Chapter 10: Medicare Advantage
Provider Network Overview

CareFirst Advantage, Inc. (CareFirst Advantage) is the entity that provides 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.

Participating Provider Responsibilities

Providers participating in CareFirst Advantage 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 Advantage 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 hard of hearing
- Participate in and cooperate with CareFirst Advantage in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by CareFirst Advantage
- 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 11 years
- Participate in and cooperate with the CareFirst Advantage appeal and grievance procedures
- Comply with all applicable federal and state laws regarding the confidentiality of patient records
- Support, cooperate and comply with CareFirst Advantage 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

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, materials governing “Provider Initiated Activities” in Section 60.1.

CMS holds plan sponsors such as CareFirst Advantage 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 Advantage without the prior express written consent of an authorized CareFirst Advantage representative, and then only in strict accordance with such consent.

Role of Primary Care Physician

Providers in the following medical specialties are recognized as Primary Care Physicians (PCPs):

- 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.

Each CareFirst Advantage 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 Advantage 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 Advantage 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 to CareFirst Advantage.

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 Advantage members and should not be used by CareFirst Advantage participating physicians.

Product Information

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

Click here to review basic information about the two plans.

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, with the exception of emergency and urgently needed services and renal dialysis for members who are temporarily outside the CareFirst service area.

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.

Appeals and Grievances

Introduction

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

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

What are Appeals and Grievances?

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

Appeal

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

- We refuse to cover or pay for services a member thinks we should cover
- We or one of our CareFirst Advantage providers refuses to render a service that a member believes should be covered
We or one of our CareFirst Advantage providers reduces or cuts back on services or benefits that a member has been receiving, or

The member believes that we are stopping coverage of a service or benefit too soon.

Grievances

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

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

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

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

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

Submitting a Grievance

Concerns about the plan are important to us. For immediate attention and assistance in resolving their concerns, members can call member services to submit a grievance verbally at 855-290-5744

Members can also fax or mail their grievance in writing to us at 443-753-2298.

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

Acting as an Authorized Representative

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

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

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

Fax: 443-753-2298

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

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

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

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

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

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

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

A provider that has furnished services or items to a member may represent that member on the appeal; however, the provider may not charge the member a fee for representation. Providers who do not have a

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contract with CareFirst Advantage must sign a “Waiver of Liability” statement that the provider will not require the member to pay for the medical service under review, regardless of the outcome of the appeal.

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

**Appeals Regarding Hospital Discharge**

There is a special type of appeal that applies only to hospital discharges. If a member feels that the CareFirst Advantage coverage of a hospital stay is ending too soon, the member or his or her authorized representative can appeal directly and immediately to the Quality Improvement Organization (QIO). QIOs are assigned regionally by CMS. The QIO for the state of Maryland is Livanta. The QIOs are groups of health professionals that are 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. One must act very quickly to make this type of appeal, and it will be decided quickly.

If a member believes that the planned discharge is too soon, the member or his/her authorized representative may ask for a QIO review to determine whether the planned discharge is medically appropriate. “The Important Message from Medicare” document given to the member within two days of admission and copied to the member within two days of discharge provides the appeal information as well as the QIO name and telephone number.

To request a QIO review regarding a hospital discharge, the member or his or her authorized representative must contact the QIO no later than the planned discharge date and before leaving the hospital. If this deadline is met, the member is permitted to stay in the hospital past the planned discharge date without financial liability. If the QIO reviews the case, it will review medical records and provide a decision within one calendar day after it has received the request and all the medical information necessary to make a decision. If the QIO decides that the discharge date was medically appropriate, the member will have no financial liability until noon of the day after the QIO provides its decision. If the QIO decides that the discharge date was too soon and that continued confinement is medically appropriate, CareFirst Advantage will continue to cover the hospital stay for as long as it is medically necessary.

