contracting and every three years thereafter. Prior to contracting, CareFirst confirms that such providers are in good standing with state and federal regulatory bodies and confirms that the providers have been reviewed and approved by an appropriate accrediting body. If the provider is not accredited, CareFirst may conduct an on-site quality assessment as part of the credentialing process. View our credentialing requirements.

How to apply

Complete a Request for Information Application and a Facility Data Sheet for each location along with all required credentialing documents. Submit the completed forms and required credentialing documents to:

CareFirst BlueCross BlueShield
Attention: Institutional Contracting
Mail Stop CG-51
Note: Home infusion therapy providers and medical specialty pharmacies wishing to apply can call 410-872-3515.

For more information regarding the credentialing process, click here to find frequently asked questions and view the Institutional/Ancillary credentialing requirements or the DME credentialing requirements.

Practice Transformation

What is Practice Transformation?

Practice transformation has traditionally been used to describe the process of implementing the Patient Centered Medical Home (PCMH) Model of Care\(^1\). The Joint Principles of the Patient-Centered Medical Home were developed in 2007, and in 2008, the NCQA began a formal program of medical home accreditation.

However, the term is now also being used more broadly to encompass the concepts of data-driven quality improvement, comprehensiveness and care coordination, with an emphasis on high-value, evidence-based care.

In the broadest sense, practice transformation means improving healthcare delivery to achieve the Triple Aim of population health, reduced healthcare costs, and patient satisfaction. Practice transformation includes foundational key components:

- **Payment transformation**, which aligns financial incentives with high-value care.
- **Engaged leadership** that prioritizes a continuous process of organizational learning and data-driven improvement.
- **Interdisciplinary, team-based care** that focuses on increasing staffing ratios with expanded roles for non-physician members. Using a team-based approach allows providers to practice at the top of their license, which reduces burnout and increases access to care.
- **Comprehensiveness and care coordination**, which are essential elements of population health management. Practices have a responsibility to connect high-needs patients with all the services and resources they require, which may involve providing the services internally or coordinating with external care teams.

Based on the NCQA PCMH Model, key elements of transformed practices include:

- **Increased staffing ratios**: This allows providers to practice at the top of their license.
- **Morning huddles**: The whole team meets to plan for the day together.
- **Co-location**: Providers sit the same area as their other team members to improve efficiency and communication.

\(^1\) [https://pcmh.ahrq.gov/page/defining-pcmh](https://pcmh.ahrq.gov/page/defining-pcmh)
- **Stable “teamlets”:** Providers are paired with the same nurse and medical assistant every day to improve team functioning.

- **Empanelment:** Patients always see the same provider. Size of provider panels are thoughtfully determined and carefully managed.

- **Standing orders:** Medical assistants can use standing orders to order preventive screening and point-of-care tests independently. Registered nurses can use standing orders to do protocol-based management of warfarin, hypertension and diabetes.

- **Documentation support:** Medical assistants can be trained to provide documentation support, increasing providers’ facetime with patients and reducing clinician administrative load.

- **Workflow mapping:** Workflows are carefully analyzed, optimized and standardized.

- **Health coaching:** Medical assistants can be trained to help facilitate patient behavior change by using structured motivational interview.

- **Expanded hours:** This reduces ER and urgent care use and makes services more accessible and convenient for patients.

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**Practice and Payment Transformation at CareFirst**

Implementing the transformation activities necessary to become formally accredited as an NCQA PCMH Program requires a substantial time and monetary investment that practices may not be willing or able to undertake.

CareFirst has many resources that can assist practices with this transformation, whether their goal is aligning office workflows with NCQA recommendations or facilitating collaboration across the healthcare system to improve continuity of care.

Our initial focus was enabling transformation within primary care. In recent years, we have started expanding our efforts to other areas, such as specialty practices and hospital systems, while also developing new payment models.

The following sections are intended to briefly summarize our efforts to date and provide strategies for successful transformation.

**Primary care**

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.

