CareFirst
The CareFirst BlueCross BlueShield family of health care plans

[STAY CONNECTED]
BlueLink

DECEMBER 2013 VOL. 15, ISSUE 8

New Behavioral Health Programs Available

CareFirst offers behavioral health benefits for our members through **Magellan Health Services** (Magellan)* to support your treatment recommendations and plan of care. This collaborative effort allows us to offer mental health-specific resources, motivational tools and personal coaching that your patients can use to improve their overall health and quality of life.

One new program, **"Are You Worried,"** focuses on awareness of teen depression and is designed to give parents of teenagers information and resources to help them identify warning signs and where to go for support. Awareness brochures and posters are available for your patients.

We realize that it's often frustrating to find a mental health provider with appointment availability, so be aware that Magellan is available to help you and your staff find and arrange an appointment with a psychiatrist or psychiatric social worker, as appropriate.

CareFirst also recently launched a six-month pilot through Magellan's Telehealth solution to expand the availability of mental health services online. During the pilot period, Telehealth services will only be available to CareFirst BlueChoice HMO patients through a participating behavioral health provider.

To find and/or refer your patients to a Telehealth provider, visit www.breakthrough.com and enter the provider type, location and insurance type for a list of participating providers.

For more information or to refer a patient:

Visit: **www.carefirst.com/providers** *> Disease Management*
www.magellanhealth.com

Call: 1-800-403-6549

Mail: Magellan Health Services
CCM Program
P.O. Box 459
Columbia, Md., 21046-0459

** Magellan is an independent company that provides behavioral health services on behalf of CareFirst.*

Listen

Dr. Winn Says...

In this recurring feature, Dr. Daniel Winn, an internist and CareFirst Vice President and Senior Medical Director, offers tips and suggestions of importance to you and your staff.

Listen as Dr. Winn discusses efforts and programs CareFirst is offering to promote behavioral health.

WHAT'S HAPPENING

ICD-10 Is Coming Soon

CareFirst and all other Health Insurance Portability and Accountability Act (HIPAA) covered entities must comply with the ICD-10 code sets by Oct. 1, 2014. CareFirst will be ready by the deadline, and we encourage all providers to make sure their documentation, systems and staff are ready for the transition.

ICD10 is Coming Soon.
Are you ready? Take this **2 min survey** to find out.

In Case You Missed It

In Case You Missed It

To help you stay up to date, we've compiled the latest CareFirst provider news in one convenient place.

Click the "In Case You Missed It" icon to catch up on recent headlines, tips and reminders that you may have missed.

This issue's highlight: Cost Saving Tips for Your Patients

Your CareFirst patients rely on you to help them make decisions regarding their health. By referring them to lower cost settings and generic drug options, you may help improve the quality of their care and reduce overall care costs.

Take advantage of the resources at **www.carefirst.com/qualityandaffordability** to help save your patients time and money. You can view recently updated cost comparison data for:

- Emergency Rooms vs. Urgent Care Centers
- Ambulatory Surgery Centers
- National Laboratories
- Medication Choices
- Radiology Centers

New Telephone Options for Provider Information and Credentialing

To better serve your needs, the Provider Information and Credentialing customer service recording options have been updated.

To speak to a customer service associate about credentialing questions or check the status of your application, call (410) 872-3500 and use Option 1. Use Option 2 to leave a message if you want a paper application mailed to you.

Stay Connected: News that Matters to You

Don't let your CareFirst emails get lost in the holiday shuffle. Make sure you're getting the news you need by selecting your networks, specialties, provider type and provider role.

Click on "Preference Center" in an email you've received from us or visit **www.carefirst.com/stayconnected** to change the preferences associated with your email address.

Not Registered?
Visit **www.carefirst.com/stayconnected** or text* CFPROVIDER to 67463 to sign up.

**Standard messaging rates apply. You will receive only a registration and a confirmation text message from CareFirst. No additional text messages will be sent to your phone.*

Stay Curious. Stay Engaged. Stay Connected.