If the member or his/her authorized representative does not ask the QIO for a review by the deadline, the member or authorized representative may ask CareFirst Advantage for an expedited appeal. If the member or authorized representative asks us for an expedited appeal of the planned discharge date and stays in the hospital past the discharge date, he or she may have financial liability for services provided beyond the discharge date. This depends on the expedited appeal decision. If the expedited appeal decision is in the member’s favor, CareFirst Advantage will continue to cover the hospital care for as long as it is medically necessary. If the expedited appeal decision is that continued confinement was not medically appropriate, we will not cover any hospital care that is provided beyond the planned discharge date, unless an IRE review overturns our decision.

**Skilled Nursing Facility, Home Health Agency or Comprehensive Outpatient Rehabilitation Facility Services**

There is another type of appeal that applies only when coverage will end for Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility Services (CORF) services. If a member feels that coverage for these services is ending too soon, he or she can appeal directly and immediately to the QIO. As with hospital services, these services may be covered during the appeal review if filed on time.
If CareFirst Advantage and/or the care 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 that the member agrees to the decision, only that the notice was provided. After the NOMNC is completed, the provider must retain a copy in the provider’s records.

**Beneficiary and Family Centered Care Quality Improvement Organization Review**

For these types of services, members have the right by law to ask for an appeal of a termination of coverage. As will be explained in the notice referenced above, the member or his or her 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, the QIO will ask for the member’s opinion about why the services should continue. The response is not required in writing. The QIO will also look at medical information, talk to the doctor, and review other information that CareFirst Advantage provides to the QIO. It is very important that the provider immediately faxes all the member’s medical records to the QIO for their review. CareFirst Advantage will provide both the member and the QIO a copy of the explanation for termination of coverage of these services.

After reviewing all the information, the QIO will decide whether it is medically appropriate for coverage to be terminated on the date that has been set for the member. The QIO will make this decision within one full day after it receives the information necessary to decide. If the QIO decides in favor of the member, CareFirst Advantage will continue to cover the stay for as long as medically necessary. If the QIO decides that our decision to terminate coverage was medically appropriate, the member will be responsible for paying the SNF, HHA or CORF charges after the termination date that appears on the advance notice. Neither Original Medicare nor CareFirst Advantage will pay for these services. If the member agrees to discontinue receiving services on or before the date given on the notice, there will be no financial liability.

If the member or his/her authorized representative does not ask the QIO for a review in a timely manner, the member or authorized representative may request an expedited appeal. It is important to note that if the member or authorized representative requests an expedited appeal regarding termination and services continue to be provided, the member may have financial liability if services are provided beyond the termination date.

If CareFirst Advantage staff decides upon an expedited appeal review that services are medically necessary to continue, 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 that was provided beyond the termination date, and the member may be financially responsible.

**Member Appeals for Coverage or Payment of Other Medical Services**

After CareFirst Advantage has made a coverage determination to not approve or pay for services a member believes should be covered or provided, the members or their authorized representative may file an appeal.
This would be a standard appeal for benefits (pre-service appeal) or payment of a claim (payment appeal).

**Payment Appeals**

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

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

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

**Standard Pre-Service Appeals**

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

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

CareFirst BlueCross BlueShield Medicare Advantage  
Clinical Appeals and Analysis  
P.O. Box 17636  
Baltimore, MD 21298-9375

**Standard Appeal Timeframes**

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

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

**Expedited Appeals**

If waiting for a pre-service decision will seriously harm the member’s health, they can ask that we process the appeal in an expedited manner. A CareFirst Advantage representative will contact the member with a decision within 72 hours of receipt of the expediated appeal request.

To file an expedited appeal, members should call Member Services at 855-290-5744 for assistance. They can also submit an expedited appeal in writing.