Our PCMH Program provides PCPs with significant clinical expertise, analytical resources, and financial incentives to help them transform their practices. Each enrolled practice receives the following:

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

Practices receive an increased fee for participating in the PCMH Program, compensation for the time they spend on care coordination, and a portion of any savings generated while maintaining a high quality of care. Eight years in, CareFirst estimates that our PCMH Program has avoided over $1 billion in healthcare
costs. To learn more and find examples of primary care transformation strategies, visit the CareFirst PCMH homepage.

**Specialty care**

Founded in 2017, CareFirst's Specialty Consulting Team is responsible for educating specialists on the utilization trends for their CareFirst patient population. The purpose is to bring price sensitivity to the market in order to facilitate quality care provided in the most cost-effective manner. In order to accomplish this, the Specialty Consulting Team contains subject matter experts who can identify clinical and operational best practices. The consultants understand the clinical disease progression for episodes that account for the highest dollars spent in the CareFirst service area. By combining data analytic tools, clinical and operational best practices, these consultants ultimately can transform practices, providing better outcomes at a lower cost for our members.

The Specialty Consulting Team manages a database of utilization trends that rate providers on the cost efficiency in which they provide care. Each specialist is compared to their peers in a very granular, case-mix adjusted manner. Two third party vendor software programs are utilized to capture and group claims into these episodes of care. Key areas, such as minimum threshold criteria and industry standard outlier control, are applied in order to collect the most sufficient sample size. This data is updated on an annual basis and provided to PCPs in the PCMH Program in order to guide their decision on when and where to refer their patients. Please note, the data provided is cost only. Quality of care determinations are left to the referring provider.

Examples of transformation strategies for specialty care practices:

- Identify lower cost settings for procedures and testing when clinically appropriate.
- Align with CareFirst's pharmacy formulary to prescribe more cost-effective prescriptions.
- Understand the frequency with which providers should see patients with chronic diseases.
- Collaborate and communicate with providers in medical community co-managing patient population (“Clinical Compact”).
- Evaluate initial consultation process to identify clinically appropriate tests prior to ordering/seeing patient.
- Share data on risks and outcomes for certain high-risk services (e.g., elective c-section).
- Provide clinical support programs for patients who need additional services.
- Educate physicians on technology and resources readily available to help manage their patient population.
- Share cost data on all services clinically related to an episode of care and share information to help providers make cost-effective decisions while maintaining the quality of care provided.

Implementing the above strategies is likely to positively impact specialists' CareFirst Cost Ranking.

**Health systems**

A large portion of costs for CareFirst members are concentrated within a few large hospitals and other health systems. Engaging these organizations in practice and payment transformation is key to improving population health across Maryland, Washington, D.C. and Northern Virginia.

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. CareFirst has also invested in hospital transition coordinators to provide additional on-site support with transitional care and discharge planning at our largest volume hospitals.

Regular meetings between CareFirst enterprise managers and health system executives help give leadership a closer view of their PCMH 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 through the PCMH Program and upcoming new value-based programs.

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 PCMH Program to prescribe lower cost medications, close gaps in care, understand cost rankings of employed specialists and reduce variance in program performance across providers and practice sites.
- Facilitate collaboration between embedded care coordinators and those provided by the PCMH Program 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.
- Link a portion of physician payment to performance in the PCMH Program and similar programs; move incentives from volume to value.
- Enroll in value-based care arrangements once available; health systems are the ideal early adopters of new payment models given infrastructure and experience.

Preparation for value-based care

Practice transformation enables organizations of any type to be successful in value-based care arrangements. CareFirst has historically used a fee-for-service reimbursement model. Moving forward in 2020 and beyond, we will begin to pilot value-based care reimbursement models for select areas of our network based on extensive research and feedback from the provider community.

Value-based care focuses on development of efficient care pathways and clinical care team optimization to support improvements in health outcomes and demonstrate increases in value. In addition to the practice transformation strategies mentioned above, there are several activities any organization can do to prepare for value-based care.

- Conduct a value-based payment readiness assessment to identify organizational strengths and weaknesses.
- Introduce a governance structure with a clearly defined vision and goals that are agreed upon by clinical leadership and communicated to all clinicians and administrators.
- Optimize electronic health records and other data tools to analyze and understand patient population from a cost and outcomes perspective.
- Develop evidence-based strategies to contain costs while maintaining or improving quality.
- Utilize care management and other preventative services in addition to evaluation and management visits.
- Implement a team-based care approach that includes daily huddles.