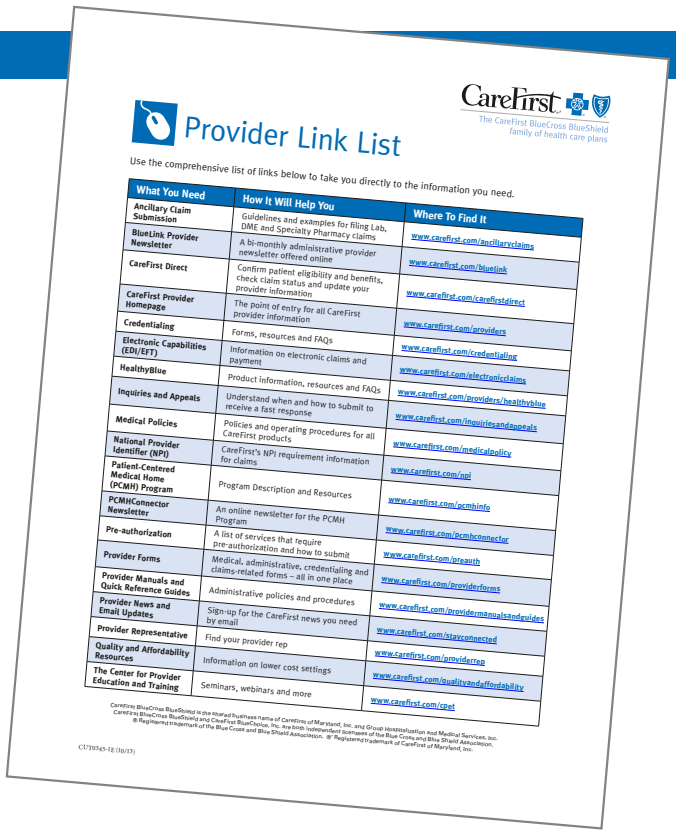
The Webpages You Use Most + The Links to Get You There

Have you seen our new **Provider Link List**? It includes the web page you need, with a user-friendly link to get you there quickly.

Make It Easy

Print and post this list for fast access to our most important web sites. The form, phone number or information you need is just a link away.

Visit **www.carefirst.com/providermanualsandguides** > *Reference Guides* to print the Provider Link List today.



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Provider Link List

Use the comprehensive list of links below to take you directly to the information you need.

What You Need	How It Will Help You	Where To Find It
Ancillary Claim Submission	Guidelines and examples for filing Lab, DME and Specialty Pharmacy claims	www.carefirst.com/ancillaryclaims
BlueLink Provider Newsletter	A bi-monthly administrative provider newsletter offered online	www.carefirst.com/bluelink
CareFirst Direct	Confirm patient eligibility and benefits, check claim status and update your provider information	www.carefirst.com/carefirstdirect
CareFirst Provider Homepage	The point of entry for all CareFirst provider information	www.carefirst.com/providers
Credentialing	Forms, resources and FAQs	www.carefirst.com/credentialing
Electronic Capabilities (EDI/EFT)	Information on electronic claims and payment	www.carefirst.com/electronicclaims
HealthyBlue	Product information, resources and FAQs	www.carefirst.com/providers/healthyblue
Inquiries and Appeals	Understand when and how to submit to receive a fast response	www.carefirst.com/inquiriesandappeals
Medical Policies	Policies and operating procedures for all CareFirst products	www.carefirst.com/medicalpolicy
National Provider Identifier (NPI)	CareFirst's NPI requirement information for claims	www.carefirst.com/npi
Patient-Centered Medical Home (PCMH) Program	Program Description and Resources	www.carefirst.com/pcmhinfo
PCMHConnector Newsletter	An online newsletter for the PCMH Program	www.carefirst.com/pcmhconnector
Pre-authorization	A list of services that require pre-authorization and how to submit	www.carefirst.com/preauth
Provider Forms	Medical, administrative, credentialing and claims-related forms – all in one place	www.carefirst.com/providerforms
Provider Manuals and Quick Reference Guides	Administrative policies and procedures	www.carefirst.com/providermanualsandguides
Provider News and Email Updates	Sign-up for the CareFirst news you need by email	www.carefirst.com/stayconnected
Provider Representative	Find your provider rep	www.carefirst.com/providerrep
Quality and Affordability Resources	Information on lower cost settings	www.carefirst.com/qualityandaffordability
The Center for Provider Education and Training	Seminars, webinars and more	www.carefirst.com/cpet

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are both independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

CU70345-1E (10/13)

Two Minutes Could Save You Two Hours

How? Watch this video or visit **www.carefirst.com/6easytools** to find out.

Do You Have Feedback For Us? We're Still Listening

Did you get an email that was especially helpful? Did an article in our *BlueLink* newsletter stand out? Are you having issues finding something on our website? We want to know.

Send your feedback, positive or negative, to us at **newsletter.editor@carefirst.com**. We're still listening.

Congratulations to Christi B., who was our Q3 feedback winner.