Fax for Clinical Pre-Service Expedited Appeals: 410-605-2566

**Mail:** CareFirst BlueCross BlueShield Medicare Advantage  
Clinical Appeals and Analysis  
P.O. Box 17636  
Baltimore, MD 21298-9375

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

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

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

When the appeal is for services that have not been received, if the member requests an extension, or if we find that some information is needed that would be beneficial to the member in this review, an extension of up to 14 calendar days may be granted. The 14-day extension is also an option with an expedited appeal. If we do not issue a decision by the end of the extended time period, the appeal is automatically forwarded to the IRE for review. CareFirst Advantage cannot take extra time when the appeal is for a Part B prescription drug.

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

Independent Review Entity

CareFirst Advantage 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 that is provided to the IRE for review. The IRE will notify the member of the receipt of the appeal, review the request, and make a decision about whether CareFirst Advantage must provide the care or payment for the care in question. For appeals regarding payment of services already received, the IRE has up to 60 calendar days to issue a decision. For standard appeals regarding medical care not yet provided, the IRE has up to 30 calendar days to issue a decision, if the appeal is for a Part B prescription drug the IRE must decide within 7 calendar days. For expedited appeals regarding medical care, the IRE has up to 72 hours to decide. These timeframes can be extended by up to 14 calendar days if more information is needed and the extension is in the member's best interest. The IRE cannot take an extension if the appeal is for a Part B prescription drug.

The IRE will issue its decision in writing to the member (or an authorized representative) and CareFirst Advantage. If the decision is not in the member's favor, the member may have the opportunity to pursue coverage of the services through the review of an Administrative Law Judge.

Administrative law judge review

If the IRE decision is not in the member's favor, and if the dollar value of the contested benefit meets minimum requirements the member or his or her authorized representative may ask for an Administrative Law Judge (ALJ) to review the case. The ALJ also works for the federal government. The IRE decision letter will instruct the member how to request an ALJ review.
During an ALJ review, the member may present evidence, review the record, and be represented by an attorney. The ALJ will not review the appeal if the dollar value of the medical care is less than the minimum requirement, and there are no further avenues for appeal. 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. The party against which the decision is made 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 party against whom the ALJ decision is made has the right to request the review by the MAC. This Council is part of the federal department that runs the Medicare program. The MAC does not review every case it receives. When it receives a case, the MAC decides whether to conduct the review. If they decide not to review the case, either party may request a review by a Federal Court Judge; however, the Federal Court Judge will only review cases when the amount in controversy meets the minimum requirement.

Federal court

The party against whom the MAC decision is made has the right to file the case with Federal Court if the dollar value of the services meets the minimum requirements. If the dollar value of the service in question is less, the Federal Court Judge will not review it and there is no further right of appeal.

Appeals for Coverage of Part D Drugs

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

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

An “appeal” is any part of the procedures that deal with the review of an unfavorable coverage determination. A member or his/her authorized representative may file an appeal if he/she wants CareFirst Advantage to reconsider and change a decision we have made about what Part D prescription drug benefits are covered or what we will pay for a prescription drug. This is called a redetermination.

It is important to note that if CareFirst Advantage 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.

Problems getting a Part D prescription drug that may be addressed by an appeal are as follows:

- If the member is not able to get a prescription drug that may be covered
- If a member has received a Part D prescription drug that may be covered but we have refused to pay for the drug
- If we will not pay for a Part D prescription drug that has been prescribed because it is not on the formulary
- If a member disagrees with the copayment amount
- If coverage of a drug is being reduced or stopped
If there is a requirement to try other drugs before the prescribed drug is covered

If there is a limit on the quantity or dose of the drug

There are several steps that members may use to request care or payment from CareFirst Advantage. At each step, qualified personnel evaluate the request, and a decision is made. If the decision is not in the member's favor, there are subsequent appeal options available.

After CareFirst Advantage has issued a coverage determination, a member or authorized representative or prescribing physician or other prescribers may file an appeal, also commonly referred to as a request for redetermination. 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, an expedited appeal may be requested. CareFirst Advantage will make every effort to gather all the information needed in order to make a decision about the appeal. Qualified individuals who were 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 or at the following address:

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

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

Members also have the right to ask us for a copy of the information that pertains to their appeal. Members or providers may reach to the Member Appeals Analyst as indicated above in order to make such a request.