**Provider Score**

In addition to the credentialing requirements described above, CareFirst will utilize practice-specific profile scores that use data to evaluate practices in quality and member experience, cost efficiency, and relationship health. CareFirst may use these profile scores as a factor in creating new networks, likely beginning in June 2020. To learn more about the measures and methodology, please email profilescore@carefirst.com.

**Role of the PCP — BlueChoice Only**

Providers in the following medical specialties are recognized as PCPs:

- Family practice
- Internal medicine
- Pediatrics
- OB/GYNs (MD only)
- Nurse Practitioners (NP)

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

Each CareFirst BlueChoice member selects a PCP upon enrollment and receives an individual 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 BlueChoice and that their new PCP is accepting new patients. The member then notifies member services of this change. Notification can also be done online at carefirst.com/myaccount.

Requests received 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.

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

**OB/GYNs as PCPs**
Only members in Maryland can select OB/GYNs specialists as their PCP. A CareFirst BlueChoice participating OB/GYN who agrees to act as PCP for a female member should give the member a letter of intent stating your decision to serve as their PCP.

The letter should include your CareFirst BlueChoice provider number and the member’s ID number and should be returned by the member to member services.

**Back-up Coverage**

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

**After Hours Care**

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

**Open/Closed Panel**

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

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

Requests for opening and closing a panel can be faxed on your letterhead to 410-872-4107 or 866-452-2304.

Written notifications should be mailed to:

**Mail Administrator**
P.O. Box 14763
Lexington, KY 40512

**Reduction, Suspension or Termination of Privileges**

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

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

Actions, other than termination of participation, include:
- Implementation of a corrective action plan
- Implementation of a monitoring plan
- Closure of PCP panels (CareFirst BlueChoice only)
- Suspension with notice to terminate
- Special letter of agreement between the practitioner and CareFirst outlining expectations and/or limitation of range of services the practitioner may supply to members.

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

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

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

**Quality of Care Termination**

Appeal requests relative to quality of care terminations are reviewed through a hearing panel. The hearing panel is comprised of clinical members of the corporate quality improvement committee who were not previously involved in the review or decision of the case, and at least three practitioners with no adverse economic interests connected to the appealing practitioner and similar experience in the appealing practitioner's expertise (if appropriate). The appealing practitioner is notified in writing of the hearing process. Following the hearing, the panel will make a final decision to affirm, amend or reverse the sanction or network termination. The medical director, in consultation with CareFirst legal representative(s), will notify the practitioner of the decision in writing, provides a statement for the basis of the decision and informs the practitioner the decision is final and not subject to further consideration by CareFirst.

**All Other Sanctions or Terminations**

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

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

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

Reimbursement

Participating providers agree to accept a plan allowance (also called allowed benefit or allowed amount) as payment in full for their services. Participating providers may not bill the member for amounts that exceed the allowed amount for covered services. Members may be liable for non-covered services, deductibles, copayments and coinsurance.

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

Fee Schedule - Place of Service Code Assignments

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

The Health Services Cost Review Commission

Maryland is the only all-payer state in the nation with respect to hospital services. This means that Medicare has provided Maryland an exemption from reimbursement under their Inpatient Prospective Payment and Outpatient Prospective Payment System methodologies and instead pays Maryland hospitals in accordance with state mandated rates set by the Health Services Cost Review Commission (HSCRC).

The HSCRC was established by Maryland state law in 1972 and received Medicare exemption in 1977. Since that time, all-payers pay approximately the same rate for hospital services in Maryland. Historically, Medicare and Medicaid received a 6% discount while commercial payers could receive up to 2.25% discount by providing advanced funding to hospitals to cover accounts receivable.
Effective July 1, 2019, Medicare and Medicaid’s discount increased to 7.7% to recognize changes in commercial policies on current bad debts as a result of increases to members’ copay and deductible provisions.

