

# Administrative Functions

This section provides Administrative Functions information for your CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (collectively CareFirst), patients.

Per the terms of the Participation Agreement, all providers are required to adhere to all policies and procedures, as applicable.

If we make any procedural changes in our ongoing efforts to improve our service to you, we will update the information in this section and notify you through [email](#) and [BlueLink](#), our online provider newsletter.

Specific requirements of a member's health benefits vary and may differ from the general procedures outlined in this manual. If you have questions regarding a member's eligibility, benefits, or claims status information, we encourage you to use one of our self-service channels; [CareFirst Direct](#) or the Voice Response Unit. Through these channels, simple questions can be answered quickly.

Read and print the [Guidelines for Provider Self-Services](#).

## Medical Credentialing

Providers wishing to participate in the CareFirst provider networks are required to submit credentialing information. This information is verified to confirm that our credentialing criteria is met. This includes, but is not limited to:

- Valid, current, unrestricted licensure
- Valid, current Drug Enforcement Agency (DEA) and Controlled Dangerous Substance (CDS) registration
- Appropriate education and training in a relevant field
- Board certification, if applicable
- Review of work history
- Active, unrestricted admitting privileges at a participating network hospital
- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
- Attestation to reasons for an inability to perform the essential functions of a clinical practitioner that could impose significant health and safety risks to members/enrollees; lack of present illegal drug use; history of loss of license and felony convictions; history of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage with minimum limits as indicated on the next page:

## Administrative Functions

Number of Practitioners in Practice	Medical Practices Primary Layer	Medical Practices Excess Layer	Mid-Level Behavioral Primary Layer	Mid-Level Behavioral Excess Layer	PT/OT/ST Primary Layer Only
1	\$1/\$3M Individual	N/A	\$.5/\$1.5M Individual	N/A	\$1/\$3M Shared (up to 24)
2–5	\$1/\$3M Shared	N/A	\$.5/\$1.5M Shared	N/A	\$1/\$3M Shared (up to 24)
6–10	\$2/\$6M Shared	N/A	\$1/\$3M Shared	N/A	\$1/\$3M Shared (up to 24)
11–24	\$2/\$6M Shared	\$5M Shared	\$1/\$3M Shared	\$3.25M Shared	\$1/\$3M Shared (up to 24)
	\$1/\$3M Shared	\$10M Shared	\$.5/\$1.5M Shared	\$7.5M Shared	
25–50	\$2/\$6M Shared	\$10M Shared	\$1/\$3M Shared	\$5M Shared	Individual Consideration
	\$1/\$3M Shared	\$15M Shared	\$.5/\$1.5M Shared	\$10M Shared	
51+	Individual Consideration	Individual Consideration	Individual Consideration	Individual Consideration	Individual Consideration

To make sure that CareFirst has obtained correct information to support credentialing applications and made fair credentialing decisions, providers have the right, upon request, to review this information, to correct inaccurate information and to obtain the status of the credentialing process. Requests can be made by calling 877-269-9593 or 410-872-3500.

CareFirst encourages the use of the Council for Affordable Quality Healthcare (CAQH) ProView application. New practitioners can go directly to CAQH ProView and complete the credentialing application online through the [CAQH ProView secure website](#). Once you have completed your application (CAQH will email you notification that your application is complete), and you have authorized CareFirst to access your data, download and print the [CAQH Provider Data Sheet](#), and fax it to CareFirst at 410-872-4107. CareFirst will add you to our CAQH ProView roster. CareFirst will then receive your application data electronically from CAQH ProView and begin the credentialing process.

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

If you are a participating primary care provider in CareFirst’s network(s), you also have the opportunity to participate in programs that emphasize primary care and work to improve quality through coordinated care and appropriately aligned incentives like the [CareFirst Patient-Centered Medical Home \(PCMH\) Program](#).

For more information on our Credentialing process, visit [www.carefirst.com/professionalcredentialing](http://www.carefirst.com/professionalcredentialing).