Upon completion of the redetermination, the member and parties to the appeal will be notified of the decision. For a standard pre-service decision about a Part D drug, CareFirst Advantage has up to 7 calendar days to issue a decision and authorize the drug in question. If the member's health condition requires it, the decision will be issued sooner. If CareFirst Advantage does not issue a decision within 7 calendar days, the request will automatically be forwarded to the IRE for review.

If the request is for reimbursement for a Part D Drug that has already been decided then CareFirst Advantage must authorize payment for the benefit within 14 calendar days from the date it receives the request and make payment (i.e., mail the payment) no later than 30 calendar days after the date CareFirst Advantage received the request.

For an expedited appeal regarding Part D drugs that have not been provided, CareFirst Advantage has up to 72 hours to issue a decision and authorize the requested medication. If the member's health condition requires it, the decision will be issued sooner. If an expedited appeal was requested and CareFirst Advantage does not comply with the 72-hour timeframe, the case will automatically be forwarded to the IRE for review.

If the redetermination does not result in the approval of the drug under review, the member may ask for review by an IRE. It is important to note that IRE review of Part D drug denials is not automatic as it is for medical services. The IRE has a contract with the federal government and is not part of CareFirst Advantage.

**Independent Review Entity**

The member or his or her authorized representative must submit a request to the IRE in writing within 60 calendar days of the appeal decision notice. An expedited IRE is also available if the member's condition...
requires it. The IRE’s name and address will be included in this notice. If a member requests review by IRE, the IRE will review the request and make a decision about whether CareFirst Advantage must cover or pay for the medication. 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. If the decision is in the member’s favor and the member has already paid for the medication, CareFirst Advantage will reimburse the member within 30 calendar days of the IRE’s decision. We will also send the IRE confirmation that we have honored their decision. If the decision is in the member’s favor and the member has not yet received the drug, CareFirst Advantage will authorize the medication within 72 hours of receiving the decision notice. Confirmation will be sent to the IRE in this situation as well. If an expedited IRE review was conducted, CareFirst Advantage will authorize the medication within 24 hours of receiving the IRE’s decision notice.

If the member is not satisfied with the result of the IRE review, he or she may request the review by an ALJ.

**Administrative Law Judge Review**

If the decision is not in the member’s favor, the member or his/her authorized representative may request the review by an ALJ. To request a review by an ALJ, the value of the drug in question must meet minimum requirements. To calculate the amount in controversy, the dollar value of the drug 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, if 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 of the claims to be heard by the ALJ.

The request must be made 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 appointed representative may present evidence, 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.

If the decision is in the member’s favor and the member has already received and paid for the drug in question, CareFirst Advantage will reimburse the member within 30 calendar days from the date we receive the ALJ decision. If the decision is in the member’s favor and the member has not yet received the drug in question, CareFirst Advantage will authorize the medication within 72 hours of the date we receive the ALJ decision. In cases where an expedited ALJ review was requested, CareFirst Advantage will authorize the medication within 24 hours of receiving the ALJ notice. If the ALJ rules against the member, the ALJ notice will provide instructions on how to request a review by the Medicare Appeals Council.

**Medicare Appeals Council**

If the decision of the ALJ is not in the member’s favor, MAC review may be requested. 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, and
this notice will advise the member if any 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. If the decision is in the member’s favor and the member has already received and paid for the drug in question, CareFirst Advantage will reimburse the member within 30 calendar days of receiving the MAC notice. If the decision is in the member’s favor, but the member has not yet received the drug in question, CareFirst Advantage will authorize the drug within 72 hours of receiving the MAC notice. If an expedited MAC review was requested and the decision is in the member’s favor, CareFirst Advantage will authorize the drug within 24 hours of receiving the MAC notice.

If the MAC reviews the case and the decision is not in the member’s favor, the member may request a judicial review, but only if the dollar value of the medication meets minimum requirements.