The waiver model has transformed over time from a focus on unit cost rates to total cost and quality measures. Hospitals are held at risk for financial and quality performance while the HSCRC provides rates that are equitable for effective and efficient hospitals to strive. CareFirst is a major supporter of the waiver and continues to be an active participant in policy setting and rate review.

**Note:** Maryland general acute and private psychiatric hospitals are reimbursed according to rate structures set by the HSCRC.

**Diagnosis Related Group**

Click [here](#) to watch a training module that explains Diagnosis Related Group (DRG) or visit [carefirst.com/cpet](#) and click on Learning Library.

### Diagnosis Related Group Inpatient Payment Methodology

In general, participating hospitals, which are not located in Maryland, are reimbursed for approved inpatient services using a methodology similar to Medicare's DRG payment method. This method uses the principal and secondary diagnoses and the principal and secondary procedures, in addition to the member's age, gender and discharge status to assign a DRG. The diagnoses and procedure codes submitted are valid ICD-10 designated codes. Each DRG is assigned a relative weight.

Reimbursement should be calculated using:

- The DRG weight, standard average length of stay and other factors (for the grouper version in use by CareFirst at the time services were rendered).
- The methodology defined in Appendix B to the Hospital Participation Agreement.

**Note:** A reimbursement description (available on the remittance schedule or through CareFirst Direct) allows you to check individual payment calculations.

### Diagnosis Related Group Reimbursement Cases

Under no circumstances may a hospital deny a continued inpatient stay that is not medically necessary, due to placement delays or problems in securing alternative financial support needed to move a patient to a lower level of care. The facility may only issue a denial notification for a CareFirst member if:

- The facility, the attending provider, and CareFirst agree and document that it is not medically necessary for the member to remain in the facility.
- An appropriate discharge plan has been developed.
- The member or family member refuses discharge.

However, the hospital is strongly encouraged to discuss the case with the attending provider, the member, and/or a family member to ensure the patient and/or family member understands their financial responsibility before the written denial is issued.

A copy of the issued denial letter must be forwarded to CareFirst.
Methods of Reimbursement for Facilities

CareFirst provides several methods of hospital reimbursement:

- All-inclusive per diem or case rate payments
- Predetermined per visit fees
- Percentage of charges (discounted)
- Predetermined flat fees
- Percentage of Medicare Resource Based Relative Value Scale fee schedule amounts
- Percentage of CareFirst standard Base Fee Schedule amounts

To determine the method(s) of payment for your facility and for the services in question, refer to the payment information contained in the Appendices to the Hospital Participation Agreement.

Office-Based Drug Reimbursement Methodology

Standard reimbursement methodology

If you obtain office injectable drugs, the following standard reimbursement methodology applies. Injectable drugs are reimbursed at 6 percent above the Average Sales Price (ASP). The ASP is calculated by CMS and available at [CMS.gov](http://CMS.gov).

Standard reimbursement of all in-office injectable drugs is updated quarterly on the first of February, May, August and November. These updates reflect the industry changes to ASP. If there are delays in industry changes for certain seasonal injectable drugs (i.e., flu), then standard reimbursements may be updated on the first day of the next month. The specific reimbursement arrangements for participants in the CareFirst Oncology Program are not impacted by the above changes to standard reimbursement.

Outpatient Hospital Methodology

Outpatient services billed on the UB-04 claim form are paid according to a fee schedule and are priced using the current procedural terminology (CPT®) or healthcare common procedure coding system (HCPCS) code that is filed in conjunction with the following services: laboratory, radiology, other therapy and diagnostics, physical, occupational and speech therapies and drugs.

Claims for outpatient surgery are paid using a methodology in which each surgical CPT-4 or HCPCS codes is categorized into one of multiple payment categories. The rates for those payment group categories, as well as other payment rules including multiple procedure discounts, are defined in the applicable Appendix B of the hospital's agreement. Please remember that this information is based on the date the services were incurred.

Free-Standing Ambulatory Surgery Center Payment Methodology

Services provided in an ASC must be submitted on a UB-04 claim form and are paid according to a schedule of fees and priced using CPT and/or HCPCS codes. However, when Medicare is primary, all claims must be submitted on a CMS-1500 claim form. If the CPT or HCPCS code is not listed on the standard approved ASC codes list, then the service is not eligible for reimbursement in an ASC.

