



CAREFIRST UPDATES AND REMINDERS

MD AAHAM

DECEMBER 2024

AGENDA

1. 2025 FEP Plan Updates
2. Medicare Advantage Plan Updates
3. Authorization Updates
4. Other Updates and Reminders

2025 FEP PLAN UPDATES



The Office of Personnel Management (OPM) announced that the Blue Cross and Blue Shield Federal Employee Program (FEP) is approved to participate in the Postal Service Health Benefits (PSHB) Program.

- The PSHB program is new in 2025 and part of the Postal Service Reform Act of 2022.
- PSHB offers health insurance to Postal Service employees, retirees and eligible family members starting January 1, 2025.
- OPM will automatically move Postal Service employees and retirees to the PSHB version of the FEP plan they are in today for 2025.
- 2025 benefits will be equivalent to the benefits for federal employees.
- Members have the option to make changes to their 2025 plan during Open Season (November 11th through December 9th)
- After Open Season, members will receive a welcome mailer with a new member ID card for each member on the contract.



FEHB Medicare Prescription Drug Program

- We no longer combine the separate Medicare Prescription Drug Program catastrophic protection out-of-pocket maximum, to the regular medical catastrophic protection out-of-pocket maximum
- The annual pharmacy out-of-pocket maximum is now \$2,000 per member for all plans.



Overseas Benefits

- We will waive the cost share for primary care, specialists and outpatient emergency room (ER) services for members overseas.



Teladoc Health Visits

- We will cover all of your telehealth visits from Teladoc Health at no out-of-pocket costs.



Family Planning Benefits

- Under our family planning services, we will now provide coverage for salpingectomies.



Gender Affirming Benefits

- Under our gender affirming surgical benefits, we now provide coverage for suction-assisted chest lipectomy related to a mastectomy.



We've made changes to our approved drug lists (formularies) for all plans.

FEP Blue Focus

- [2025 FEP Blue Focus Traditional Drug List](#)
- [2025 FEP Blue Focus MPDP Drug List](#)

FEP Blue Basic

- [2025 FEP Blue Basic Traditional Drug List](#)
- [2025 FEP Blue Basic MPDP Drug List](#)

FEP Blue Standard

- [2025 FEP Blue Standard Traditional Drug List](#)
- [2025 FEP Blue Standard MPDP Drug List](#)

FEP Blue Basic Updates

- For Self Only contracts, the Preferred Provider catastrophic out-of-pocket maximum is now \$7,500. For Self Plus One and Self and Family, the Preferred Provider catastrophic out-of-pocket maximum is now \$15,000.
- The copayment for office visits, allergy care, treatment therapies and services, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, hearing services, vision services, foot care services, alternative treatments, and diabetic education, when performed by Preferred specialists is now \$50 per visit.
- The copayment for an inpatient admission is now a \$350 per day copayment for up to \$1,750 per admission for unlimited days.
- The cost-share for outpatient surgical and treatment services performed and billed by a facility is now a \$250 copayment per day per facility.
- The copayment for outpatient observation services performed and billed by a hospital or freestanding ambulatory facility is now a \$350 per day copayment up to \$1,750.

FEP Blue Basic Updates

- The cost-share for outpatient diagnostic testing and treatment services performed and billed by a facility is now a \$250 copayment per day per facility.
- The cost-share for outpatient hospital emergency room services and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital is now a \$350 per day per facility copayment.
- The cost-share for professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by an urgent care center is now \$50.
- For members enrolled in our regular pharmacy program, the copayment for Tier 2 (preferred brand-name drugs) without Medicare Part B primary, is now \$75 for each purchase of up to a 30-day supply (\$200 for a 31 to 90-day supply.)

FEP Blue Basic Updates

- For members enrolled in our regular pharmacy program, the copayment for a Tier 4 (preferred specialty drug) is now a \$120 copayment for a 30-day supply at a Preferred Retail Pharmacy or through the Specialty Drug Pharmacy Program, and \$350 copayment for a 31 to 90-day supply through the Specialty Drug Pharmacy Program.
- For members enrolled in our regular pharmacy program, the copayment for a Tier 5 (non-preferred specialty drug) is now a \$200 copayment for a 30-day supply at a Preferred Retail Pharmacy or through the Specialty Drug Pharmacy Program, and \$500 copayment for a 31 to 90-day supply through the Specialty Drug Pharmacy Program.
- We have reduced the pharmacy drug out-of-pocket catastrophic maximum to \$2,000 for Basic Option members enrolled in the FEP Medicare Prescription Drug Program.

FEP Blue Standard Option Updates

- For members enrolled in our Medicare Prescription Drug Program, they will now have \$35 copayment for each purchase of up to a 30-day supply, (\$105 copayment for a 31 to 90-day supply), with no deductible for Tier 2 preferred brand name drugs.
- For members enrolled in our Medicare Prescription Drug Program, they will now have a \$20 copayment for each purchase of up to a 30-day supply, (\$60 copayment for a 31 to 90-day supply), with no deductible for Tier 2 preferred brand name asthma medications.
- For members enrolled in our Medicare Prescription Drug Program, they will now have a \$20 copayment for each purchase of up to a 30-day supply, (\$50 copayment for a 31 to 90-day supply), with no deductible for Tier 2 preferred diabetic medications and supplies.

MEDICARE ADVANTAGE PLAN UPDATES

What's Changing?



31 Dec 2024

As of 12/31/2024, CareFirst is no longer offering a Medicare Advantage (MA) HMO product and services including:

- CareFirst Blue Cross BlueShield Advantage Core (HMO)
- CareFirst Blue Cross BlueShield Advantage Enhanced (HMO)



1 Jan 2025

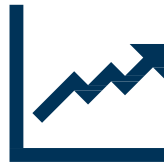
On January 1, 2025, CareFirst will **launch three new** Medicare Advantage (MA) (PPO) plans in the Individual market and two new Group Medicare Advantage Prescriptions Drug Plans (MAPD):

- CareFirst BlueCross BlueShield Advantage Essential (MAPD) (PPO)
- CareFirst BlueCross BlueShield Advantage Complete (MAPD) (PPO)
- CareFirst BlueCross BlueShield Advantage Salute (MA) (PPO)

Why Are We Changing Our Products and Plans?