HEALTH CARE REFORM

☑ **October 1st, 2013** Launch of the new Health Care Exchanges

☐ **January 1st, 2014** First effective date for new members purchasing health insurance plans on the Exchange

On Jan. 1, 2014, when Exchange coverage goes into effect, you want to be prepared. We intend to ease your concerns and help answer any questions about CareFirst products offered on the Exchanges.

CareFirst and Health Care Exchanges: The Top 5 Things You Need to Remember

1. **Our processes will not change.**

   You should continue to follow current procedures for verifying eligibility (CareFirst Direct or the FirstLine VRU), submitting claims and obtaining pre-authorizations and processing referrals.

2. **The products are based on the same ones you already know.**

   CareFirst products offered on the Exchanges are based on current commercial products like HealthyBlue, BlueChoice, BluePreferred and Point-of-Service. Products cover the same core benefits but have different monthly premiums and varying out-of-pocket costs (deductibles, coinsurance and copayments).

3. **Essential Health Benefits and certain no-cost preventive services are included.**

   The Essential Health Benefits required by the ACA are covered. Moreover, certain preventive services are offered at no charge. For your patients, this means they can get these services without paying a copay, coinsurance or having to meet a deductible.

4. **HMO and RPN networks support all of our products.**

   All CareFirst products offered on the Exchanges will use the CareFirst BlueChoice (HMO) and/or the Regional Participating Preferred Network (RPN/PPO) Networks.

5. **New prefixes, normal business rules.**

   Beginning Jan. 1, 2014, there will be new prefixes on member ID cards for some products. Deductible and cost sharing information will also be included on member ID cards, as usual. New prefixes will be available in CareFirst Direct and the VRU for you to check patient information and coverage prior to rendering care.

HEALTH CARE REFORM (CONT'D)

What will this suitcase logo mean on some ID cards?

This logo will identify the PPO Basic Network, which

- is a combination of BlueCard PPO networks and new Exchange networks created by certain plans
- does not apply to local CareFirst providers since the PPO Basic network includes all doctors and facilities that are included in the entire Regional Participating Preferred Network (RPN) Network, and
- is identifiable on member ID cards by a "PPO B" suitcase logo.

30-day Grace Period Under ACA

The 30-day Grace Period is a provision in ACA that only applies to CareFirst members who purchased from the Exchange and qualify for the Advanced Premium Tax Credit (APTC).

If a member stops paying their premium, you will still be paid for services provided in the first 30 days.

How will you know if a member is behind on payment?
CareFirst will provide a notice on the Notice of Payment (NOP) or 835 during the Grace Period (second and third month of delinquency).

At this point, the subscriber liability will be equal to the claim charge on the NOP and allow you the option to bill the member for services during the delinquency period (except Maryland HMO members).

CLAIMS AND BILLING

New Partner for Direct Claims Submission Services

To continue our focus on time-saving, online self-services, we recently announced our partnership with Availity* for direct claims submission services.

What does this mean for you?
When you visit www.carefirst.com/electronicclaims and register to use Availity's Web Portal, you can submit claims for CareFirst members online *and* also do the following – **at no cost**:

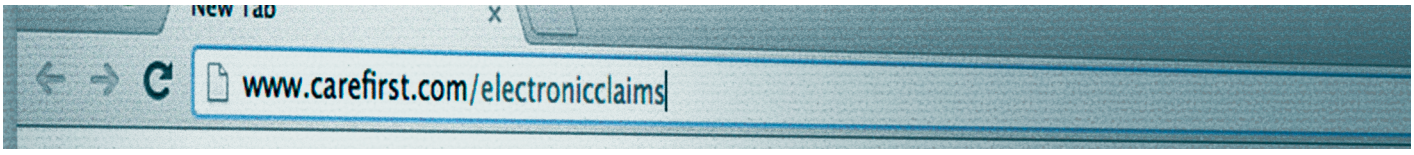
- Check member eligibility
- Access claim status information
- Enroll to receive an electronic remittance advice (ERA/835)
- Enroll to receive payments through electronic fund transfer (EFT)

In addition to providing a wide range of online tools, Availity offers training sessions about registration, their claims submission process and other online functionalities. For more information, visit www.Availity.com.

For general questions about Electronic Data Interchange (EDI), contact the CareFirst EDI Help Desk at 877-536-8390.

A full list of CareFirst's preferred clearinghouses can also be found at www.carefirst.com/electronicclaims.