ASC procedures for facility and technical services and supplies include but are not limited to:

- Operating and recovery room services
Supplies
- Anesthesia supplies
- Drugs
- High-cost devices
- Integral radiology

These allowed amounts do not include the amounts due to providers for their professional services.

With the exception of the codes identified on the provider portal, if a member receives more than one included ambulatory surgery procedure rendered at the ASC on any one day, the allowed amount due to the provider shall be equal to the sum of: (a) 100% of the allowed amount due to ASC for the procedure that has the highest allowed amount plus (b) 50% of the allowed amount(s) that would apply to other included and properly billed outpatient surgery procedures rendered to the member at the ASC on that same day. In addition, procedures performed bilaterally shall be listed on individual lines.

The list of CPT codes eligible for payment in an ASC will be periodically reviewed and updated. Based on the review process, additional CPT codes may be added to the list or deleted from the list.

Ambulatory surgery procedures not on the ASC codes list are not eligible for payment. As new ambulatory surgery procedures are developed, or as established inpatient procedures migrate to the ambulatory setting, CareFirst will review such procedures and add them selectively, on a periodic basis, to the ASC codes list. CareFirst will review written recommendations regarding the addition of such procedures and related requests for payment. The reviews will be based on the available medical literature, relevant industry standards, data submitted by persons making recommendations and other documentation. Any decisions made by CareFirst to add ambulatory surgery procedures to the standard approved ASC codes list for reimbursement in an ASC will be effective on a prospective basis only. All recommendations should be submitted to the Institutional Contracting Department at the following address:

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Mail Stop: CG-51, Fifth Floor
Owings Mills, Maryland 21117-0825

Hospice Reimbursement Methodology

Services provided by hospice agencies must be submitted on a UB-04 claim form with revenue codes and will be paid according to an all-inclusive per diem schedule of fees including supplies. Exclusions to the all-inclusive rate paid to hospice agencies include but are not limited to:

- DME
- Infusion medications
- Laboratory and radiology services not related to hospice care
- Physical, occupational and speech therapy
- Ambulance transports

Excluded services must be coordinated with and provided by participating providers and must receive prior authorization when required.
Reimbursement for Limited Licensed Providers

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

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

<table>
<thead>
<tr>
<th>LLP Types</th>
<th>Related Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse midwife</td>
<td>90%</td>
</tr>
<tr>
<td>Nurse practitioner</td>
<td>85%</td>
</tr>
<tr>
<td>Board certified behavior analyst (BCBA)</td>
<td>75%</td>
</tr>
<tr>
<td>Dietician/nutritionian</td>
<td>75%</td>
</tr>
<tr>
<td>Licensed professional counselor, licensed marriage and family therapist, licensed alcohol and drug therapist</td>
<td>75%</td>
</tr>
<tr>
<td>Naturopathic provider</td>
<td>75%</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
<td>75%</td>
</tr>
<tr>
<td>Licensed clinical social worker</td>
<td>75%</td>
</tr>
<tr>
<td>Lactation consultant</td>
<td>75%</td>
</tr>
</tbody>
</table>

Physician Assistants, Anesthesia Assistants, Assistant Behavior Analysts and Registered Behavior Technicians

CareFirst does not contract with physician assistants, anesthesia assistants, assistant behavior analysts and registered behavior technicians.

Covered services rendered by physician assistants, anesthesia assistants, assistant behavior analysts and registered behavior technicians are eligible for reimbursement under the following circumstances:
- The assistant or technician (listed above) is under the supervision of a physician or licensed board-certified behavior analyst as required by local licensing agencies.

- Services rendered by the assistant or technician are to be submitted under the supervising physician's or licensed board-certified behavior analyst's name and provider number.

Services rendered by anesthesia assistants should be listed on the same claim as the supervising physician. The same procedure code can be listed on two different lines of the claim with the appropriate modifier (QK, AD, QX, QY) on each line. The system will accommodate and calculate allowances appropriately.

