CareFirst

Family of health care plans

PROVIDER MANUAL

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Chapter 4: Guidelines by Specialty/Service

Institutional Ancillary Providers

Information on the following ancillary providers is contained in this section:

- Air Ambulance
- Ambulatory Surgical Centers (ASC)
- Dialysis Facilities
- Durable Medical Equipment (DME)
- Home Health
- Home Infusion Therapy (HIT)
- Hospice
- Skilled Nursing Facilities

Contract Information

In order to be in-network for most of the CareFirst BlueCross BlueShield and CareFirst BlueChoice (CareFirst) memberships both locally and nationally, providers should hold two types of provider contracts:

- Regional Participating Preferred Network (RPN)
- BlueChoice Network

Claims and Billing Information

Use the CareFirst self-service tools, CareFirst Direct and CareFirst on Call, to verify a member's eligibility, benefits, authorization requirements and claim status. As a reminder, Third-Party Administrators (TPA) maintain all information on their members' and should be contacted directly for eligibility, benefits, claims status and payments.

All claims should be submitted electronically. If a paper claim needs to be submitted, use the current version of the form for your provider type. All required fields must be completed, or the claim will be rejected or returned:

- Current version of the CMS-1500 form (version 02/12) on original red-ink-on-white-paper. To order a supply of forms, please use your normal process.
- Current version of the UB-04 form. Visit the National Uniform Billing Committee™ website to find details for using and ordering the new form.

Providers are required to submit claims using standard code sets (e.g., CPT, HCPCS, ICD-10, revenue codes, etc.). Please refer to the section below for your specific provider type for more detailed information and to your provider contract when submitting a claim. Where needed, please use modifiers appropriately.

When needed, for more specific information, please refer to the CareFirst Medical Policies online.

Please keep medical records current in the event additional documentation is requested to adjudicate the claim. You will be contacted if this documentation is needed.

Submit claims timely. Timely filing is 365 days from the date of service unless a member's contract or health plan specifies differently.

Air Ambulance

Refer to Payment Policy PP CO 700.01 in our Payment Policy Database for more information.

Ambulatory Surgery Centers

Refer to Payment Policy PP CO 020.01 in our Payment Policy Database for more information.

Prior authorizations and referrals for ASCs

Prior authorization is not required for in-network freestanding ASCs for CareFirst members. Services are still subject to benefit exclusions under the patient's policy.

Prior authorization may be required for:

- BlueCard members
- TPA members
- Self-insured accounts

For these types of plans, check the member's benefits to determine if an authorization is required.

Dialysis Facilities

Refer to Payment Policy PP CO 800.01 in our Payment Policy Database for more information.

No authorization or referral is required if a CareFirst or FEP member uses an in-network dialysis facility.

For those members who are out of state/BlueCard, providers should contact the member's home plan and ask if an authorization is required. Please call 800-676-BLUE.

TPA Members should contact the TPA directly using the phone number on the back of the member's identification card.

Durable Medical Equipment

Refer to Payment Policy PP CO 100.01 in our Payment Policy Database for more information.

Home Health

Refer to Payment Policy PP CO 900.01 in our Payment Policy Database for more information.

Home Infusion Therapy

Claims and billing requirements

Please refer to Attachment A and Schedule A & B for specific code requirements. Please keep the following reminders in mind when submitting your claims:

- CareFirst has one HIT policy and processing guidelines for all lines of business.
- Submit claims electronically using HIPAA 837P.
    - If you do not have electronic capabilities, paper claims must be submitted using the current version of CMS-1500 or they will be rejected.
- Claims must be submitted with the provider's NPI.
- Do not submit attachments with claims.
- Please bill claims by year. The same claim cannot span multiple years.
- Medicare Explanation of Medical Benefits (EOMB) is waived for 99601 and 99602.