Competitor Market
Changes



Grow Membership



Member and
Prospect Feedback



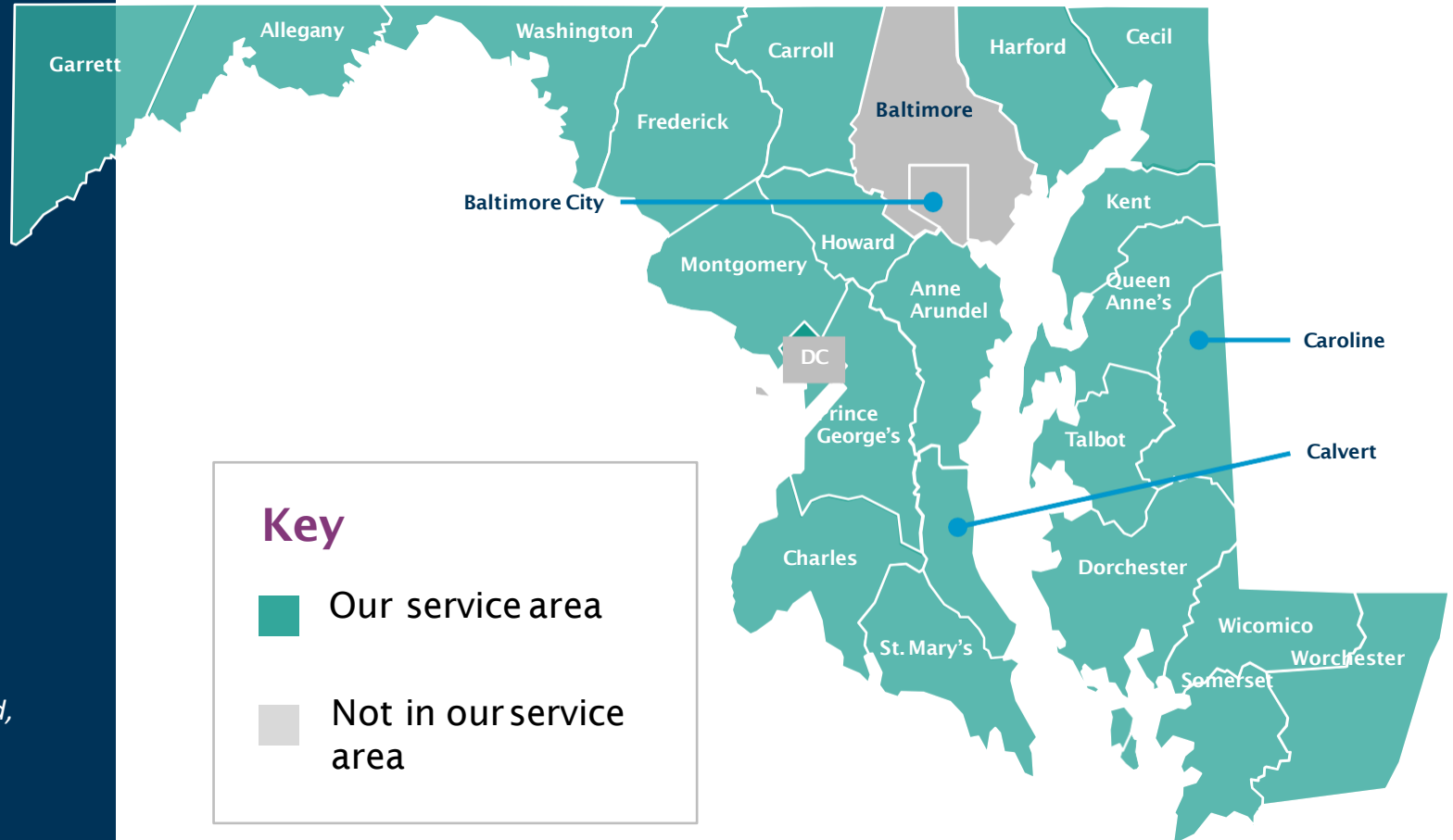
Serve Unique
Populations



CareFirst BlueCross BlueShield Advantage Essential (PPO)

Available in all Maryland counties except
Baltimore county and Baltimore city.

*Includes the following counties in Maryland:
Allegany, Anne Arundel, Calvert, Caroline, Carroll, Cecil,
Charles, Dorchester, Frederick, Garrett, Harford, Howard,
Kent, Montgomery, Prince George's, Queen Anne's, St.
Mary's, Somerset, Talbot, Washington, Wicomico, and
Worcester.*



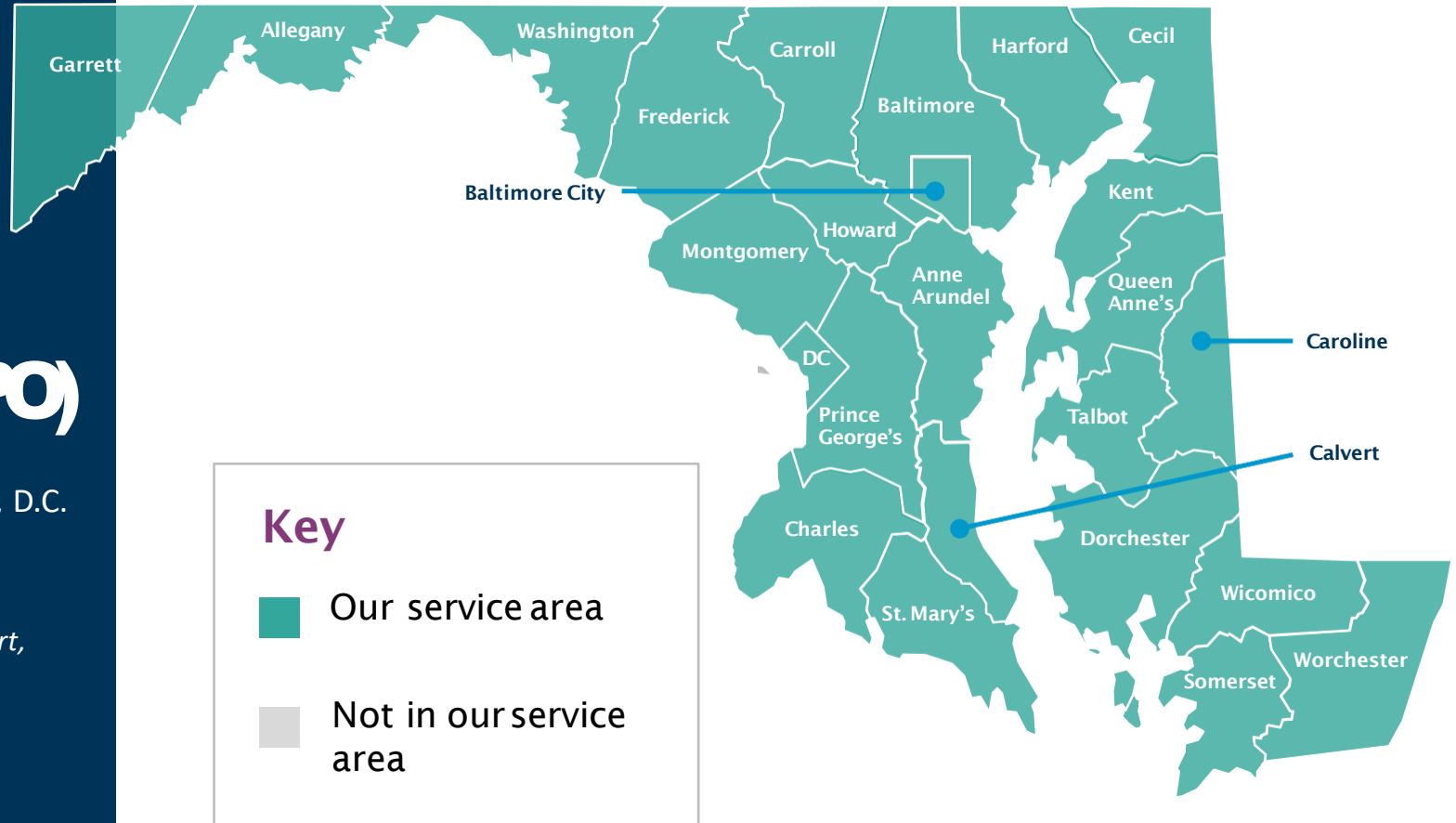
Service Area- Complete and Salute (PPO)