Services rendered by physician assistants, assistant behavior analysts and registered behavior technicians do not require additional modifiers to distinguish between provider types. Allowances will be based on the fee schedule for the supervising physician or licensed board-certified behavior analyst.

Concierge Services Policy

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

To verify member benefits, use CareFirst Direct.

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

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

- 90-day written notification detailing your intent to transition to a concierge practice

The written notice should be forwarded to your professional provider relations representative.

For providers enrolled in the PCMH program, please visit carefirst.com/pcmhinfolink to learn more about requirements related to the concierge practice model.

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

Confidentiality

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

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

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

Ensure its workforce members comply with the HIPAA

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

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

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

**General Policy**

- All records and other member communications that have confidential medical and insurance information must be handled and discarded in a way that ensures the privacy and security of the records.
- All medical information that identifies a member is confidential and protected by law from unauthorized disclosure and access.
- The release or re-release of confidential information to unauthorized persons is strictly prohibited.
- CareFirst limits access to a member’s personal information to persons who need to know, such as our claims and medical management staff.
- The disposal of member information must be done in a way that protects the information from unauthorized disclosure.
- CareFirst releases minimum necessary protected health information in accordance with the Privacy Rule as outlined in HIPAA and our notice of privacy practices (NPP).

**Member Access to Medical Records**

It is the responsibility of the provider to give member access to their personal medical record. The member must follow the provider’s procedures for accessing medical information from the provider, so long as such procedures are compliant with applicable law. Members may access their medical records by contacting the Primary Care Provider’s (PCPs) office or the provider of care (such as a hospital). If the member contacts CareFirst for a copy of their personal medical record, we will refer the member back to the provider.

**Treatment Setting**

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

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

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

Quality Improvement Measurement

Data for quality improvement measures is collected from administrative sources, such as claims and pharmacy data, and/or from member medical records.

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

Notice of Privacy Practices

CareFirst is committed to keeping the confidential information of members private. Under HIPAA, we are required to send our NPPs to fully insured members. The notice outlines the uses and disclosures of protected health information, the individual's rights and CareFirst's responsibility for protecting the member's health information. Providers must develop and provide their own NPPs to members.

Administrative Services Policy

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against members for covered services. This includes administrative services which are inherent in the delivery of covered services. Examples of such charges for administrative services include annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses and malpractice coverage increases. Additional examples of such services may also include but not be limited to:

- Writing new/refill prescriptions with or without an office visit
- Telephone consultations
- Copying and faxing
- Completing referral forms or providing pertinent paperwork related to referrals to other physicians
- Completion of physical forms, medication forms, preop forms and/or CareFirst requested forms
- Other expenses related to the overall management of patients and compliance with government laws and regulations required of healthcare providers

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

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

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

**Member Complaints**

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

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

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

- Send an e-mail to [quality.care.complaints@carefirst.com](mailto:quality.care.complaints@carefirst.com)
- Fax a written complaint to 301-470-5866
- Mail a written complaint to:
  CareFirst BlueCross BlueShield and  
  CareFirst BlueChoice, Inc.  
  Quality of Care Department  
  P.O. Box 17636  
  Baltimore, MD 21298-9375

Please include the following information when submitting a complaint:

- Your telephone number and name
- Your provider number
- The member’s name and ID number
- Date(s) of service
- As much detail about the event as possible
Requests for Charts

Affordable Care Act Risk Adjustment

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

Background

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

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

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

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

Clinical outreach

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

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

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

Medical record retrieval

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

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

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

Best practices in medical record documentation

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

- Diagnoses need to be clearly documented in the medical record.
Chronic conditions need to be evaluated and reported on a regular basis (at least annually).

Medical records need to be legible, signed, credentialed and dated by the physician.

Patient's name and date of service need to appear on all pages of the record.

Treatment and reason for level of care needs to be documented; chronic conditions that potentially affect treatment choices considered should be documented.

CareFirst requests that all providers comply with CMS guidelines on implementing ICD-10.