**Availity is an independent company that provides claims submission services for CareFirst.*



FEP

FEP Benefit Changes for 2014

2014 BENEFIT CHANGES	STANDARD OPTION ONLY	BASIC OPTION ONLY
Calendar Year Deductible	$350 deductible per person; $700 deductible per family No change, same as 2013 *Deductible is now included in the out-of-pocket maximum. Only coinsurance and copayments previously counted towards the out-of-pocket maximum*	Not Applicable
Catastrophic out-of-pocket maximum (Change-Accumulation will be based on the Enrollment code and has increased)	$5000 (Self Only Enrollment) $6000 (Self & Family Enrollment) per year when you use Preferred providers and $7000 (Self Only Enrollment) $8000 (Self & Family Enrollment) per year when you use a combination of Preferred and Non-preferred providers The previous out-of-pocket maximum was $5000 for Preferred providers and $7000 for both Preferred and Non-preferred providers	$5500 (Self Enrollment Only) $7000 (Self & Family Enrollment) per year for coinsurance and copayments when you use Preferred providers. The previous out-of-pocket maximum was $5000 for Preferred providers *The coinsurance paid for non-preferred Brand Name drugs purchased at Preferred retail pharmacies is now included in the out-of-pocket maximum. This amount was not previously included*
	What we pay:	**What we pay:**
Home Nursing Care for 2 hours per day when: › A registered nurse (RN) or licensed practical nurse provides the services; and › A physician orders the care	Preferred: 85% of the Plan Allowance after deductible Participating: 65% of the Plan Allowance after deductible Non-participating: 65% of the Plan Allowance after deductible, plus and difference between our allowance and the billed amount *Limited to 50 visits per person, per calendar year including visits which apply to the deductible. Previous limit was 25*	Preferred: 100% after a $25 copayment *70% of the Plan Allowance for agents, drugs and/or supplies administered or obtained in connection with these services* *Limited to 25 visits per person, per calendar year. Previous limit was 25* Participating/Non-participating: Not covered
Neurological testing performed by a Preferred professional provider	No change	100% after a $40 copayment *There was no previous copayment*
Diagnostic tests such as EEGs, ultrasounds and X-rays performed by a Preferred professional provider	No change	100% after a $40 copayment *There was no previous copayment*

FEP (CONTINUED)

2014 BENEFIT CHANGES (CONT'D)	STANDARD OPTION ONLY What we pay:	BASIC OPTION ONLY What we pay:
Diagnostic tests by Preferred providers limited to: › Bone density tests › CT scans/MRIs/PET scans › Angiographies › Nuclear medicine › Sleep studies › Genetic testing (See page 40 of the Service Benefit Plan Brochure for coverage details)	No change	100% after a $100 copayment *The copayment was previously $75* *70% of the Plan allowance for agents, drugs and/or supplies administered in connection with these services*
Outpatient diagnostic testing services performed and billed by a hospital or freestanding ambulatory facility including, but not limited to: › EEGs › Ultrasounds › Neurological testing › X-rays (including set-up of portable X-rays equipment)	No change	Preferred: 100% after a $40 copayment per day per facility Member: 100% after a $40 copayment per day per facility Non-member: 100% of Plan Allowance after a $40 copayment per day per facility, plus any difference between Plan Allowance and billed charges *70% of the Plan Allowance for agents or drugs administered or obtained in connection with these services*
Outpatient diagnostic testing services performed and billed by a hospital or freestanding ambulatory facility, limited to: › Angiographies › Bone density tests › CT scans/MRIs/PET scans › Genetic testing › Nuclear medicine › Sleep studies	No change	Preferred: 100% after a $150 copayment per day per facility Member: 100% after a $150 copayment per day per facility Non-member: 100% of Plan Allowance after a $150 copayment, plus any difference between our allowance and the billed amount *70% of the Plan allowance for agents, drugs and/or supplies administered in connection with these services*
Acupuncture performed and billed by a medical practitioner who is licensed or certified to perform acupuncture by state where the services are provided, and who is acting within the scope of that license or certification	No change	Limited to 10 visits a year Preferred primary care provider or other health care professional: 100% after a $25 copayment per visit. Preferred specialist: 100% after $35 copayment 70% of the Plan Allowance for drugs and supplies *Acupuncture benefits were previously only available when services were rendered by a physician*

FEP (CONTINUED)