### Verify Provider Information Requirement

To keep the information we have on file for your practice up to date, CareFirst requires providers to review and verify practice information twice per calendar year. Validation must occur once between January 1 and June 30 and once between July 1 and December 31 (but not less than three months apart).

To view the information we have on file for your practice, log in to the Provider Portal (CareFirst Direct) at [www.carefirst.com/providerlogin](http://www.carefirst.com/providerlogin) and follow our [step-by-step guide](#). If the information displayed is correct, click the “Verify Provider Information” button to meet the requirement.

If the information is incorrect, use the “Update” links directly within the Portal to make changes quickly and conveniently. For changes to information where

## Administrative Functions

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“Update” links are not available, submit a [Change in Provider Information – Professional](#) form.

### Role of the Primary Care Provider (PCP) – (CareFirst BlueChoice only)

Providers in the following medical specialties are recognized as PCPs:

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

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

Each CareFirst BlueChoice member selects a PCP upon enrollment and receives an individual membership identification card with the name of the PCP located on the card.

If a member chooses to change PCPs, the member must call the selected provider’s office to confirm that they still participate with CareFirst BlueChoice and are accepting new patients. The member then notifies Member Services of this change. Notification can also be done online at [www.carefirst.com/myaccount](http://www.carefirst.com/myaccount).

Requests received on or before the 20th of the month will be effective the first day of the following month. Requests received after the 20th will be effective on the first day of the second month following the request.

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**For example: Changes received by Jan. 20 will be effective Feb. 1. Changes received on Jan. 21 will be effective March 1. New cards will be issued after the PCP change is processed.**

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If you no longer wish to be a CareFirst BlueChoice member’s PCP, you must verify that you are the patient’s current PCP, and notify Provider Services in writing prior to notifying the member. Additionally, you must give the patient 30 days notice prior to their release. A Member Services Representative will help the member select a new PCP.

### OB/GYNs as PCPs

Only members in Maryland have the opportunity to select obstetrics and gynecology specialists as their PCP. A CareFirst BlueChoice participating OB/GYN who agrees to act as PCP for a female member should give the member a “letter of intent” stating your decision to serve as PCP.

The letter should include your CareFirst BlueChoice provider number and the member’s identification number and should be returned by the member to Member Services.

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**Note: Nurse practitioners (NPs) must be certified by the relevant approved National Certification Board and meet all licensing/certification guidelines of the state in which the NP practices. NPs must have a written collaborative agreement with a physician of the same specialty who is in good standing in the same CareFirst provider networks.**

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### Back-up Coverage

When you are not available to provide service to patients, you must arrange effective coverage through another practitioner who is a PCP in the CareFirst BlueChoice network. The covering practitioner must indicate on the paper claim form “covering for Dr. [provider’s name]” when submitting the claim to CareFirst BlueChoice.

### After Hours Care

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

### Open/Closed Panel

As stated in the Physician Participation Agreement, you may close your panel to new members with at least 60 days prior written notice to Provider Information and Credentialing, provided your panel includes at least 200 CareFirst BlueChoice members.

## Administrative Functions

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

Requests for opening and closing a panel can be made via the Provider Self-Service Portal, or faxed on your letterhead to 410-872-4107 or 866-452-2304. Written notifications should be mailed to:

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

### Reduction, Suspension or Termination of Privileges

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

After review of relevant and objective evidence supplied to or obtained by CareFirst, our Medical Director may elect to reduce, suspend or terminate practitioner privileges for cause. When a potential problem with quality of care, competence or professional conduct is identified and there is imminent danger to the health of a member, the Medical Director may immediately terminate the practitioner's participation. Actions, other than termination of participation, include:

- implementation of a corrective action plan
- implementation of a monitoring plan relative to billing and/or member satisfaction
- closure of PCP panels (BlueChoice only)
- suspension with notice to terminate
- special letter of agreement between the practitioner and CareFirst outlining expectations and/or limitation of range of services the practitioner may supply to members

To make final determinations, the Medical Director seeks advice from the Credentialing Advisory

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

The Medical Director notifies the practitioner in writing of the reason(s) for the termination and/or sanction, his/her right to appeal the determination and the appeal process. The practitioner may appeal the decision by submitting a written notice with relevant materials he/ she considers pertinent to the decision within 30 days of being notified of the decision. The practitioner forfeits his/her right to appeal if he/she fails to file an appeal within 30 days of receiving notification of the decision.