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

Make sure to avoid these common errors:

- Incomplete medical record documentation
  - Lack of condition specificity where required
  - Key condition statuses (e.g., transplant, amputation)

- Missing provider signature and/or credentials
  - Missing provider signature on medical records
  - Missing provider credentials on medical records

- Short-hand documentation of medical record
  - Use of symbols or other medical terminology that cannot be translated into diagnosis codes
  - Lack of condition specificity where possible

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

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

**HHS Risk Adjustment Data Validation**

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

**Background**

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

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

**Provider outreach**

One or more of your patients’ medical records may be identified for further review. If this is the case, CareFirst's contracted third-party vendor will work with you to receive the necessary medical records.
If your patients are identified, staff from the CareFirst designated third-party vendor will contact your office to determine a method of retrieval (e.g., mail, fax, electronic transmission or on-site collection).

**HEDIS**

CareFirst participates in several programs, such as HEDIS, required to evaluate and monitor the health status of identified members using different tools.

“The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that the public, policy makers and payers have the information they need to compare performance.”²

HEDIS data is collected mostly via claims (e.g., visit, lab, pharmacy), but also from medical records. In the process of retrieving the medical records, we reach out to providers each year to collect their preferred methods of medical record collection.

Results from the HEDIS data collection serve as a measurement of the quality of healthcare received by our members and provide benchmarking that can be compared to other plans. The results are used to identify gaps in care and, opportunities for improvement of care, and to develop necessary provider and member education initiatives and effective preventive care programs.

**Medical record retrieval process**

Currently, we have contracted with Change Healthcare, LLC, our medical record retrieval and review vendor, to help coordinate the medical record retrieval process for the HEDIS and RA Programs for the 2020 reporting year. This medical record retrieval process is time sensitive and lasts only for three months (from the first week of February until the first week of May). Requested medical records need to be provided to Change Healthcare, LLC within 15 business days of the received request.

You may use any of the data collection methods listed below when submitting your records.

- Vendor remote electronic medical record (EMR) access
  - Your data is sent directly from the provider EMR system to Change Healthcare, LLC. After setting up remote access with help from your IT staff, Change Healthcare, LLC will access the EMR from another location and extract the information needed.

- Secure dropbox
  - For this method, providers upload requested medical records to a secure web portal, and Change Healthcare, LLC will collect the information needed.

- Onsite chart collections
  - Change Healthcare, LLC will come onsite to your office and scan the medical records we need into their system while at your office. This option will require Change Healthcare, LLC to have access to a computer and some space to work in the office. Your office will be contacted to schedule a time when a Change Healthcare, LLC representative can come to your office for chart retrieval.

- Fax
  - You can send records directly to Change Healthcare, LLC by fax.
Mail

You can mail your records directly to Change Healthcare, LLC, who will also provide prepaid postage labels.

Medical record email or fax requests will include a member list from Change Healthcare, LLC identifying their assigned measure(s) and the minimum necessary information relevant to the measure(s).

There is no specific cost to you for this process; however, the retrieval process may require time from some of your office staff, and you will be responsible for any associated costs that accompany the copying and/or mailing of medical records.

**CareFirst is not responsible for any associated costs related to the medical record retrieval process.**

All participating provider offices are contractually obligated to provide copies of member medical records at no charge to CareFirst and/or Change Healthcare, LLC.

If you are using a third-party chart copying service/vendor, you are still responsible and obligated to obtain the records from the vendor or cause the vendor to send the requested medical records at no charge to CareFirst or Change Healthcare, LLC. Failure to comply with this request will be considered a breach of contract.

As a CareFirst provider, you have full responsibility for the cost of invoices issued to CareFirst from your copy service or medical records management vendor or partner.

**CareFirst will not pay for copies of medical records or postage.**

CareFirst is firmly committed to securing and protecting the privacy of our members. Change Healthcare, LLC has signed a Business Associate Agreement with CareFirst to make sure that the privacy of our members is protected and in compliance with all HIPAA regulations and requirements. If you have questions regarding the data collection process, contact the Change Healthcare Provider Relations line at 855-767-2650, or contact your CareFirst Provider Representative.

**Documentation standards**

Documentation standards help us quickly collect and review medical records as part of the medical record retrieval process. Please use the [Medical Record Documentation Standards](#) on all your medical documentation.