**Federal Court**

If the member is not satisfied with the decision made by the MAC, to request judicial review of the case, the member must file civil action in a United States District Court. 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 Advantage is obligated to authorize or pay for services under the same time constraints as outlined above. If the Judge issues a decision that is not in the member’s favor, the decision is final and there is no further right of appeal.

<table>
<thead>
<tr>
<th>Amount in Controversy, Federal Minimum Requirements for Filing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal Level</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>ALJ Hearing</td>
</tr>
<tr>
<td>Judicial Review</td>
</tr>
</tbody>
</table>

**Member Grievances**

A grievance is different from an appeal in that it usually does 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 pharmacy
- Disrespectful or rude behavior by pharmacists or other staff
- The cleanliness or condition of a network pharmacy
- If a member disagrees with our decision not to expedite a request for coverage determination
- If CareFirst Advantage does not provide a decision within the required timeframe
If CareFirst Advantage does not forward a case to an IRE if we do not comply with required timeframes for reconsideration

If CareFirst Advantage does not provide the member with required notices

Members can file an expedited grievance under certain conditions.

Members are encouraged to contact our Member Services first for immediate assistance to resolve their concern. If our Member Services staff is not able to resolve the telephone complaint, the complaint will be reviewed and followed up on with our Grievance team. Members may file a grievance by calling our Member Services Department or in writing. Grievances received orally will be followed up on orally. Grievances received in writing will be followed up on in writing. Quality of Care grievances will always receive a written response.

Grievances can be sent to the following address:
CareFirst BlueCross BlueShield Medicare Advantage
P.O. Box 3626
Scranton, PA 18505

If the member would like to have someone else file a grievance on their behalf, an AOR must be completed. Grievances must be filed within 60 days of the date of the incident.

**Grievances**

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

**Expedited Grievances**

CareFirst Advantage also has a process in place when 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 expedited grievances in the following circumstances if the member disagrees with the action:

- When we have extended the timeframe to make an Organization Determination
- When we have extended the timeframe to resolve a Reconsideration
- When we have refused to grant a Member's request for an expedited Organization Determination
- When CareFirst Advantage has refused to grant a Member's request for an expedited Reconsideration (Appeal)

The circumstances outlined above are the only times that an expedited grievance review is available. When an expedited grievance is filed, a decision will be communicated to the member or the member's appointed representative within 24 hours of receiving the request. All affected parties will be notified of the decision by telephone within 24 hours of filing the Expedited Grievance, and 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 paid incorrectly or not paid at all. If the services were paid but the payment 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 Advantage has a two-level payment dispute process**

**First Level Contracted Provider Disputes**

When a provider disagrees with a payment amount or with a payment denial with no member liability the provider should contact CareFirst Advantage customer service for a verbal dispute and review of the payment. This can be completed by contacting customer service and providing the reason for the payment dispute. The customer service team will research the issue and follow up with the provider on the outcome. If the response satisfies the provider, the verbal dispute is considered closed. If the provider continues to disagree with the payment, then a written second level payment dispute should be filed.

**Second Level Provider Disputes**

- To request a provider dispute, contracted providers must make a written request for a payment dispute which must be received by the plan within
  - 180 calendar days of the date of their denial notice denying a post-service claim. When an authorization has been denied, provider must adhere to the 60 day timeframe, the 180 days once the claim has been denied does not apply.

- When submitting a written request for a payment dispute, the provider is required to submit any and all supporting documentation including, but not limited to, a copy of the denied claim the reason for the appeal, and the member’s medical records containing all pertinent information regarding the services rendered by the provider.

- All post service payment provider appeal reviews will be completed within 60 days of the date the written request was received.

- The provider will be informed of the decision in writing by mailing notification within 60 days from receipt. If the appeal is approved, payment will be issued within 60 calendar days of notification.

**Quality Improvement**

**Star Rating Program**

CMS uses the Star Rating system to measure MAPD 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 Advantage 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.