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

### Quality of Care Terminations

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

## Administrative Functions

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### All Other Sanctions or Terminations

The Medical Director will reconsider appeals for all other sanctions or terminations on the basis of new information provided by the practitioner. The Medical Director may seek recommendations from the CAC prior to making a final decision. The Medical Director notifies the practitioner of the decision in writing and informs the practitioner that the decision is final and not subject to further consideration with CareFirst.

### Member to be Held Harmless

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

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

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### Reimbursement

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

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

### Fee Schedule – Place of Service Code Assignments

[Place of Service Code Assignments](#) are used by CareFirst providers when submitting claims for payment. These codes are also located in the Reference Guides tab at [www.carefirst.com/providerguides](http://www.carefirst.com/providerguides).

### Health Insurance Portability and Accountability Act (HIPAA) Compliant Codes

To comply with the requirements of HIPAA, CareFirst will add the HIPAA-compliant codes and plan allowances to your fee schedule when they are released from the American Medical Association (AMA) or the Centers for Medicare and Medicaid Services (CMS). These updates are made as needed during the calendar year.

### "Concierge" Services Policy

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

According to our standard Participation Agreement, contracted providers must:

- submit claims to CareFirst for all covered services, including preventive services.
- bill members for payment of applicable deductibles, copayments and/or coinsurance.

To verify member benefits, use [CareFirst Direct](#).

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

## Administrative Functions

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

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

The written notice should be forwarded to your [professional provider relations representative](#).

For providers enrolled in the PCMH Program, please visit [www.carefirst.com/pcmhinfo](http://www.carefirst.com/pcmhinfo) to learn more about requirements related to the “concierge” practice model.

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

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## Administrative Services Policy

To help you evaluate your office’s current practices, our Administrative Services policy is provided below. In short, providers cannot require the payment of charges above and beyond coinsurance, copayments and deductibles.

*Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against subscribers or members for covered services, including those that are inherent in the delivery of covered services. The practice of charging for office administration and expense is not in accordance with the Participation Agreement and Participating Provider Manual. Such charges for administrative services would include, by way of example, annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses, malpractice coverage increases, writing prescriptions, copying and faxing, completing referral forms or other expenses related to the overall management of patients and compliance with government laws and regulations, required of health care providers.*

*The provider may look to the subscriber or member for payment of deductibles, copayments or coinsurance, or for providing specific health care services not covered under the member’s Health Benefit Plan as well as fees for some administrative services. Such fees for administrative services may include, by way of example, fees for completion of certain forms not connected with the providing of covered services, missed appointment fees, and charges for copies of medical records when the records are being processed for the subscriber or member directly. Fees or charges for administrative tasks, such as those enumerated above may not be assessed against all members in the form of an office administrative fee, but rather to only those members who utilize the administrative service.*

## Administrative Functions

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### Notice of Payment/Electronic Remittance Advice

Participating providers are reimbursed by CareFirst for covered services rendered to CareFirst members. A Notice of Payment (NOP) or Electronic Remittance Advice (ERA) accompanies each check and enables providers to identify members and the claims processed for services rendered to those members.

### Reimbursement for Limited Licensed Providers (LLPs)

CareFirst reimburses LLPs at a percentage of the provider fee schedule. This reimbursement policy applies to all CareFirst provider contracts.

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

#### *LLPs Affected and Related Percentages of the Provider Fee Schedule*

Nurse midwife	90%
Nurse practitioner	85%
Board Certified Behavior Analyst (BCBA)	75%
Dietician/Nutritionist	75%
Licensed professional counselor, licensed marriage and family therapist, licensed alcohol and drug therapist	75%
Naturopathic provider	75%
Psychiatric nurse	75%
Licensed clinical social worker	75%

### Physician Assistants

Covered services rendered by physician assistants (PAs) are eligible for reimbursement under the following circumstances:

- the PA is under the supervision of a physician as required by local licensing agencies
- services rendered by the PA are submitted under the supervising physician's name and provider number

CareFirst does not contract with PAs. PA services are to be submitted under the supervising physician's name and provider number.