CareFirst BlueCross BlueShield Advantage Complete and Salute (PPO)

Available in all Maryland counties and Washington, D.C.




*Includes the following counties in Maryland:
Allegany, Anne Arundel, Baltimore, Baltimore City, Calvert,
Caroline, Carroll, Cecil, Charles, Dorchester, Frederick,
Garrett, Harford, Howard, Kent, Montgomery, Prince
George's, Queen Anne's, St. Mary's, Somerset, Talbot,
Washington, Wicomico, Worcester and District of
Columbia.*




Identifying Medicare Advantage (PPO) ID Cards – Essential (PPO)



- CareFirst BlueCross BlueShield Advantage **Essential (PPO)** will be prominently displayed on the front of the member ID card with Medicare Advantage printed under the CareFirst logo
- The bottom right of the card also displays the words **MA PPO** in a suitcase indicating that the member has a PPO plan and displays the words **Medicare Rx** indicating that the member has prescription coverage
- The **prefix** for CareFirst BlueCross BlueShield Advantage **Essential (PPO)** is **MJX**




 Medicare Advantage		CareFirst BlueCross BlueShield Advantage Essential (PPO) ←	
Member Name F_NAME M_INIT L_NAME	PCP Office IN: \$X OON: \$X		
Member ID MJX SBSB_ID	Specialist Office IN: \$X OON: \$X		
Group Number GRGR_ID	Urgent Care Center IN: \$X OON: \$X		
	Emergency Room IN: \$X OON: \$X		
	RxBIN RXBIN		
	RxPCN RXPCN		
	RxGRP RX_GROUP		
Effective Date M_R_DT			
BC/BS Plan 193/963			
Issuer (80840)			
Dental Preferred (PPO) with National Network			
CMS-H7379-001			
→  			


carefirst.com/medicareadvantage	
	
CareFirst BlueCross BlueShield Advantage Essential (PPO) ←	Important Phone Numbers
Medical Claim Submission Address for CareFirst Service Area Providers Medicare Medical Claims P.O. Box 4495, Scranton, PA 18505	Member/Provider Services: 833-536-2001 Pharmacy Services: 888-970-0917 24-Hour Nurse Advice Line: 833-968-1773 Hearing Services: 877-246-1666 Vision Services: 800-783-5602 Routine Transportation: 833-536-2001 TTY: 711 Provider Services: 833-536-2001 To locate a CareFirst contracted medical provider, visit carefirst.com/findadocmappo
Rx Claims Submission Address Medicare Prescription Drug Claims P.O. Box 52066, Phoenix, AZ 85072-2066	
Dental Claims Submission Address Medicare Dental Claims PO Box 14115, Lexington, KY 40512 For non-Medicare covered routine vision claims, file with Davis Vision. For routine hearing claims, file with Nations Benefits.	
CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association. CST MA02524IND (8/24)	
File claims with local Blue Cross and/or Blue Shield plan. PROVIDERS MUST NOT BILL MEDICARE. MA PPO products provided by CareFirst Advantage PPO, Inc. an independent licensee of the Blue Cross and Blue Shield Association.	
IN= In-network OON= Out-of-network	

Identifying Medicare Advantage (PPO) ID Cards – Complete (PPO)



- CareFirst BlueCross BlueShield Advantage **Complete (PPO)** will be prominently displayed on the front of the member ID card with Medicare Advantage printed under the CareFirst logo
- The bottom right of the card also displays the words **MA PPO** in a suitcase indicating that the member has a PPO plan and displays the words **Medicare Rx** indicating that the member has prescription coverage
- The **prefix** for CareFirst BlueCross BlueShield Advantage **Complete (PPO)** is **MXJ**



 Medicare Advantage		CareFirst BlueCross BlueShield Advantage Complete (PPO) ←	
Member Name F_NAME M_INIT L_NAME	PCP Office IN: \$X OON: \$X		
Member ID MXJ- <SBSB_ID	Specialist Office IN: \$X OON: \$X		
Group Number GRGR_ID	Urgent Care Center IN: \$X OON: \$X		
	Emergency Room IN: \$X OON: \$X		
Effective Date M_R_DT	RxBIN RXBIN		
BC/BS Plan 193/963	RxPCN RXPCN		
Issuer (80840)	RxGRP RX_GROUP		
Dental Preferred (PPO) with National Network		CMS-H7379-002	
		→  	

carefirst.com/medicareadvantage	
	
CareFirst BlueCross BlueShield Advantage Complete (PPO) ←	Important Phone Numbers
Medical Claim Submission Address for CareFirst Service Area Providers Medicare Medical Claims P.O. Box 4495, Scranton, PA 18505	Member/Provider Services: 833-536-2001 Pharmacy Services: 888-970-0917 24-Hour Nurse Advice Line: 833-968-1773 Hearing Services: 877-246-1666 Vision Services: 800-783-5602 Routine Transportation: 833-536-2001 TTY: 711 Provider Services: 833-536-2001 To locate a CareFirst contracted medical provider, visit carefirst.com/findadocmappo
Rx Claims Submission Address Medicare Prescription Drug Claims P.O. Box 52066, Phoenix, AZ 85072-2066	
Dental Claims Submission Address Medicare Dental Claims PO Box 14115, Lexington, KY 40512	
For non-Medicare covered routine vision claims, file with Davis Vision. For routine hearing claims, file with Nations Benefits.	
CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association.	File claims with local Blue Cross and/or Blue Shield plan. PROVIDERS MUST NOT BILL MEDICARE. MA PPO products provided by CareFirst Advantage PPO, Inc. an independent licensee of the Blue Cross and Blue Shield Association.
CST MA02624IND (8/24)	IN= In-network OON= Out-of-network