2014 BENEFIT CHANGES (CONT'D)	STANDARD OPTION ONLY What we pay:	BASIC OPTION ONLY What we pay:
Surgical procedures rendered outside of an office setting (See pages 63-73 of the Service Benefit Plan Brochure for details)	No change	Preferred: 100% after a $200 copayment per performing surgeon *$150 copayment for office services* *70% of the Plan allowance for agents, drugs and/or supplies administered in connection with these services*
Inpatient Hospital Admission	No change	Preferred: 100% after a $175 per day copayment up to $875 per admission
CHANGES FOR STANDARD AND BASIC OPTIONS	**2014 BENEFIT**	**PREVIOUS BENEFIT**
Services provided by any licensed medical practitioner within the scope of their license, as required by Section 2706(a) of the Public Health Service Act (PHSA) Benefits for certain medical practitioners were previously limited to services performed in Medically Underserved Areas (MUAs)	Services now covered	Benefits for certain medical practitioners were previously limited to services performed in Medically Underserved Areas (MUAs)
Preventive care benefits for testing for deleterious mutations in BRCA1 and BRCA2 for females age 18 and over who have been diagnosed with breast or ovarian cancer (page 17 of the 2014 brochure)	Limited to one BRCA test per lifetime, whether under Preventive Care Benefits or under diagnostic testing benefits	Benefits were previously provided for one BRCA test per lifetime, only for members with a personal history of cancer Preventive care benefits were not previously available for this service
Wigs for hair loss due to cancer treatment	Limited to a maximum of $350 for one wig per lifetime	Benefits were previously only available for hair loss due to chemotherapy
Chiropractic Care	No longer limited to one office visit and one set of x-rays per year. Benefits are provided for office visits and x-rays as for any other covered professional provider	Limited previously to one office visit and one set of x-rays per year
Insulin and diabetic supplies	Covered only when obtained from a retail pharmacy or through the Mail Service Prescription Drug Program for Standard Option members	Insulin and diabetic supplies were also previously covered when obtained from physicians and other health care professionals, including medical supply companies and DME providers
Vitamin D Supplements	Covered in full only when purchased from a Preferred Retail Pharmacy	No previous charge for vitamin supplements

FEP (CONTINUED)

CHANGES FOR STANDARD AND BASIC OPTIONS (CONT'D)	2014 BENEFIT	PREVIOUS BENEFIT
Professional Provider Services Rendered Overseas	The Overseas Fee Schedule is now used as Plan Allowance	A customary percentage of the billed charge was previously used as Plan Allowance
Drugs administered or dispensed by non-participating physicians and other covered health professionals	Medicare Part B Drug Average Sales Price (ASP) will be considered when determining Plan Allowance	We previously did not consider the ASP when determining Plan Allowance for drugs
Heart-lung transplants performed at Blue Distinction Centers for Transplants	Benefits no longer provided for heart-lung transplants performed at Blue Distinction Centers for Transplants	Benefits were previously available for heart-lung transplants performed at Blue Distinction Centers for Transplants
CHANGES TO PRESCRIPTION DRUG	**2014 BENEFIT**	**PREVIOUS BENEFIT**
	What member pays	**What member pays**
Standard Option Generic Incentive Program	The list of generic drug replacements has been modified. (See page 101 of the Service Benefit Plan Brochure)	Not Applicable
Tier 2 preferred brand-name drugs: Mail Service Prescription Drug Program	$80 per prescription for up to a 90-day supply. (Previously, the member paid $70 for Tier 2 Brand Name drugs)	Not Applicable
Tier 3 preferred brand-name drugs: Mail Service Prescription Drug Program	$105 per prescription for up to a 90-day supply. (The member previously paid $95 for Tier 3 Brand Name drugs)	Not Applicable
2 tiers of specialty drugs	Tier 4 includes preferred specialty drugs. Tier 5 includes non-preferred specialty drugs *All specialty drugs were previously included in Tier 4*	Tier 4 includes preferred specialty drugs. Tier 5 includes non-preferred specialty drugs *All specialty drugs were previously included in Tier 4*
Filling Prescriptions for Specialty Drugs at a Preferred Retail Pharmacy or through the Specialty Drug Program	› New prescriptions of Tier 4 or Tier 5 specialty drugs may be filled at a Preferred Retail Pharmacy or through the Specialty Drug Pharmacy Program › The first three refills of specialty drugs must be purchased through the Specialty Drug Pharmacy Program for up to a 30-day supply › Beginning with the fourth refill, up to a 90-day supply can be purchased through the Specialty Drug Pharmacy Program *90-day supplies of a new or refilled prescription could previously be purchased through a retail or specialty pharmacy*	› New prescriptions of Tier 4 or Tier 5 specialty drugs may be filled at a Preferred Retail Pharmacy or through the Specialty Drug Pharmacy Program › The first three refills of specialty drugs must be purchased through the Specialty Drug Pharmacy Program for up to a 30-day supply › Beginning with the fourth refill, up to a 90-day supply can be purchased through the Specialty Drug Pharmacy Program *90-day supplies of a new or refilled prescription could previously be purchased through a retail or specialty pharmacy*