Home infusion therapy claims

- Home infusion therapy claims are billed with:
  - Per Diem code (S codes)
  - In-home nursing code (99601 & 99602)
  - Drug codes (J, S, P, Q, and B codes)
  - Modifiers for multiple therapies (SH - second concurrent therapy and SJ – third or more concurrent therapy)

In-home nursing for FEP

- Limit of 2 hours per day, up to 25 visits per calendar year (99601)
- Additional nursing (99602) will not be allowed or reimbursed. Please see the member's benefit booklet for more information.
- Please confirm that copays/coinsurance are applicable.

Drug volume

- CareFirst does not reimburse for the amount of drugs used for priming or residual use.
- Overfill/overflow is not covered.
- Reimbursement is based on the dosage prescribed, not the concentration ordered.

Renal failure/dialysis

- When a patient is receiving dialysis, the HIT provider is unable to bill for infusion of drugs (e.g., EPOGEN®) or other related ancillary services.

Stock supplies

In the event of discontinuation of therapy, cancellation of orders, change in medication, readmission to a facility or in the event of death, CareFirst will reimburse for 72 hours of drugs or Total Parenteral Nutrition stock supply.

- Clear documentation should be kept in the patient's service record.

Utilization of drug code J3490

- This code can be utilized when no other HCPCS are available for a specific drug.
- The corresponding National Drug Code number must be included.

Documentation required in the patient's file

- Signed and dated Plan of Treatment/Certificate of Medical Necessity or physicians' orders must be current
- Nursing assessment
- Nursing notes, documentation on additional nursing services beyond the contract limitations

Note: All treatment plans, certificates of medical necessity or physicians' orders must be updated yearly

Items not covered

- Oral medications
- Subcutaneous injections

- Please bill through the patient's pharmacy benefit.

- Growth Hormone
- Synagis®
- Hormonal Therapy

Written requests

Written requests for any new or non-listed therapies should be submitted to Pharmacy Management:

Attn: Manager Home Infusion Therapy
CareFirst BlueCross BlueShield
1501 S. Clinton St.
Mail Stop Canton
Baltimore, MD 21224

Hospice

Refer to Payment Policy PP CO 900.02 in our Payment Policy Database for more information.

Authorization process

Prior Authorizations may be required for both inpatient and outpatient services for:

- CareFirst members
- BlueCard members
- TPA members
- Self-insured accounts

Be sure to check the member's benefits to determine if an authorization is required.

For inpatient authorizations contact the appropriate area for assistance:

Authorization Contacts	
Member type	**Phone number**
CareFirst member	Inpatient hospice 866-PRE-AUTH, option 1 (866-773-2884)
FEP member	800-360-7654, Care Management
BlueCard member	Contact home plan 800-676-BLUE (800-676-2583)
Self-Insured member	877-228-7268

Authorization Contacts	
TPA member	Contact the member's TPA at the phone number on the back of the member identifications card for instructions or refer to the number on the TPA prefix listing.

Skilled Nursing Facilities

Check a member's benefits to determine if a prior authorization is required. Please contact the appropriate authorization area using the phone numbers below.

Authorization Contacts	
Member type	**Phone number**
CareFirst member—admitted from inpatient setting	866-PRE-AUTH, option 1 (866-773-2884)
CareFirst member—admitted from home or community	1-866-Pre-Auth, Option 1 1-866-773-2884
Case Management	1-800-443-5434, Option 5
FEP member	800-360-7654, Care Management
BlueCard member	Contact home plan 800-676-BLUE (800-676-2583)
Self-Insured member	877-228-7268
TPA member	Contact the member's TPA at the phone number on the back of the member ID card for instructions or refer to the number on the TPA prefix listing.

When there is a need for a member to be admitted into a Post-Acute Facility (SNF, Acute Rehab, Long-Term Acute Care, Hospice) from an inpatient facility, the facility discharge planner works with the member/member's family and the CareFirst Utilization Management Specialists (UMS) to determine the appropriate level of care for the member. The facility discharge planner must complete and fax the Utilization Management Request for Authorization form to the Post-Acute Care Team at 410-505-2588. CareFirst's UMS's are available to assist with the member's care coordination. The UMS will provide an admission decision within 24 hours of the request for transfer. The authorization is given to the facility within 24 hours of verification of the admission.