Identifying Medicare Advantage (PPO) ID Cards – Salute (PPO)



- CareFirst BlueCross BlueShield Advantage **Salute (PPO)** will be prominently displayed on the front of the member ID card with Medicare Advantage printed under the CareFirst logo
- The bottom right of the card also displays the words **MA PPO** indicating that the member is enrolled in a PPO product
- The **prefix** for CareFirst BlueCross BlueShield Advantage Salute (PPO) is **MXJ**

 CareFirst Medicare Advantage		CareFirst BlueCross BlueShield Advantage Salute (PPO) ←	
Member Name F_NAME M_INIT L_NAME	PCP Office Specialist Office Urgent Care Center Emergency Room	IN: \$X IN: \$X IN: \$X IN: \$X	OON: \$X OON: \$X OON: \$X OON: \$X
Member ID MXJ SBSB_ID			
Group Number GRGR_ID			
Effective Date BC/BS Plan Issuer	M_R_DT 193/963 (80840)		
Dental Preferred (PPO) with National Network		CMS-H7379-003 → 	

carefirst.com/medicareadvantage



CareFirst BlueCross BlueShield Advantage Complete (PPO) ←

Medical Claim Submission Address for CareFirst Service Area Providers
Medicare Medical Claims
P.O. Box 4495, Scranton, PA 18505

Rx Claims Submission Address
Medicare Prescription Drug Claims
P.O. Box 52066, Phoenix, AZ 85072-2066

Dental Claims Submission Address
Medicare Dental Claims
PO Box 14115, Lexington, KY 40512

For non-Medicare covered routine vision claims, file with Davis Vision. For routine hearing claims, file with Nations Benefits.

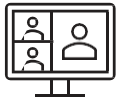
CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
CST MA02624IND (8/24)

Important Phone Numbers
Member/Provider Services: 833-536-2001
Pharmacy Services: 888-970-0917
24-Hour Nurse Advice Line: 833-968-1773
Hearing Services: 877-246-1666
Vision Services: 800-783-5602
Routine Transportation: 833-536-2001
TTY: 711
Provider Services: 833-536-2001
To locate a CareFirst contracted medical provider, visit carefirst.com/findadocmappo

File claims with local Blue Cross and/or Blue Shield plan. PROVIDERS MUST NOT BILL MEDICARE.
MA PPO products provided by CareFirst Advantage PPO, Inc. an independent licensee of the Blue Cross and Blue Shield Association.

IN= In-network OON= Out-of-network

CareFirst is offering six live webinar opportunities to learn more about the new Medicare Advantage products.



[Thursday, December 12th at 10am](#)



[Thursday, December 19th at 1pm](#)



[Tuesday, December 31st at 10am](#)



[Tuesday, January 7th at 10am](#)



[Thursday, January 9th at 1pm](#)



[Wednesday, January 15th at 10am](#)

Topics include:

- Types of Plans
- How to Determine Which Networks You Participate In
- How to Identify Member ID Cards
- Verifying Eligibility and Benefits
- Authorizations
- Claims, Appeals, and Disputes

AUTHORIZATION UPDATES

Effective March 3, 2025 CareFirst will review prior authorization requests for inpatient NCU admissions to ensure that all services are an appropriate duration and level of care as documented in the Level of Care Authorization – Facility (Maryland only) Payment Policy.

- This new [payment policy](#) is related to the Inpatient and Observation Care Notification Requirements Policy that became effective August 1, 2024
 - One of the key requirements is to ensure LOC information is included on all inpatient requests by indicating the appropriate revenue code on all authorization requests

How will the authorization process change March 3rd?

- Clinical documentation of ongoing hospitalizations will be reviewed concurrently, in most cases, to substantiate the LOC
- If it is determined the reported LOC does not meet the established [MCG Clinical criteria](#)*, a denial for the bed day or authorization will be issued
- If the hospital agrees with the review assessment, the hospital may resubmit an authorization request with an updated LOC most consistent with the guidelines for the specific date in question
- If the hospital does not agree with the review assessment, it may request a peer-to-peer review and/or follow the normal appeal process

*Learn how to access and utilize the MCG Clinical Criteria Tool in [this tutorial](#).

New NICU Prior Authorization Request Form



To support the Inpatient and Observation Care Notification Requirements and the Level of Care Authorization – Facility (MD Only) Payment Policies, a new NICU specific Prior Authorization Request Form will be available soon.

- The form now includes a specific location to enter the patient's level of care
- Locate this form by navigation to provider.carefirst.com > Resources > [Administrative – Forms](#) > Authorization/Extension Requests > NICU Authorization Request Form

NICU Authorization Request Form



INSTRUCTIONS	
For Participating and Non-Participating Providers: Please complete all fields for a timely response to avoid a delay of authorizations. In most cases, you should receive a response via fax or telephone within two business days.	
Please submit this request via fax to 410-781-7661 or you may call 866-773-2884 and select Option 1 .	
IMPORTANT:	
<ul style="list-style-type: none">• Please submit supporting clinical documentation if CareFirst does not have EMR access to your facility.• Please separate requests if more than one infant/multiple.	

Name	Date	
Phone	Fax	
CareFirst Provider ID Number, or Individual NPI Number (under which you bill claims). Note: Enter Hospital/Facility NPI in space indicated lower on page.		
Mother's Name	Date of Birth	Discharge Date
Infant's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Infant's Date of Birth	
Mother's Member Identification Number	Group Number	
Address	Phone	
City	State	Zip
Date(s) of Service or Admission Date(s)	Level of Care (Revenue Code) (check one) <input type="checkbox"/> 171 <input type="checkbox"/> 172 <input type="checkbox"/> 173 <input type="checkbox"/> 174	
Place of Service (check one) <input type="checkbox"/> Inpatient – Emergent <input type="checkbox"/> Inpatient – Scheduled <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____		
Admitting/Treating Physician's Name		
Provider's NPI Number	Phone	
Physician's Address		
Diagnosis Code(s) (ICD-10)	Procedure Code(s) (CPT-4)	
Hospital/Facility	UR Phone	
Hospital/Facility Address		
Hospital/Facility Phone	Hospital/Facility NPI Number	

Effective January 1st, CareFirst's Electronic Prior Authorization Portal will be available to utilize for CareFirst CHPMD and Advantage DualPrime members

- Submit authorization requests electronically
- Offers easy to read dashboards and a user-friendly interface
- Has streamlined real time decision capabilities
- Ability to utilize CareFirst Direct to check eligibility and benefits, as well



Register for live webinars to learn more!