This is in addition to the Quality Improvement activities outlined in Chapter 7 of this manual.

**Risk Adjustment Program**

Risk adjustment is a clinical initiative to properly capture all diagnoses, complications, and chronic conditions of members within a physician's panel once a year. This supports the development of a comprehensive profile of each patient and populations at large. This helps support the prediction of patient needs and helps to provide the most efficient coordination of high-quality care.

Physicians are at the center of a successful risk adjustment operations as their clinical documentation influences the data collected on each patient. A strong risk adjustment operation allows the State and Federal governments to appropriately allocate revenue to health plans for the high-risk patients under their care.

Comprehensive patient data is a key to population health strategy. A strong risk adjustment program that focuses on accurate coding and documentation will deliver a comprehensive review of the health status of a population. Risk adjustment is central to CMS' payment structure for understanding the needs of patients with chronic and significant health conditions.

**Practice Transformation**

**What is Practice Transformation?**

Practice transformation encompasses 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 foundation 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.
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.
- **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 provider's 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.
- **Virtual care**: Technology that supports the use of telemedicine that increase accessibility and convenience for patients.

**Practice and Payment Transformation at CareFirst**

CareFirst Advantage has many resources that can assist practices with this transformation, whether their goal is aligning office workflows with CMS or National Committee for Quality Assurance (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 in the MA sector.

**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 Advantage offers ACO programs for providers in our MA networks. To participate in CareFirst Advantage's 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, they 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 Advantage's volume to value strategy. They allow CareFirst Advantage 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 Advantage has equipped health systems with additional resources to enable transformation activities. In addition to field-based practice consultants, CareFirst Advantage 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 Advantage 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 Advantage 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 Advantage 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 Advantage 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 Advantage will have one formulary option for both the Core and Enhanced plans. Members who choose the Enhanced plan will have additional coverage for generic drugs in the Tier 1 during the coverage gap. This is denoted by the symbol GC in both the printable and searchable versions of the formulary.

CareFirst Advantage delegates formulary creation to its Pharmacy Benefits Manager (PBM), CVS Caremark. The formulary is reviewed and approved by an independent national committee comprised of physicians, pharmacists, and other healthcare professionals who make sure the drugs on the formulary are safe and clinically effective. The Medicare formulary is also reviewed and approved by the CMS. CareFirst Advantage 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 Advantage 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 Advantage 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 Advantage has certain medications that require PA and/or ST. CVS Caremark handles initial request while CareFirst Advantage is responsible for appeals. Lists of medications, including those with PA or ST, are available at carefirst.com/Medicare.

**Ensuring Appropriate Utilization of Opioids**

A topic applicable and relevant for any population, CareFirst Advantage 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 Beneficiaries can continue to receive medications they may have been taking before joining CareFirst Advantage, 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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Transition Fill Days’ Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New &amp; Renewing Members</strong></td>
<td></td>
</tr>
<tr>
<td>Not in long-term care (LTC)</td>
<td>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.</td>
</tr>
<tr>
<td>In LTC</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Non-LTC Resident Level of Care Change</strong></td>
<td></td>
</tr>
<tr>
<td>Member released from LTC facility within the past 30 days</td>
<td>30 days’ supply; multiple fills up to a cumulative applicable month’s supply are allowed to accommodate fills for amounts less than prescribed.</td>
</tr>
</tbody>
</table>

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 MA-PD 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 of at least $4,376 annually on medications, which is projected from three months’ worth of claims

Qualifying members will be enrolled automatically and can opt-out. CareFirst Advantage MTM members will receive a comprehensive annual review of medications, as well as outreach for potential targeted medication reviews. You may receive letters requesting changes to medication regimens pursuant to these reviews.

**Medication Reconciliation Post-Discharge**

Medication reconciliation is a critical part of post-discharge care coordination for all members. As such, CareFirst Advantage will support this initiative by outreaching to members who have been recently discharged from the hospital and review their medications. We may send you documents detailing our discussions with them and may ask for certain changes to the medication regimen we discuss.