FEP (CONTINUED)

CHANGES TO PRESCRIPTION DRUG	2014 BENEFIT What member pays	PREVIOUS BENEFIT What member pays
Copayment for Tier 4 preferred specialty drug dispensed by the Specialty Drug Pharmacy Program	$35 for a 30-day supply $95 for a 90-day supply *The previous copayment was $80 for a 90-day supply*	$50 for up to a 30-day supply and $140 for up to a 90-day supply *The copayment was previously $40 for up to a 34-day supply or $120 for up to a 90-day supply*
Copayment for Tier 4 preferred specialty drug dispensed by a Preferred retail pharmacy	Not Applicable	$60 limited to a 30-day supply for each prescription filled *The copayment was previously $50 for up to a 34-day supply or $150 for up to a 90-day supply*
Coinsurance for Tier 5 non-preferred specialty drug dispensed by a Preferred retail pharmacy	Member pays 30% of the plan allowance *There were previously no Tier 5 non-preferred specialty drugs*	Not Applicable
Copayment for Tier 5 non-preferred specialty drugs dispensed by a Preferred retail pharmacy	Not Applicable	$80 limited to a 30-day supply for each prescription filled *There were no previous Tier 5 non-preferred specialty drugs*
Copayment for Tier 5 non-preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program	Not Applicable	$70 for up to a 30-day supply or $195 for up to a 90-day supply *There were no previous Tier 5 non-preferred specialty drugs*
Tiers 1-3 Preferred Retail Pharmacy	Not Applicable	Initial purchase of a new prescription limited to a 30-day supply. Subsequent purchases may be up to a 90-day supply *Preferred retail pharmacy purchases were previously limited to a 34-day supply*
Tier 2 preferred brand-name drugs purchased at a Preferred Retail Pharmacy	Not Applicable	$45 copayment per prescription up to a 30-day supply *The copayment was previously $40*
Tier 3 non-preferred brand-name drugs purchased at a Preferred Retail Pharmacy	Not Applicable	$55 minimum copayment per prescription up to a 30-day supply *The previous copayment minimum was $50*

New Technology Evaluated

Our Technology Assessment Unit evaluates new and existing technologies to apply to our local indemnity and managed care benefit plans. The unit relies on current scientific evidence published in peer-reviewed medical literature, local expert consultants and physicians to determine whether those technologies meet CareFirst and CareFirst BlueChoice criteria for coverage. Policies for non-local accounts like NASCO and FEP may differ from our local determinations. Please verify member eligibility and benefits prior to rendering services via **FirstLine** or **CareFirst Direct**. The Technology Assessment Unit recently made the following determinations:

TECHNOLOGY	DESCRIPTION	CAREFIRST AND CAREFIRST BLUE CHOICE DETERMINATION
Low-dose CT screening scan for lung cancer	Lungs can be screened using a CT with reduced radiation exposure	Considered medically necessary for high risk individuals HCPCS reporting code S8092
Transcranial magnetic stimulation for treatment-resistant major depression	Magnetic energy is applied to the skin of the head to stimulate an anti-depressive effect	Considered medically necessary for patients meeting defined criteria. CPT® reporting codes 90867, 90868
Transanal hemorrhoidal dearterialization	Ligation of the branch of the rectal artery that supplies the hemorrhoid	Considered experimental / investigational CPT® reporting code 0249T
Percutaneous left ventricular assist device, e.g. Impella®	A device implanted via percutaneous route between the left ventricle and aorta using a pump to increase cardiac output	Considered experimental / investigational CPT® reporting codes 33990-33992
SmartPill™ ingestible capsule gastrointestinal monitoring system	Capsule collects information regarding pH, pressure and temperature to aid in diagnosis of gastroparesis or intestinal dysmotility	Considered medically necessary CPT® reporting code 91112

CATEGORY III CPT® CODES EFFECTIVE 1/1/14 WITH CAREFIRST DETERMINATION:	
0335T	Experimental / investigational
0336T	Experimental / investigational
0337T	Experimental / investigational
0338T	Experimental / investigational
0339T	Experimental / investigational
0340T	Experimental / investigational
0341T	Experimental / investigational
0342T	Experimental / investigational
0343T	Medically necessary
0344T	Medically necessary
0345T	Medically necessary
0346T	Experimental / investigational

Medical Policy Updates

Our Health Care Policy department continuously reviews medical policies and operating procedures as new, evidence-based information becomes available regarding advances on new or emerging technologies, as well as current technologies, procedures and services. The table below is designed to provide updates on changes to existing or new local policies and procedures during our review process. Each local policy or procedure listed includes a brief description of its status, select reporting instructions and effective dates. Policies from non-local accounts, such as NASCO and FEP, may differ from our local determinations. Please verify member eligibility and benefits prior to rendering service through FirstLine or CareFirst Direct.