- [December 17 @ 1 p.m.](#) *(CHPMD/DualPrime Quarterly Webinar)*
- [December 18 @ 10 a.m.](#) *(CHPMD/DualPrime Quarterly Webinar)*
- [December 26 @ 11 a.m.](#)
- [January 2 @ 2 p.m.](#)
- [January 8 @ 3 p.m.](#)
- [January 14 @ 10 a.m.](#)



Important Note: Providers who ONLY participate in our CareFirst CHPMD or Advantage DualPrime networks will continue to use the digital prior authorization form and MyHealth Portal at this time.

We are excited to share a new authorization tool is coming soon to assist providers in determining which services they provide require an authorization.



The tool will be located on the **Prior Authorization/Notification** landing page



More communication and training will be coming soon!

Key Features


- User friendly interface where you can quickly enter required information to determine if a prior authorization is required
- Links to applicable medical and payment policies, as well as clinical guidelines
- A clear 'Yes' or 'No' response for prior authorization requirements
- Ability to enter multiple service codes for the same member
- A direct link to the appropriate prior authorization system to enter your request

A Sneak Peek into the Prior Authorization Lookup Tool


NEW

Need to determine Authorization requirements?

Verify Authorization



Already know what you're here for?




Medical

Inpatient Authorization (Inpatient Notification)
Outpatient Authorization (Medical Prior-Authorization)
Genetic Testing (FEP & Medicare Advantage only)

Learn More

Start




Medications (Commercial / FEP / Medicare Advantage)

(Formerly Pharmacy)
Authorizations for drugs covered under both medical and pharmacy policies.


Learn More

Start





Genetic Testing (Co

Learn More

CareFirst 

Provider Portal



John Doe

CAREFIRST DIRECT | PRIOR AUTH / NOTIFICATIONS | TOOLS | PROGRAMS / SERVICES | RESOURCES

Authorization Verification

I. Member Lookup

Member ID *

Date of Birth *

Date of Service

123456789

03/27/1985

10/01/2024

Search

II. Policy Details

Member: Jane Doe

Product Type

Coverage Date

LOB

Insurance Type

BlueChoice

00/00/0000 - 00/00/0000

Commercial

HMO

Group

Coverage

Risk Type

Jurisdiction



0099 - State of Maryland

Active

Risk

No

III. Verify Authorization

Auth Decision Request No.	Auth Type	Place of Service	Service Code	Procedure Modifier Code	Comments	Auth Required	Action
HSHHF67155	Outpatient	11 - Office	97012 - Mechanical Traction	RR - Rented DME		Yes	Create Auth
HSHHF67155	Inpatient	22 - On Campus Outpatient Hospital	93797 - Cardiac Rehabilitation	NU - Purchase of New DME		No	N/A

Reset

Done

As a reminder, the MCG user interface is integrated within the prior authorization/notification portal to reduce authorization time while maintaining decision quality.

MCG is where you can select additional clinical information for your patient when required.

MCG uses evidence and analytics to proactively manage care, predict resource needs, and benchmark recovery process.



View the step-by-step MCG interactive user guide [here](#).



It is imperative when navigating the MCG interface, you **do not** attempt to close the interface or your web browser.

Always remember to select **Submit Request** after documenting your clinical

MCG: Not sure which guidelines to select?

MCG

Geographic Regions: Maryland Clear

Maryland

Procedure Code: 95807 (CPT/HCPCS)

Description: Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist

A-0145 - Polysomnography (PSG), Sleep Center - (AC)

The procedure is/was needed for appropriate care of the patient because of ...

- ☐ Adult with obesity hypoventilation syndrome, suspected, as indicated by ...
- ☐ Adult with obstructive sleep apnea, suspected, as indicated by ...
- ☐ Central sleep apnea or sleep-related hypoventilation, suspected, as indicated by ...
- ☐ Child, infant, or adolescent with obstructive sleep apnea, suspected, and ...
- ☐ Insomnia and ...
- ☐ Narcolepsy, suspected, as indicated by ...
- ☐ Parasomnia, as indicated by ...
- ☐ Periodic limb movement disorder and ...
- ☐ Postoperative assessment needed after performance of surgery to treat sleep apnea in child, as indicated by ...
- ☐ Restless leg syndrome and ...

Save Cancel

Submit Request

If you are not sure what to select when the guidelines display, you can select 'Cancel' when you see this screen, and a 'No guidelines apply' option will appear for you to select so you can appropriately 'Submit Your Request'.



View the step-by-step MCG interactive user guide [here](#).

Attach clinical documentation within the authorization system.

Step-by-step instructions:
[Uploading Clinical Documentation to Authorizations](#)

Ability to edit dates of service on authorizations is available.

Step-by-step instructions:
[How to Edit Dates of Service in the Authorization System](#)


Ensure you enter the request prior to the date of service.

Include your contact information in the 'Add Note' section with the authorization system.


Include your name, email address, and phone number.

Courses


Authorization Basics (Course)




Accessing the Authorization System (Course)




Entering Inpatient Authorizations (Course)




Entering Outpatient Authorizations (Course)



Requesting Outpatient Extensions (Course)



Withdrawing Pended Authorizations (Course)




Guides


Entering Inpatient Authorizations (Guide)




Entering Outpatient Authorizations (Guide)




Additional Features and Information (Guide)




How to Determine if an Authorization is Required



[MCG Walk Through](#)



[Frequently Asked Questions](#)



FAQs

OTHER UPDATES AND REMINDERS

Effective January 1, 2024, for new and renewing plans, CareFirst Maryland plans listed below will include hearing aid coverage for adults 18 years of age or older

What plans are included in this benefit update?

- Maryland fully insured plans: 51+ Group, Grandfathered Individual, Grandfathered 51+ Group
- Choice to opt in: Administrative Services Only (ASO) and CareFirst Administrators (CFA) ASO Groups

What does coverage include?