### Referrals (BlueChoice only)

Unless otherwise stated, all office services not rendered by a PCP require a written referral, except for OB-GYN services and services rendered for members with the Open Access feature.

A written referral is valid for a maximum of 120 days and limited to three visits except for longstanding referral situations, and in-network services rendered to CareFirst BlueChoice members with the Open Access feature included in their coverage.

Decisions to issue additional referrals rest solely with the PCP.

Additional information about covered services and benefits guidelines is available through the [Medical Policy Reference Manual](#).

### Electronic Capabilities

To support our paperless initiative and improve your claims processing experience, CareFirst strongly encourages providers to utilize electronic capabilities.

#### Electronic Claims

We strongly encourage providers to submit all claims electronically. Electronic submission can help your practice save time, money and eliminate incomplete submissions.

We understand that certain claims require additional documentation from CareFirst and cannot be submitted electronically. However, we urge you to take advantage of all the benefits by filing electronically whenever possible, including when submitting the following types of claims:

- Initial
- Corrected (Institutional and Professional)
- Late Charge (Institutional only)
- Interim (Institutional only)
- Medicare Secondary that do not automatically crossover from CMS (Institutional and Professional)

Your billing [National Provider Identifier \(NPI\)](#) must be used to identify your practice when submitting claims.

Throughout the electronic claims submission process you will receive reports from both your clearinghouse and CareFirst that will confirm if a claim has been received or if the claim encountered an error which

## Administrative Functions

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will require you to correct and resubmit the claim. If a claim encounters an error, you must correct the error and resubmit through your clearinghouse. If not, the claim has not been filed with CareFirst, and may result in a timely filing rejection.

To locate a claim, start from the point of initial electronic filing to identify any potential transmission problems. If the claim is not showing on the system, please [contact your clearinghouse](#), or contact the CareFirst EDI Help Desk at 1-877-526-8390 or [edi@directsubmission.com](mailto:edi@directsubmission.com).

Claims Receipt Reports should be filed and kept for an appropriate period of time for follow up and research activities. CareFirst does not keep copies of these reports.

You can always login at [www.carefirst.com/carefirstdirect](http://www.carefirst.com/carefirstdirect) to check on the status of a claim that has been received but not fully processed. To identify any issues, [contact Provider Services](#). For more information, visit [www.carefirst.com/electronicclaims](http://www.carefirst.com/electronicclaims).

### Electronic Remittance Advice (ERA)

If you submit claims electronically, you can receive payment vouchers through an Electronic Remittance Advice (ERA 835), delivered by your clearinghouse and including the payment details, HIPAA adjustment reason codes and HIPAA remark codes necessary for you to reconcile your patient accounts. Receiving your payment information electronically allows you to realize claim resolution faster and save money.

For more information and to set up ERA, please [contact your clearinghouse](#).

### Electronic Fund Transfer (EFT)

If you are submitting claims electronically and receiving an Electronic Remittance Advice (ERA), you can also take advantage of Electronic Fund Transfer (EFT), which allows you to get paid faster with secure direct deposits from CareFirst and reduced paperwork. All of our [preferred clearinghouses](#) offer EFT enrollment services.

### Paper Claims Submission Process

Paper claims are scanned and a digitized version of the claim is produced and stored electronically. Successful imaging of the claim depends on print darkness. Light print produces unacceptable imaging

and your claim may be returned to you. Please make sure to change your printer cartridges regularly so that the print is dark.