When there is a need for a member that is out of CareFirst's service area (outside of Maryland, D.C., or Northern Virginia) to transfer into a Post-Acute Facility, the facility must complete and fax the Utilization Management Request for Authorization form to Post-Acute Care Team at 410-505-2588.

CareFirst will verify the member's benefits, and the UMS will provide an admission decision and authorization within 24 hours of the request for transfer. The UMS assigned to the Post-Acute Facility will also be responsible for continued stay review and decision.

Refer to Payment Policy PP CO 900.03 in our Payment Policy Database for more information.

Professional Services, Tips and Reminders

Primary Care

The Patient-Centered Medical Home (PCMH) Program is designed to provide primary care providers (PCPs) with a more complete view of their patients' needs. PCMH guides members to establish a relationship with their PCP to receive consistent quality care. Using PCPs as a first contact or "home base" for most medical and behavioral needs ensures members get the care they need, when they need it, leading to improved health, increased communication and better outcomes.

To aid in this communication and relationship, providers are given exclusive access to resources like electronic medical records and a large network of specialized clinicians. Behavioral health clinicians and Registered Nurses help providers better coordinate their member's overall health and assist in navigating the complex healthcare landscape.

The PCMH Program requires greater provider engagement and CareFirst meaningfully compensates providers for that engagement. PCMH is structured around PCPs organized into teams called Panels—groups of five to 15 physicians—for purposes of coordinating the care of CareFirst members to improve healthcare outcomes and reduce the global cost of care. As care-giving teams, Panels have the opportunity to earn robust financial incentives—a 12% participation fee increase and a reimbursement for Care Coordination. In addition, Panels can earn Outcome Incentive Awards that are paid as increases to their fee schedules based on both the level of quality and degree of savings they achieve against projected costs each year.

For more information on how to join and be successful in the PCMH Program, view our Adult and Pediatric program description and guidelines or visit carefirst.com/pcmhinfo.

Helpful Information for Specialists

Specialty type	Medical society resources	Key medical policies	Healthcare Effectiveness Data and Information Set (HEDIS)® focus
Gastroenterology	American College of Gastroenterology Society of American Gastrointestinal and Endoscopy American Gastroenterological Association	Screening for colorectal cancer – 2.03.011A Surgery – 7.01 Obesity – 7.01.036	■ Colorectal cancer screening ■ Optimal diabetes care ■ Hypertension

Specialty type	Medical society resources	Key medical policies	Healthcare Effectiveness Data and Information Set (HEDIS)® focus
		Transplants 7.03	■ All cause readmission ■ Emergency department utilization
General Surgery	American College of Surgeons	Surgery – 7.01 Surgical Assistants – 10.01.008A	■ Smoking Cessation ■ Optimal Diabetes Care ■ Hypertension ■ All cause readmission ■ Emergency department utilization
Obstetrics/Gynecology	American Gynecological & Obstetrical Society American College of Obstetricians and Gynecologists	Global Maternity Care – 4.01.006A Preventive services – 10.01.003A Global surgical care rules – 10.01.009A Multifetal pregnancy reduction – 4.02.003A Preimplantation genetic testing – 4.02.007 Lactation consultations – 4.01.010	■ Breast cancer screening ■ Cervix cancer screening ■ Early elective delivers ■ Prenatal and postpartum ■ Optimal diabetes care ■ Hypertension ■ All cause readmission
Orthopedic Surgeons	Academy of Orthopedic Surgeons	Durable medical equipment – 1.0	■ Use of imaging for lower back pain

Specialty type	Medical society resources	Key medical policies	Healthcare Effectiveness Data and Information Set (HEDIS)® focus
	American Orthopedic Society for Sports Medicine	Medical Equipment – 1.01 Medical supplies – 1.02 Orthotic devices and orthopedic appliances – 1.03 Prosthetics – 1.04 Surgery – 7.01 Rehabilitation therapy – 8.00 Physical/occupational /speech therapy – 8.01	■ Optimal diabetes care ■ Hypertension ■ All cause readmission ■ Emergency department utilization