- One (1) hearing aid per hearing-impaired ear every 36 months and,
- Up to \$1,400 per hearing aid.*

Additional Information:

- Benefits are available in- and out-of-network, when applicable for plans with out-of-network coverage
- Cost sharing, limitations, and prior authorization requirements may apply
- Coverage for hearing aid services and equipment must be provided upon the recommendation of an otolaryngologist, licensed audiologist or licensed hearing specialist
- Hearing aids means a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by adults; and is non-disposable
- Members can choose a higher-priced hearing aid and may pay the difference in cost above \$1,400*
- There are no changes for the mandated hearing aids for children benefit due to this implementation

* The \$1,400 dollar maximum will **not** apply to PPACA (*Patient Protection and Affordable Care Act*) compliant plans including Grandfathered plans that have PPACA compliant benefits.

Colonoscopy and Esophagogastroduodenoscopy Site of Service Update

The May Medical Policy Update announced a site of care change for colonoscopy and esophagogastroduodenoscopy (EGD) services.

- Effective January 1, 2025, A colonoscopy performed at an Ambulatory Surgery Center will not require prior authorization.
- A colonoscopy performed at an outpatient hospital-based surgery center will require prior authorization.
- EGD will require prior authorization for medical necessity and for site of service.
- Learn more in Policy 2.01.086 – Ambulatory Surgery Center – Site of Service

View all Medical Policies and policy updates on the [Medical Policy webpage](#).

Effective October 1, 2024, Care Management referrals for any CareFirst member, across all lines of business, may be submitted to one team.

Easy Referrals 24/7

- [Online referral form](#) in the provider portal
- Secure/encrypted email to caremanagement@carefirst.com
- Care Management Fax: 410-505-2122
- Care Management Direct Line: 833-536-2004



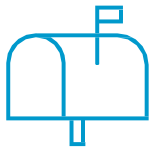
Timely Communication

- Confirmation of the referral can be expected within 24 business hours with ongoing communication throughout the care plan, including activation, graduation, and acute event follow ups.

Behind the scenes our team will...

- Check Care Plan Eligibility
- Holistically Support Your Patient
- Incorporate Specialized Care management

Effective immediately, all NetLease claims and correspondence should be sent to:



P.O. Box 11415
Lexington, KY 40512

Do not use the previous address in El Paso, Tx as this is no longer being utilized.

Reminder

CareFirst jointly administers – with third-party administrators (TPAs), self-insured employers, and health and welfare funds – the Network Lease claims product.

This product enables employers to use the CareFirst network of providers while still designing and administering their health benefits.

CareFirst: collect and price claims, training, and the maintenance of provider networks

TPAs: issue ID cards, handle claims adjudication, benefit and claims inquiries, correspondence, appeals, etc.

Medical Record Requests

- Each year, CareFirst is required to participate in several medical record retrieval requests to report certain information about the health status of identified members.
- The purpose is to provide the Center for Medicare and Medicaid Services (CMS) with a better understanding of the data they receive regarding disease prevalence, coding interpretation, and variances across the country.

Snapshot of each retrieval period:

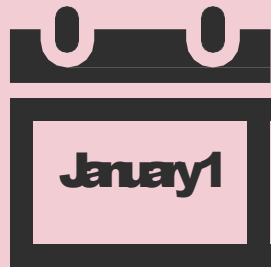
Regulatory Program	Lines of Business	2025 Retrieval Period	Vendor
ACA Risk Adjustment Retrospective	Commercial/ACA	January - March	Reveleer
ACA RADV Risk Adjustment Retrospective	Commercial/ACA	July - November	Cognisight, LLC
HEDIS Quality	Commercial	January - March	Reveleer
Government Programs HEDIS Quality	Medicare Advantage Medicaid	January - March	CareFirst Quality Team
DSNP & Group PPO Risk Adjustment	Medicare Advantage	July 2025 - January 2026	Reveleer

Your participation is part of your CareFirst contract. Providers must provide requested records at no charge, within 15 days of the request. Benefits include:

- Member's data will be more accurate in CareFirst systems, allowing us to better coordinate their care and identify resources or programs they are entitled to.
- CareFirst can better report on and adjust for the complexity of our members. For those in value-based programs, this translates into a more accurate budget to care for your assigned population and more actionable quality reporting to coordinate care.
- There will be fewer gaps in quality and scoring tools, which can increase provider incentives and improve CareFirst plan performance.



Questions? Questions specific to a medical records request should be directed to the vendor. General questions may be directed to Provider Relations.



As the first of the year approaches be sure to collect the member’s most current identification card.

Remember! ID Cards for most members are available on CareFirst Direct.

CareFirst Direct | Eligibility Summary

Eligibility / Benefits & Claims Status Remittance / NOP Fee Schedules

< Back Eligibility Summary

Date of Service

LASTNAME, FIRSTNAME

DOB:01/13/1955 (64 yrs) Male

Member ID:

Medical

Group

GROUP NAME

Status

Active Coverage

01/01/2019 - 12/31/2019

Relationship to Policy Holder

Self

Insurance Type

PPO

Plan Description

BluePreferred PPO

Renewal Month

Every January

Contract

N/A

Benefit

N/A

more...