Incomplete claims create unnecessary processing and payment delays for all providers. The fields listed below must be completed on all claims submitted to CareFirst. Claims missing information in any of the following fields will be returned:

- block 1a: Insured's ID Number\*
- block 2: Patient's Name
- block 3: Patient's Birth Date
- block 21: ICD-10
- block 24a: Dates of Service
- block 24b: Place of Service
- block 24d: Procedures, Services or Supplies
- block 24f: Charges
- block 24g: Days or Units
- block 24j: Rendering Provider NPI
- block 25: Federal Tax ID Number
- block 31: Signature of Provider (including degree or credentials)
- block 33a: Provider's Billing National Provider Identifier (NPI) (Required, or it will be returned to the provider).

\*The 3-digit prefix must be included if present on the subscriber's identification card. FEP membership numbers do not have a 3-digit prefix, but begin with an "R" and have 8 numeric digits.

All claims must be submitted on an original (red/white) [CMS1500 form \(version 02/12\)](#). All information must fit properly in the blocks provided.

### Timely Filing of Claims

To expedite quick and accurate claims processing, please report services for only one provider per claim. If more than one provider in your practice renders services for a given member, separate claims must be submitted for each provider.

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**Note: To be considered for payment, claims must be submitted within 365 days from the date of service.**

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## Administrative Functions

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### Reconsideration

Claims submitted beyond the timely filing limits are generally rejected as not meeting these guidelines. If your claim is rejected, but you have proof that the claim was submitted to CareFirst within the guidelines, you may request processing reconsideration.

Timely filing reconsideration requests must be received within six months of the provider receiving the original rejection notification Notice of Payment (NOP) or Electronic Remittance Advice (ERA). Requests received after six months will not be accepted and the charges may not be billed to the member.

Documentation is necessary to prove the claim was submitted within the timely filing guidelines.

- **For electronic claims:**

A confirmation is needed from the vendor/clearinghouse that CareFirst successfully accepted the claim. Error records are not acceptable documentation.

- **For paper claims:**

A screen print from the provider's software indicating the original bill creation date along with a duplicate of the clean claim or a duplicate of the originally submitted clean claim with the signature date in field 12, indicating the original bill creation date.

### Guidelines for Ancillary Claims Filing

For a full list of claims filing guidelines for Lab, DME and Specialty Pharmacy, visit [www.carefirst.com/ancillaryclaims](http://www.carefirst.com/ancillaryclaims).

#### Billing DME on a CMS 1500 claim form

- DME rental periods for a one month rental period should be billed as 1 unit, not 30 units with an RR modifier.
- Correct billing of HCPCS codes for Lancets, per box of 100 should only be billed as 1 unit, not 100 units of 100 lancets.
- Bill a modifier of NU for purchase of DME.
- Unlisted CPT and HCPCS codes should only be reported when there is no established code to describe the service.
- Submissions of claims containing unlisted procedure codes must be submitted with a complete description of the service or procedure

code provided. Any applicable records or reports must be submitted with the claim.

- The following services are reimbursed on a daily basis according to the terms of the CareFirst provider contract, and the RR (Rental) modifier must be appended to the claim.
  - Enteral Nutrition Infusion Pump – with or without an alarm
  - Parental Nutrition Infusion Pump – portable or stationary
- Phototherapy (bilirubin) light with the photometer.
- Continuous passive motion exercise therapy device for use on the knee only.
- Negative pressure wounds therapy electrical pump, stationary or portable.
- Repair or non routine service for DME other than oxygen equipment requiring the skill of a technician.
- Repair or non routine service for oxygen equipment requiring the skill of a technician.

### Medicare Crossover Claims Submission

Check CareFirst Direct or CareFirst on Call to verify that the claim has not been received by CareFirst. You do not need to wait 30 days from Medicare's processing date to check CareFirst Direct or CareFirst on Call. You may check any time after the receipt of a Medicare Remittance Notice. The following rules govern the submission process of Medicare Secondary claims:

- Wait 30 days from the Medicare Explanation of Benefits (EOB) date before submitting your secondary claim.
- If you are submitting a secondary claim electronically (professional providers only), you must include the Medicare EOB or remittance advice date.
- Out-of-area member claims for covered services are now rejected by the member's home plan. When you receive a rejection notification, you must resubmit these claims to CareFirst for processing through BlueCard®.
- Medicare claims billed using a 'GY' modifier can be submitted directly to CareFirst without prior submission to Medicare. These claims are not

## Administrative Functions

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impacted by the 30 day requirement and do not require the inclusion of a Medicare EOB.