**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, appropriateness, and covered benefits of the Member 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

**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
Please send written requests to the address below:

Preservice Review Department
CareFirst BlueCross BlueShield
1501 S. Clinton St.
8th Floor, Cube 18001
Baltimore, MD 21224

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 Advantage members.

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 Advantage 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.

Emergency Hospital Admissions
When ER professionals recommend emergency admission for an MA 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 Advantage by following the authorization process 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 Advantage uses the Modified AEP Criteria which is modified from a small version of AEP that addresses inpatient procedures that cannot safely be performed in another setting. Components of the
Modified AEP Criteria include treatment, monitoring and patient status. Evidenced based AEP is used as a monitoring tool and is used by healthcare organizations, and represents a collaboration between health care organizations, facilities, and medical providers. Additionally, AEP is a statistical proven tool for the assessment of inpatient stay and quality clinical outcomes without designating or putting emphasis on diagnosis and diagnostic codes.

The Apollo Managed Care Physical Therapy, Occupational Therapy, and Rehabilitation Criteria (Apollo Managed Care Guidelines®) is used when reviewing home care, durable medical equipment, rehabilitation, and physical and occupational therapy requests.

**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 Medical Policy Reference Manual** is an electronic database that contains both medical policies and medical policy operating procedures.

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](http://www.perio.org))
- Parameters of Care, American Association of Oral and Maxillofacial Surgery ([www.aaoms.org](http://www.aaoms.org))
- Position Statements, American Association of Dental Consultants ([www.aadc.org](http://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 Advantage physician reviews are available to discuss UM decisions. Providers may call 410-528-7041 or 800-367-3387, ext. 7041 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 Advantage affirms that all UM decision-making is based only on appropriateness of care and service and existence of coverage. CareFirst Advantage 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, he/she 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 Advantage.

**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 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.

In-Area Authorization Process

The hospital is responsible for initiating authorization for all emergency admissions. CareFirst Advantage 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

In the case of an out-of-area emergency admission, the hospital is responsible for obtaining the authorization.

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 Advantage if additional information is needed before approving the authorization. Failure to notify the hospital within this timeframe may result in a delay or denial of the authorization.

CareFirst Advantage 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 hospital transition of care (HTC) coordinator nurse monitors admissions of plan members to hospitals anywhere in the country.
If the admission date for an elective admission changes, CareFirst Advantage 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.

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

CareFirst Palliative Care
CareFirst Advantage is partnering with Aspire Health® to provide palliative care to MA members who are facing advanced illness. The program is a non-hospice, community-based alternative offering home based, 24/7 support to qualifying members at no additional cost. Support is provided by a team of doctors, nurse practitioners, nurses, and social workers in collaboration with you to ensure the highest quality care in alignment with a patient's goals and values. Aspire Health also assists patients and families with advanced care planning.

For questions or to request a referral, please contact Care Management.

CareFirst Video Visit
CareFirst Video Visit allows MA members to connect securely with a doctor or licensed provider through their smartphone, tablet, or computer from the comfort of their home. Members have access to urgent care 24 hours a day, 7 days a week without an appointment to receive treatment for common health issues such as fevers, sore throat, cold and flu and migraines. Members also have access to scheduled therapy and psychiatry appointments. For more information, visit carefirst.com/videovisit or go to carefirstvideovisit.com.

24 Hour Nurse Advice Line
The 24-Hour Nurse Advice Line is designed to support providers by offering information and education to MA members after hours about medical conditions, health care and prevention. Members can call 1-833-968-1773 which is also listed on the back of the member's ID card. Nurses provide triage services and help direct members to appropriate levels of care for their medical condition.

Features of the 24-Hour Nurse Advice Line include:

- Availability 24 hours a day, 7 days a week.
- Information based on nationally recognized and evidence-based guidelines.
- Education for members regarding appropriate alternatives for handling nonemergent medical conditions.