Total Care and Cost Improvement (TCCI) Program Information

Coordination of Benefits No info on file

Benefits

General Health Benefits

Search for Different Benefit

Manage Benefit Favorites

I would like to

View Claims

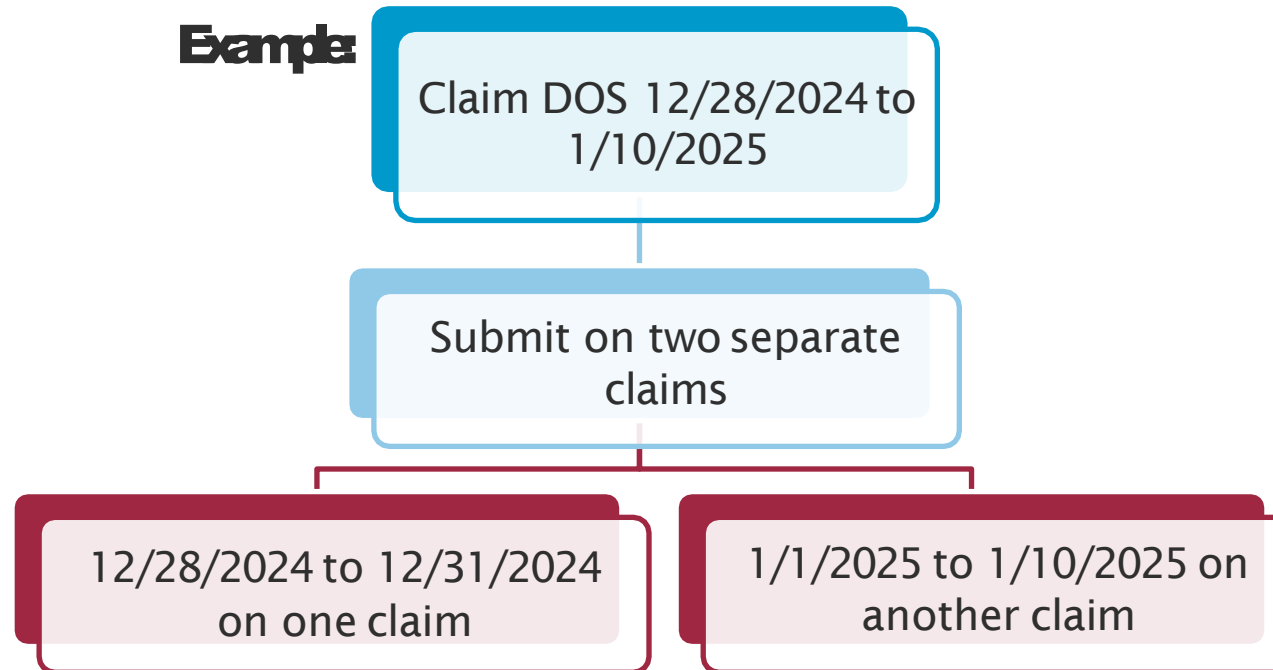
Prior Auth/Notifications

New Member Search

Claims that span between years can be submitted as one claim, regardless of line of business.

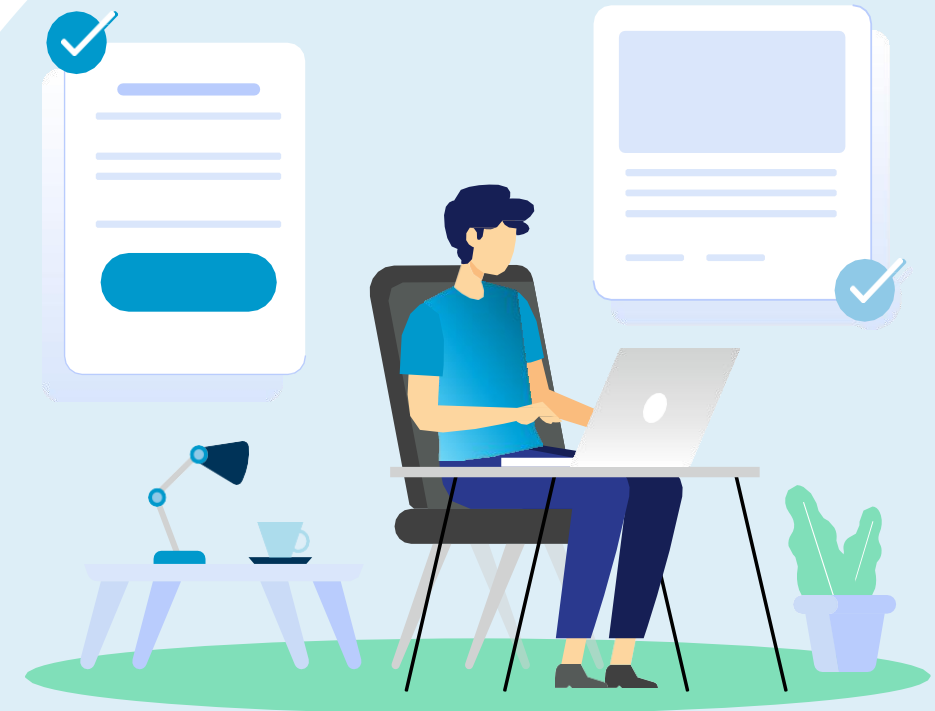
Exception to the rule:
If a patient switched coverage, and the new coverage is effective January 1.

Example

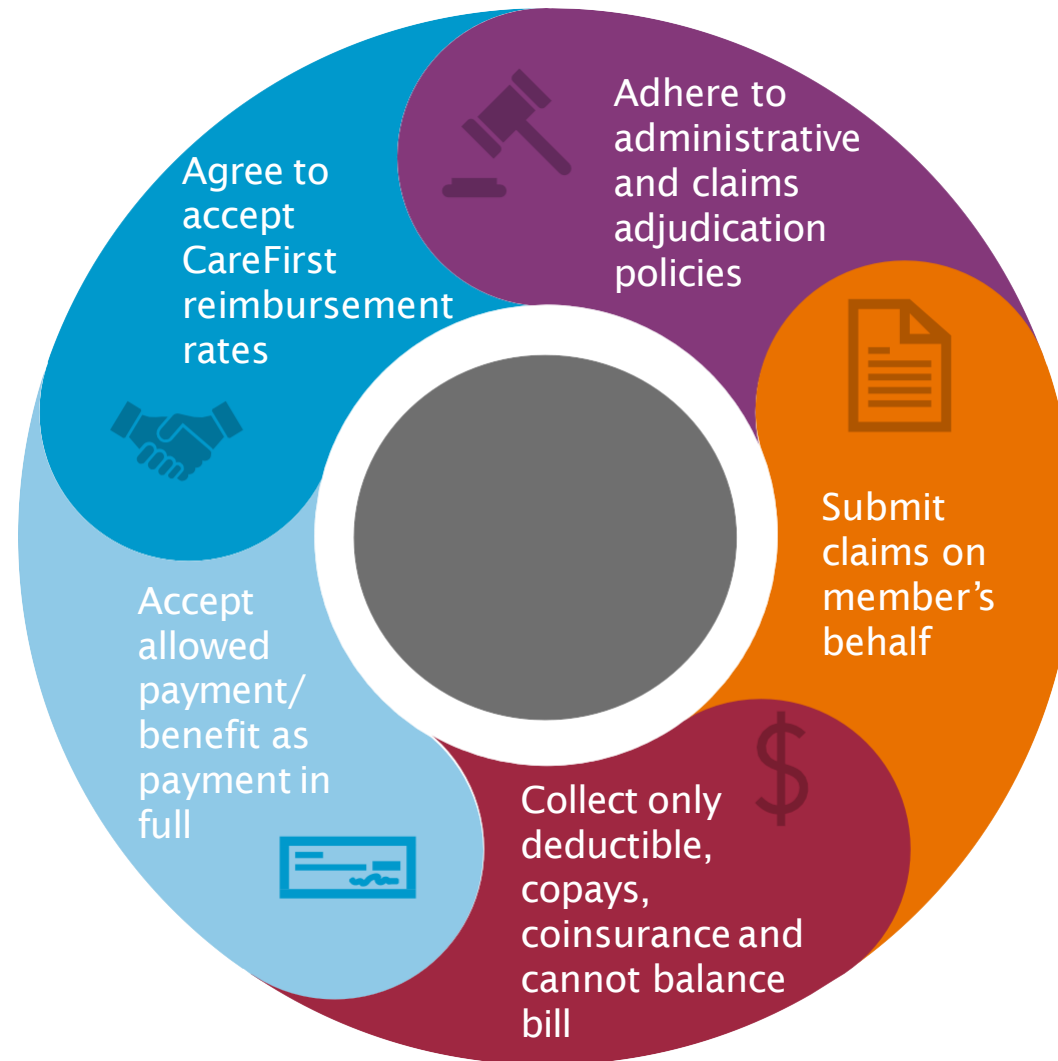


Providers servicing MDDual Special Needs (Dual Prime) Plan Members Complete the required Model of Care Training course for 2024 today!