For these requirements and directions on how to submit Medicare Secondary claims, visit [www.carefirst.com/electronicclaims](http://www.carefirst.com/electronicclaims) > Medicare Secondary page.

### Effective Follow-Up for Claims

To follow-up on claims submitted more than 30 days ago, you can check [CareFirst Direct](#) or [CareFirst on Call](#) to determine the claim status.

**Do not resubmit claims without checking [CareFirst Direct](#) or [CareFirst on Call](#) first. Submitting a duplicate of a claim already in process will generate a rejection, which will cause a backlog of unnecessary claims to be processed.**

### Step-By-Step Instructions for Effective Follow-Up

#### *Claim Status*

The most effective way to accomplish follow-up on submitted claims is to access [CareFirst Direct](#) or [CareFirst on Call](#). If there is no record of the claim, the claim must be resubmitted.

If the claim has been pending in the system for less than 30 days, wait until 30 days have elapsed from the processing date given on CareFirst Direct or CareFirst on Call. If processing has not been completed after 30 days, the preferred method for submitting an inquiry is electronically through CareFirst Direct's inquiry Analysis and Control System (IASH) function.

When you cannot use CareFirst Direct's IASH function, please use the [Provider Inquiry Resolution Form](#) (PIRF) to submit your Inquiry.

#### *Large Volume of Unpaid Claims*

- Please be sure that all NOPs or ERAs have been posted.
- Use CareFirst Direct or CareFirst on Call to verify receipt and status of claims.
- If you still have questions, please contact the appropriate provider customer service unit for assistance.

### Claims Overpayment

If a claims overpayment is discovered, please mail the amount to the following address:

**CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.**  
**P.O. Box 791021**  
**Baltimore, MD 21279**

Please include with your check:

- Membership number
- Patient name
- Claim number
- Reason for the refund

Make the check payable to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.

### Collection of Retroactively Denied Claims

A provider reimbursement may be offset against a retroactively denied claim by an affiliated company of CareFirst.

### Inquiries

Inquiries may include issues pertaining to: Authorizations, Correct Frequency, ICD-10, Medical Records, Procedures/Codes and Referrals.

#### **Instructions for Submitting an Inquiry**

The preferred method for submitting an Inquiry is electronically through CareFirst Direct's Inquiry Analysis and Control System (IASH) function.

When you cannot use CareFirst Direct, please use the [Provider Inquiry Resolution Form](#) (PIRF) to submit your Inquiry.

Helpful Tips when completing a PIRF:

- use a separate form for each patient
- include the entire subscriber identification number, including the prefix
- attach a copy of the claim with any additional information that might assist in the review process
- a copy of the form can be located on the website at [www.carefirst.com/providerforms](http://www.carefirst.com/providerforms)

An Inquiry must be submitted to the appropriate addresses below within 180 days or six months from

## Administrative Functions

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the date of the Explanation of Benefits. Please allow 30 days for a response.

■ Correspondence Address:

**Mail Administrator**  
**P.O. Box 14114, 14112, or 14111 (see below)**  
**Lexington, KY 40512**

■ Select the appropriate P.O. Box:

- 14114 – MD, National Capital Area (NCA), BlueChoice, local BlueCard and NASCO
- 14112 – Federal Employee Program (FEP) providers in Montgomery & Prince George’s counties, Washington, DC and Northern Virginia
- 14111 – All other MD FEP Inquiries

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**Note: Before sending an Inquiry, consider submitting a corrected claim that will replace the original claim submitted.**

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### Appeals

An Appeal is a formal written request to the Plan for reconsideration of a medical or contractual adverse decision.