Note: The effective dates for the policies listed below represent claims processed on and after that date.

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
1.01.012 Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders	Under Policy Guidelines, added 2013 rationale statement. Report device with appropriate HCPCS code	Periodic review and update Effective 11/18/13
2.01.018 Sleep Disorders	Under Policy Guidelines, added statement "An unattended sleep study with simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (95806) is not time-based and should be reported only one time per study"	Policy revision Effective 2/10/14
2.01.051 Extracorporeal Photopheresis	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 36522	Periodic review and update Effective 10/21/13
2.01.065 Ingestible pH and Pressure Capsule for Assessing Gastrointestinal Motility	Policy changed from experimental / investigational to medically necessary when used in accordance with FDA-approved labeling. See policy for details. Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 91112	Periodic review and update Effective 11/18/13
2.02.012 Measurement of Exhaled Volatile Organic Compounds for Detection of Heart Transplant	Under Policy Guidelines, added 2013 rationale statement. Report service with Category III CPT® code 0085T	Periodic review and update Effective 10/21/13
4.01.009 Progesterone Administration for the Prevention of Preterm Labor	Added to medically necessary indications, daily vaginal progesterone initiated between 20 and 24 weeks gestation for women with a singleton pregnancy and short cervical length. Refer to policy for details. Under Policy Guidelines, added 2013 rationale statement. Report service with HCPCS code J3490, J1725 or S9542	Periodic review and update Effective 11/18/13
5.01.015 Naltrexone, Extended-Release Injectable Suspension (e.g. Vivtrol)	Under Provider Guidelines, added 2013 rationale statement. Report service with HCPCS code J2315	Periodic review and update Effective 11/18/13

HEALTH CARE POLICY (CONT'D)

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
5.01.019 Palivizumab (Synagis®) for Immune Prophylaxis for Respiratory Syncytial Virus (RSV)	Under Provider Guidelines, current preauthorization guidelines revised. Refer to policy for details. Report service with Category I CPT® code 90378	Policy revision Effective 9/12/13
6.01.005 Radioimmunoscintigraphy Imaging (Monoclonal Antibody Imaging)	Under Policy Guidelines, added 2013 rationale statement. Report service with the appropriate Category I CPT® or HCPCS code	Periodic review and update Effective 10/21/13
6.01.022 Magnetic Resonance Imaging (MRI) of the Breast	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 77058 or 77059	Periodic review and update Effective 10/21/13
6.01.026 Whole Body Computed Tomography Scan as a Screening Test	Under Policy Guidelines, added 2013 rationale statement. Report service with HCPCS code S8092	Periodic review and update Effective 11/18/13
6.01.027 Computed Tomography as a Screening Test for Lung Cancer	Policy changed from experimental/investigational to medically necessary for specific criteria. See policy for details. Under Policy Guidelines, added 2013 rationale statement. Report service with HCPCS code S8092	Periodic review and update Effective 11/18/13
6.01.034 Magnetic Resonance Spectroscopy	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 76390	Periodic review and update Effective 10/21/13
6.01.041 Carotid Intima-Media Thickness Measurement to Assess Risk for Coronary Artery Disease	Under Policy Guidelines, added 2013 rationale statement. Report service with Category III CPT® code 0126T	Periodic review and update Effective 11/18/13
7.01.085 Ultrasound Guided Cryoablation of Benign Fibroadenomas of the Breast	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 19105	Periodic review and update Effective 11/18/13
7.01.101 Percutaneous Intervertebral Thermal Annuloplasty Procedures for Low Back Pain	Under Policy Guidelines, added 2013 rationale statement. Report services with Category I CPT® codes 22526, 22527 or 22899	Periodic review and update Effective 11/18/13
7.01.107 Neurosurgical Intervention for Cervicogenic Headache / Occipital Neuralgia	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 64600, 64640, 64744, 64802 or 64804	Periodic review and update Effective 10/21/13

HEALTH CARE POLICY (CONT'D)