**Claim filing tips**

All claims should include the appropriate CPTII codes with the date of service. Please include additional claim lines on the standard claim with global codes to reflect the specific care provided on a specific date of service.

The tables below provide CPT II codes and their definitions for several of our billing areas. We recommend billing these CPT II codes, when appropriate, to increase the specificity of your claims so we can collect the information for HEDIS purposes from our claims systems and therefore reduce the number of charts we will request from your office for the HEDIS review.
## Maternity Care

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Code Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0500F</td>
<td>Initial prenatal care visit (refer to AMA CPT standard for details)</td>
</tr>
</tbody>
</table>
| 0501F       | Prenatal flow sheet documented in medical record by first prenatal visit. Documentation includes:  
  - Date of Service  
  - Week of Pregnancy  
  - Gestational age  
  - Blood Pressure  
  - Weight  
  - Urine Protein  
  - Uterine Size  
  - Fetal heart tones  
  - Estimated Due Date |
| 0502F       | Subsequent Prenatal Visit (refer to AMA CPT standard for details) |
| 0503F       | Postpartum Care Visit |

## PCP, Nephrology, Ophthalmology and Endocrinology

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Code Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3044F</td>
<td>Most recent HbA1c level less than 7%</td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent HbA1c level 7-9%</td>
</tr>
<tr>
<td>3046F</td>
<td>Most recent HbA1c level greater than 9%</td>
</tr>
<tr>
<td>2022F</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed</td>
</tr>
<tr>
<td>3072F</td>
<td>Low risk for retinopathy (no evidence of retinopathy in the prior year)</td>
</tr>
</tbody>
</table>
### PCP, Nephrology, Ophthalmology and Endocrinology

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Code Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3066F</td>
<td>Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, renal insufficiency, any visit to a nephrologist)</td>
</tr>
<tr>
<td>3060F</td>
<td>Positive microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3074F</td>
<td>Most recent systolic blood pressure less than 130 mm of Hg</td>
</tr>
<tr>
<td>3075F</td>
<td>Most recent systolic blood pressure 130-139 mm of Hg</td>
</tr>
<tr>
<td>3077F</td>
<td>Most recent systolic blood pressure greater than or equal to 140 mm of Hg</td>
</tr>
<tr>
<td>3078F</td>
<td>Most recent diastolic blood pressure less than 80mm of Hg</td>
</tr>
<tr>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80-89 mm of Hg</td>
</tr>
<tr>
<td>3080F</td>
<td>Most recent diastolic blood pressure greater than or equal to 90 mm of Hg</td>
</tr>
</tbody>
</table>

### High Blood Pressure

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Code Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3074F</td>
<td>Most recent systolic blood pressure less than 130 mm of Hg</td>
</tr>
<tr>
<td>3075F</td>
<td>Most recent systolic blood pressure 130-139 mm of Hg</td>
</tr>
<tr>
<td>3077F</td>
<td>Most recent systolic blood pressure greater than or equal to 140 mm of Hg</td>
</tr>
<tr>
<td>3078F</td>
<td>Most recent diastolic blood pressure less than 80mm of Hg</td>
</tr>
<tr>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80-89 mm of Hg</td>
</tr>
<tr>
<td>3080F</td>
<td>Most recent diastolic blood pressure greater than or equal to 90 mm of Hg</td>
</tr>
</tbody>
</table>
FIGmd

In 2019, CareFirst launched a clinical data integration initiative with our partner, FIGmd. FIGmd is a cloud-based, interoperable, clinical data and quality management platform. FIGmd’s core competency is to securely extract and store medical records.

Why did CareFirst partner with FIGmd?

As the state of healthcare transforms, there has been a shift to electronic medical records. This shift presents an incredible opportunity to improve the quality and efficiency of healthcare delivery. Interoperability among various electronic health record systems available on the market has not yet been achieved. Achieving interoperability would represent a quantum leap in improving healthcare delivery and outcomes.

Nearly two years ago, CareFirst set out to solve this problem by partnering with FIGmd, a company able to extract data from 160 different electronic health record systems (and growing) and conform all structured and unstructured data into a common, curated format. They are also the operators of a collection of medical society registries established to measure clinical quality and performance of providers for multiple specialties.