#### Instructions for Submitting an Appeal

Please submit an Appeal in letter form on your office letterhead describing the reason(s) for the Appeal and the clinical justification/rationale. Please be sure to include:

- Patient name and identification number
- Claim number
- Admission and discharge dates (if applicable) or date(s) of service
- A copy of the original claim or Explanation of Benefits (EOB) denial information and/or denial letter/notice
- Supporting clinical notes or medical records including: lab reports, X-rays, treatment plans, progress notes, etc.

Written appeals should be mailed to:

**Mail Administrator**  
**P.O. Box 14114**  
**Lexington, KY 40512**

An Appeal must be submitted within 180 days from the date of the Explanation of Benefits or Adverse Decision Notice. All Appeal decisions are answered in writing. Please allow 30 days for a response to an Appeal.

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**IMPORTANT: Do not use a Provider Inquiry Resolution Form (PIRF) to submit an Appeal. Visit [www.carefirst.com/inquiriesandappeals](http://www.carefirst.com/inquiriesandappeals) for more information.**

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### Expedited or Emergency Appeals Process

You may request an expedited or emergency Appeal after an adverse decision for pre-authorization of a service, admission, continued length of stay, or awaiting service or treatment.

- An expedited or emergency Appeal is defined as one where a delay in receiving the health care service could seriously jeopardize the life or health of the member, or the member’s ability to function, or cause the member to be a danger to self or others.
- Retrospective or past service denials are not eligible for expedited review.
- We will answer an expedited or emergency Appeal within 24 hours from the date the Appeal is received.

Expedited appeals may be faxed to 410-528-7053.

### Appeal Resolution

Once the internal Appeal process is complete, you will receive a written decision that will include the following information:

- The specific reason for the Appeal decision,
- A reference to the specific benefit provision, guideline protocol or other criteria on which the decision was based,
- A statement regarding the availability of all documents, records or other information relevant to the Appeal decision, free of charge, including copies of the benefit provision, guideline, protocol or other decision was based,
- Notification that the diagnosis code and its corresponding meaning, and the treatment code

## Administrative Functions

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and its corresponding meaning will be provided free of charge upon request,

- Contact information regarding a State consumer assistance program, and
- Information regarding the next level of Appeal, as appropriate.

### Member Complaints

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

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

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

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

Please include the following information when submitting a complaint:

- your telephone number and name
- your provider number
- the member's name and ID number
- date(s) of service
- as much detail about the event as possible

## Coordination with Other Payers

### Coordination of Benefits

Coordination of Benefits (COB) is a cost-containment provision included in most group and member contracts and is designed to avoid duplicate payment for covered services. COB is applied whenever a member covered under a CareFirst contract is also eligible for health insurance benefits through another insurance company or Medicare.

If CareFirst is the primary carrier, benefits are provided as stipulated in the member's contract.

Please note that, the member may be billed for any deductible, coinsurance, non-covered services or services for which benefits have been exhausted. These charges may then be submitted to the secondary carrier for consideration. Group contracts may stipulate different methods of benefits coordination, but generally, CareFirst's standard method of providing secondary benefits for covered services is the lesser of

- the balance remaining up to the provider's full charge; or
- the amount CareFirst would have paid as primary, minus the other carrier's payment (i.e., the combined primary and secondary payments will not exceed CareFirst allowance for the service)

When coordinating benefits with Medicare, the amount paid by CareFirst, when added to the amount paid by Medicare, will not exceed the Medicare allowable amount. Claims for secondary benefits must be accompanied by the Explanation of Benefits (EOB) from the primary carrier.

### Subrogation

Subrogation refers to the right of CareFirst to recover payments made on behalf of a participant whose illness, condition or injury was caused by the negligence or wrong doing of another party. Such action will not affect the submission and processing of claims, and all provisions of the participating provider agreement apply.

### No-Fault Automobile Insurance

The no-fault automobile insurance laws may require the automobile insurer to provide benefits for

## Administrative Functions

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accident-related expenses without determination of fault. A copy of the record of payment from the automobile insurer must be attached to the claim form submitted to CareFirst.

