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VIA ELECTRONIC TRANSMISSION

December 23, 2024

Mary Kwei
Associate Commissioner
Market Regulation & Professional Licensing
Maryland Insurance Administration
200 Saint Paul Place, Suite 2700
Baltimore, MD 21202

RE: Coding and Coverage of Preventive Services without Cost Sharing

Dear Associate Commissioner Kwei:

CareFirst BlueCross BlueShield (CareFirst) appreciates the opportunity to comment on the Maryland Insurance Administration's (MIA) proposed bulletin on preventive services under the Affordable Care Act (ACA). We believe certain clarifications to the bulletin would improve its alignment with existing federal guidance and operational feasibility, and therefore respectfully raise the following points for consideration:

Provider Education

The MIA's proposed bulletin states: "The Administration expects that, at a minimum, carriers will supply coding guidelines related to preventive services to health care providers as required by § 15-113(d)." CareFirst is concerned with this characterization of Md. Ins. 15-113(d). That subsection states: "A carrier shall provide a health care practitioner, a set of health care practitioners, or an eligible provider with a copy of... a description of the coding guidelines used by the carrier that are applicable to the services billed by a health care practitioner in that specialty." CareFirst complies with this section by describing its use of national coding guidelines in the Medical Provider Manual and through its proprietary Payment Policies, both of which are publicly available. The subsection does not obligate carriers to "supply" non-proprietary national coding guidelines, such as those published by the American Medical Association (AMA), which are copyrighted materials owned by other entities. We believe providers performing preventive services are well-equipped to access widely available national guidelines, which are already integral to clinical practice.

As a matter of policy, ensuring patients are not erroneously charged cost-sharing for preventive services is best accomplished by promoting provider compliance with national standards. Accordingly, CareFirst recommends this portion of the bulletin be amended to more closely reflect the statutory language.

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Clarification of Cost-Sharing Policies for Mixed Preventive and Non-Preventive Services

Federal guidance does not require the entire claim to be processed without cost-sharing but instead mandates the *preventive services and integral portions* of those services are covered without cost-sharing. For example, services with both preventative (screening colonoscopy) and non-preventative (EGD) procedures - applying zero cost share to the entire claim is contradictory to both industry standards and federal guidance. In theory, if a surgical specimen was taken during the EGD, this service is not considered preventative and should be subject to applicable cost-sharing. It is appropriate to apply cost sharing to the portions of the claim, as in this example, that pertain only to non-preventive services.

However, the MIA proposed bulletin currently states: "Claims should be processed without cost sharing if the provider bills with codes from standard code sets that indicate a service is preventive." This is incorrect because the phrasing of this statement implies the entire claim should be processed without cost-sharing if a preventive service appears anywhere on the claim. However, this interpretation exceeds the scope of federal guidance in FAQ Part 68. If the MIA interprets existing law to require the entire claim, including non-preventive services, to be paid without cost-sharing, this will have unintended consequences. Such a policy would violate member contracts that require cost-sharing for non-preventive services and impair high-deductible health plan members' ability to make lawful contributions to a health savings account, as non-preventive services would be covered without cost-sharing before meeting the deductible. CareFirst recommends the MIA clarify that when an encounter includes mixed preventive and non-preventive services, only the preventive and integral-to-preventive portions of the claim are entitled to zero cost-sharing.

Of note, modifier 33 was created to denote certain recommended preventive products and services by the United States Preventive Services Task Force (with a grade A or B), the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, the Health Resources and Services Administration (HRSA) Bright Futures Project, and the HRSA-sponsored Women's Preventive Services Initiative, in accordance with Section 2713 of the Affordable Care Act. For separately reported services specifically identified as preventive, the modifier should not be used.

CareFirst claims editor uses both the AMA's and the Centers for Medicare & Medicaid Services' Private Payer Guides to identify which CPT Codes may be billed under modifier 33, however throughout the industry, there is inconsistent use of modifier 33 among carriers) within their payor logic). Without guidance from the MIA as to which services should be considered for modifier 33, it would be difficult to align billing practices.

Reversal of Cost Sharing When Made Aware of Preventive Service

The proposed bulletin states: "FAQ Part 68 notes that a carrier would be in violation of PHS Act section 2713 if it does not promptly reverse cost-sharing requirements upon being made aware that the service was preventive, or integral to a preventive service." CareFirst believes it is important to note the language above was included in FAQ Part 68 to affirm the condition for "awareness." Specifically, the "awareness" referenced in the FAQ is triggered when national coding standards are used and when the insurer receives clarifying information to confirm the coding is accurate. As stated in the FAQ: "*using industry-standard coding practices*, the claim identifies the service as a recommended preventive service, and the plan does not have individualized information to establish that the service was not a recommended preventive service." Therefore, CareFirst recommends the MIA similarly specify that the appropriate source of "awareness" is providers' use of industry-standard coding practices and their furnishing of any

required supplemental documentation. As currently written in the proposed bulletin, the reference to "being made aware" could be misinterpreted as obligating carriers to process claims based on unsubstantiated verbal or written statements from providers or members. This would create an unsustainable burden, requiring carriers to honor claims that lack proper documentation or coding.

CareFirst is committed to advancing equitable access to high-quality preventive care and ensuring compliance with federal and state regulations. We appreciate the MIA's efforts to enhance the clarity of how Maryland law interacts with FAQ Part 68 and respectfully request consideration of the clarifications above.

Sincerely,

Kimberly Y. Robinson