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
7.01.109 Surgical Treatment of Femoracetabular Impingement	Under Policy Guidelines, added 2013 rationale statement. Under Provider Guidelines added arthroscopic femoroplasty should be reported with Category I CPT® code 29914, 29915 or 29916; or open treatment of femoracetabular impingement with Category I CPT® unlisted code 27299. Refer to policy for details	Periodic review and update Effective 10/21/13
7.01.114 Transcatheter Aortic Valve Implantation (TAVI)	Under Policy Guidelines, added 2013 rationale statement. Report services with appropriate Category I CPT® code	Periodic review and update Effective 10/21/13
7.01.115 Shoulder Resurfacing Arthroplasty	Under Policy Guidelines, added 2013 rationale statement. Report the procedure with Category I CPT® unlisted code 23929	Periodic review and update Effective 10/21/13
7.03.005 Donor Leukocyte Infusion for Malignancies Treated with an Allogeneic Hematopoietic Stem-Cell Transplant	Medically necessary policy statement modified to include hematologic malignancies following allogeneic-hematopoietic stem cell transplantation that was originally considered medically necessary for the treatment of a hematologic malignancy if (1) the patient has relapsed or is refractory, (2) the purpose of the infusion is to prevent relapse in patients who are at high risk of relapse, or (3) to convert a patient from mixed to full donor chimerism. Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 38242	Periodic review and update Effective 10/21/13
7.03.011 Ventricular Assist Devices and Associated Services	Under Policy Guidelines, added 2013 rationale statement. Policy indications are unchanged. See policy for details. Report services with the appropriate Category I CPT® code	Periodic review and update Effective 11/18/13
11.01.008 Salivary Melatonin Profile	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 83519	Periodic review and update Effective 11/18/13
11.01.034 Molecular Genetic Expression Test for Identification of Heart Transplant Rejection	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® unlisted code 88299	Periodic review and update Effective 10/21/13
11.01.036 Lipoprotein-Associated Phospholipase A2 (Lp-PLA2)	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 83698	Periodic review and update Effective 11/18/13

CPET CORNER

CPET Corner—Two New Webinars Announced

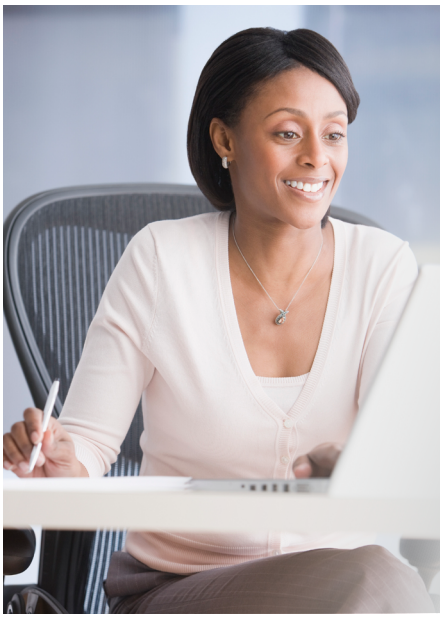
The Center for Provider Education and Training offers Professional, Hospital and Ancillary seminars, as well as an array of webinars to attend without leaving your office.

This issue's highlights:

The *Healthcare Exchanges Overview Webinars* begin in December and give an overview of what providers need to know about the Maryland, District of Columbia and Virginia Healthcare Exchanges established under the Affordable Care Act.

Our *Infertility Pre-Authorization Webinars,* which also begin in December, offer a detailed training session of the new system that now allows Infertility providers to create notifications and pre-authorizations.

Visit www.carefirst.com/cpet.



PHARMACY UPDATES

Prior Authorization

The following prescription drugs require prior authorization for prescriptions covered under the CareFirst and CareFirst BlueChoice prescription drug plan:

Fabior (tazoretene) for the treatment of acne vulgaris

Gilotrif (afatinib) for the treatment of metastatic non-small cell lung cancer

New Generics

The following drugs will be available as generic. The generics will be covered on tier 1 and the Brand Name drugs will be on tier 3 or non-preferred.

BRAND NAME	GENERIC NAME
Campral	acamprosate
Temodar	temozolomide
Vfend Solution	voriconazole
Zymaxid	gatifloxacin
Zemplar	paricalcitol

Added to Preferred Drug List

The following drugs are now tier 2 or preferred drugs.

BRAND NAME	GENERIC NAME
Tivicay	dolutegravir
Xarelto	rivaroxaban

Removed from Preferred Drug List

The following drugs have been moved to tier 3 or non-preferred drugs.

BRAND NAME	GENERIC NAME
Pradaxa	dabigatran

For the most current preferred drug list, visit www.carefirst.com/preferreddrugs. For information about medications that require prior authorization, visit www.carefirst.com/preauth. For a paper copy of the formulary and pharmaceutical management procedures, call (877) 800-3086.

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