### Workers' Compensation

Health benefits programs administered by CareFirst exclude benefits for services or supplies if the participant obtained or could have obtained benefits under a Workers' Compensation Act, the Longshoreman's Act, or a similar law. Affected claims should only be filed if workers' compensation benefits have been denied or exhausted. In the event that CareFirst benefits are inadvertently or mistakenly paid despite this exclusion, CareFirst will exercise its right to recover its payments.

### Office Injectable Drugs

Medications administered in the provider's office are covered under the member's medical benefit, not their prescription drug benefit. Prescription drug benefits cover injectable medications only when they are self-administered.

Providers will need to obtain office administered injectable medications and bill CareFirst directly. Providers cannot write a prescription for a medication and have the member obtain the medication from the pharmacy so the member can deliver the drug to the provider. These medications are not covered by the member's prescription drug benefit.

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**Note: Depo-Provera® (when used for contraception) is the only non-self-administered injectable covered under the prescription drug benefit.**

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For commercial members, providers may obtain injectable medications from a source of their choice. CareFirst has a contract with [CVS Caremark](#). CVS Caremark can ship single doses of most injectable medications and vaccines, on an individual patient (prescription) basis, directly to the provider office for administering. This option is available for most office injectables, eliminating the upfront cost of stocking expensive specialty injectables. [CVS Caremark](#) obtain eligibility and benefits then bill CareFirst directly. Your practice should continue to bill CareFirst for the administration by following Current Procedural

Terminology (CPT®) guidelines and using the appropriate CPT® codes.

Orders for non-refrigerated, refrigerated and frozen medications and vaccines are packed in temperature controlled containers and shipped directly to your office, typically within 48 hours. Priority overnight delivery is also available. This is an optional service we make available and is not a guarantee of availability or supply by CareFirst. Not all drugs or individual prescriptions are available using this option.

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**Note: The arrangement with CVS Caremark does not apply to members whose primary coverage is Medicare.**

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**FEP members only:** Providers must obtain office injectables from [CVS Caremark](#).

### Standard Reimbursement Methodology

If you obtain office injectable drugs, the following standard reimbursement methodology applies. Injectable drugs are reimbursed at a percentage above the Average Sales Price (ASP). Injectable drugs without an ASP are reimbursed at a percentage off the *lowest* Average Wholesale Price (AWP). The ASP is calculated by the Centers for Medicare & Medicaid Services (CMS) and available at [CMS.gov](#). The AWP is based on the most cost effective product and package size as referenced in Thomson's Red Book.

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

### Exceptions to Standard Pricing Methodology

Exemptions to the Standard Pricing Methodology exist, including:

- Certain generic oncology drug codes, referred to as MAC codes, are reimbursed at greater than the standard ASP+12%. CareFirst encourages the use

## Administrative Functions

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of these select generic oncology products where medically appropriate.

- Certain high cost oncology, biologic and specialty drugs are reimbursed at ASP +8%.
- Pediatric vaccines are reimbursed at 100% of AWP.
- Certain high cost Rheumatoid Arthritis drugs are reimbursed at ASP+8%.
- Enzyme Replacement drugs are reimbursed at ASP+8%.
- Hyaluronic Acid (HA) derivative drugs, with the exception of Synvisc and Synvisc-One.
  - Synvisc and Synvisc-One are reimbursed at ASP+8%.

### Medical Injectables

Certain medical injectables require pre-authorization when administered in an outpatient hospital and home or office settings. This requirement applies to both BlueChoice and Indemnity. The complete list of medications that require pre-authorization is available at [www.carefirst.com/preauth](http://www.carefirst.com/preauth) > *Medications*.

You can request pre-authorization:

- **Online:** Log in at [www.carefirst.com/providerlogin](http://www.carefirst.com/providerlogin) and click the *Pre-Auth / Notifications* tab to begin your request.
- **By Phone:** Call (888) 877-0518.
- **By Fax:** Visit [www.carefirst.com/providerforms](http://www.carefirst.com/providerforms) to download the appropriate prior authorization form.