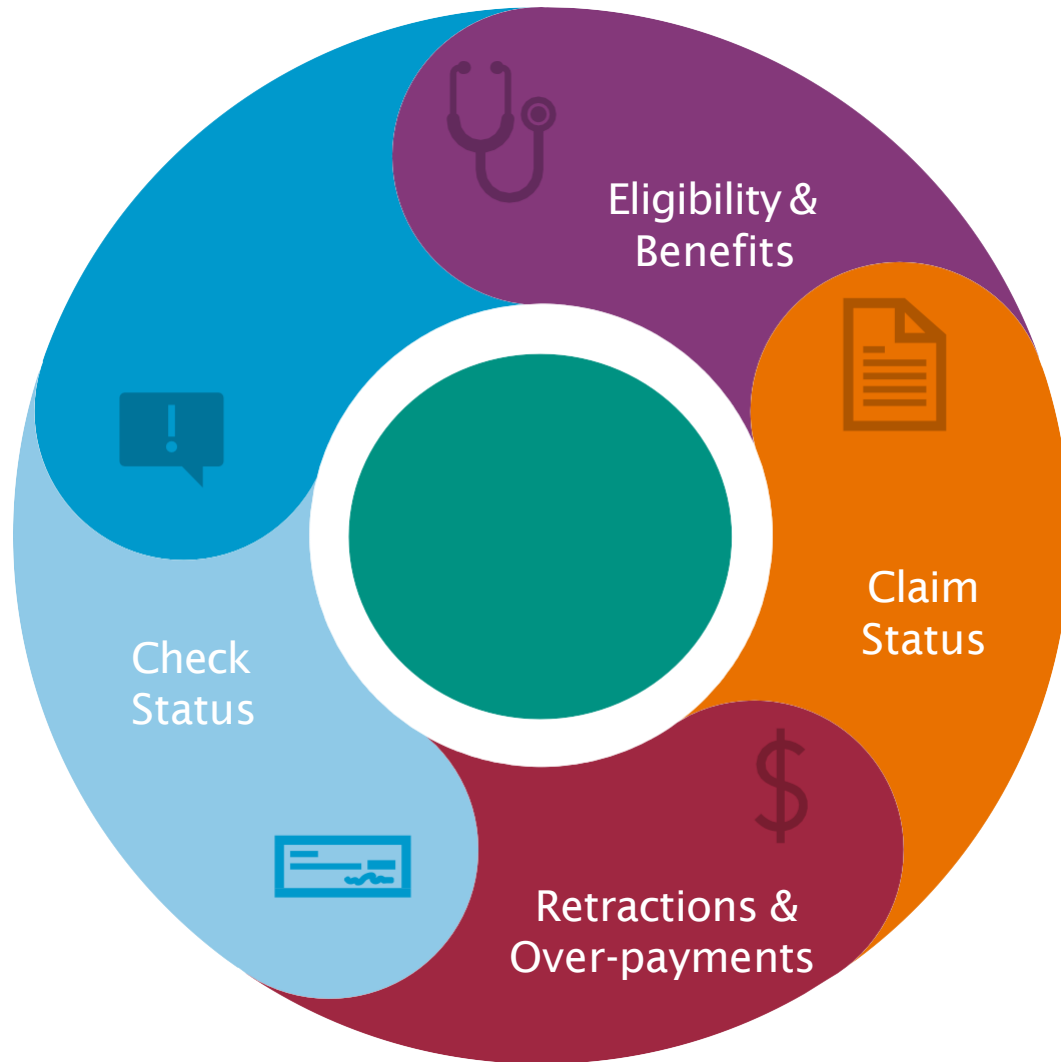
- The Centers for Medicare and Medicaid Services (CMS) require providers to receive basic training about CareFirst Medicare Advantage DualPrime Model of Care (MOC) Program.
- MOC is the documentation of the CMS-directed plan for delivering coordinated care and case management to members within DualPrime.
- CareFirst offers a course that meets the regulatory requirements to ensure all employees and providers who work with our DualPrime members have the specialized training this unique population requires.
- Access the training [here](#).



Participating Provider Roles



Provider Service vs. Provider Relations Roles



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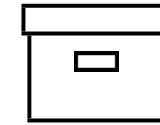
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- Your field of practice
- Your role
- Your provider type



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- The information you provide for subscription will be used only for maintaining this email list. We will never use this information to sell or rent to others or for solicitation.

Please note, the credentialing email address (picrequests@carefirst.com) is no longer active.

How should I contact the Provider Information and Credentialing department?



- By phone:
 - (877) 269-9593
 - (410) 872-3500

When should I contact the Provider Information and Credentialing department?

- To check status of application/demographic information update outside of credentialing timeframes



- By fax:
 - 410-872-4107

When faxing, please include your request on your organization's letterhead.

Note: Please utilize faxing only when necessary (e.g. for retro requests). Utilize the self-service tool whenever possible.



Find answers to your questions quickly on our webpage titled “Looking for Support?”

This page pulls together common requests and shows where you can get information you need.

- Credentialing
- Updating Provider Data
- CareFirst Direct Access
- Eligibility, Benefits, and Claims Status
- Claims Questions
- Fee Schedules
- Electronic Capabilities
- Training and Resources
- Escalated Issues

www.carefirst.com/providersupport

Important Upcoming Dates

Webinars

Registration links available soon on the LEC!



Q1 Hospital Quarterly:

- March 11th at 10 a.m.
- March 12th at 1 p.m.



Q4 CHPVDDualPrime Quarterly:

- [December 17th @ 1pm](#)
- [December 18th @ 10am](#)

**View more webinar opportunities on the
Learning and Engagement Center at
www.carefirst.com/learning.**

Closures



Christmas Day: December 25th



New Year's Day: January 1st



Martin Luther King Jr. Day: January 20th



Presidents Day: February 17th

Any Questions?





THANK YOU
