CareFirst
The CareFirst BlueCross BlueShield family of health care plans

[STAY CONNECTED]

BlueLink

JANUARY/FEBRUARY 2014 VOL. 16, ISSUE 1

Manage Your Provider Data Online

Better Data. Better Service. You're in Control.

Is your provider/practice information up-to-date?
In just three easy steps, you can update your provider and practice information online through the Provider Portal (CareFirst Direct). Here's how:

1. Log in to the Provider Portal at www.carefirst.com/providers.
2. Click the *Verify and Update Your Provider Information* Quick Link.
3. Edit any information that has an "Update" link.

Most updates are reflected in the Provider Portal within 24 to 48 hours and in the claims payment systems within two to three business days.

Top 3 Reasons to Update Your Data Online

1. Faster reimbursement
2. Reduced errors
3. Increased patient population – our members can find you online

To find out more, register for training at www.carefirst.com/cpet.

IN THIS ISSUE:

WHAT'S HAPPENING

In Case You Missed It

Start the year off right. Click the "In Case You Missed It" icon to catch up on headlines, tips and reminders that you may have missed from 2013.

In Case You Missed It

This issue's highlights: Top 5 Provider Updates from 2013

1. **6 Easy Tools for You video** - Watch this short video to learn about the online tools and resources available to help you save time.
2. **Health Care Reform section** - Read our reoccurring Health Care Reform section in the latest issue of *BlueLink* to find out how the Affordable Care Act may impact your practice.
3. **Online Prior Authorization** - Log in to the Provider Portal to submit your pre-authorization requests online for services requiring pre-auth.
4. **Provider Link List** - Download our new Provider Link List for quick access to the information you use most.
5. **Electronic Claims (EDI/EFT)** - Get paid faster by submitting your claims online.

And the Winner is. . .

Congratulations to **Mary Anne K.** who received a gift for providing feedback in Q4 2013.

This year, be more specific with your feedback to us. Tell us what is working and what is not to help us develop better communications for you in the future.

Which of our Top 5 Provider Updates of 2013 helped you the most?

Email newsletter.editor@carefirst.com and tell us why.

Get Connected in 2014

Don't miss out on our provider updates. Register for CareFirst Provider News & Updates by email at www.carefirst.com/stayconnected.

Submit Pre-Service Review Requests Online for Out-of-Area Members

You can now submit and track your requests online for Pre-Service Review (including notification, pre-certification, pre-authorization and prior approval) for out-of-area members.

To determine whether Pre-Service Review is required, check eligibility in CareFirst Direct or visit www.carefirst.com/preauth > *Out-of-Area* and enter the out-of-area member's alpha prefix.

If Pre-Service Review is required, you can submit the request online:

1. Log in to CareFirst Direct (Provider Portal) at www.carefirst.com/providers
2. Click on the *Pre-Auth / Notifications* tab
3. Enter the membership number including the alpha prefix

The Blue Cross and Blue Shield Association's Electronic Provider Access (EPA) tool will route you to the member's Home Plan EPA landing page to complete your request.

The availability of EPA will vary depending on the capabilities of each Home Plan. If you experience technical issues, call 1-800-676-BLUE to be routed to a Home Plan to obtain a Pre-Service Review by phone.

Learn More

Register for training at www.carefirst.com/cpet.

WHAT'S HAPPENING

CVS Caremark New Pharmacy Benefit Manager

What You Need to Know for a Smooth Transition

Effective Jan. 1, 2014, CareFirst changed its Pharmacy Benefit Manager from Argus/Walgreens[1] to CVS Caremark[2]. To help you transition seamlessly, we've compiled a list of how the changes will impact you:

ID Cards

CareFirst members who have pharmacy coverage received a new ID card with new BIN, PCN and Group numbers. Verify that your patients have the new ID card with new BIN/PCN/Group numbers prior to requesting prior authorization or filling prescriptions.

- RxBIN: 004336
- RxPCN: ADV
- Group: Rx7546

Drug Formularies

The preferred drug list can be viewed at www.carefirst.com/preferreddrugs. To obtain a paper copy of a formulary, call (877) 800-3086.

[1] Argus/Walgreens are independent companies that provide pharmacy benefit management services for CareFirst members.

[2] CVS Caremark is an independent company that now provides pharmacy benefit management services.

Prior Authorizations

Visit www.carefirst.com/preauth to determine which medications require prior authorization.

For services requiring prior authorization, there are now three ways to submit a request:

1. Log in to the Provider Portal (CareFirst Direct) and click '*Pre-Auth/Notifications*' tab.
2. **New!** Call CVS Caremark directly at (855) 582-2038.
3. Fax the appropriate prior authorization form. Forms can be located at www.carefirst.com > *For Members* > *Prescription Drug Tools.*

Reminders:

Synagis® Pre-Authorization Requests
Fax the Physician Request for Synagis® form to CVS Caremark at (800) 323-2445.

Infertility Therapy Pre-Authorization Requests
Fax the Assisted Reproductive Technology Pre-Treatment Request form to CVS Caremark at (855) 330-1720.

Rx Mail-Order Services

Patients previously using Walgreen's Rx Mail-Order Services were converted to CVS Caremark's Rx Mail-Order Services and all current prescriptions were transferred to CVS Caremark, with the exception of controlled and/or compound medications.

If you have patients who use Rx Mail-Order Services, they will need new prescriptions for:

- Controlled substances
- Compound medications
- Prescriptions that expired prior to Jan. 1, 2014
- Prescriptions that have no refills remaining on Jan. 1, 2014

Your patients can download the new Rx Mail-Order Service Form at www.carefirst.com > *For Members* > *Prescription Drug Tools.*

Specialty Pharmacy

Effective Jan. 1, 2014, you can order single doses of most injectable medications and vaccines for delivery to your office from CVS Caremark.

Listen

Dr. Winn Says...

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

As noted in the previous article, CareFirst recently changed its Pharmacy Benefits Manager to CVS Caremark. Listen as Dr. Winn discusses how to improve adherence to medications, a focus of CVS Caremark and CareFirst.

CLAIMS AND BILLING

ID Card for Patients With Benefits Through a TPA

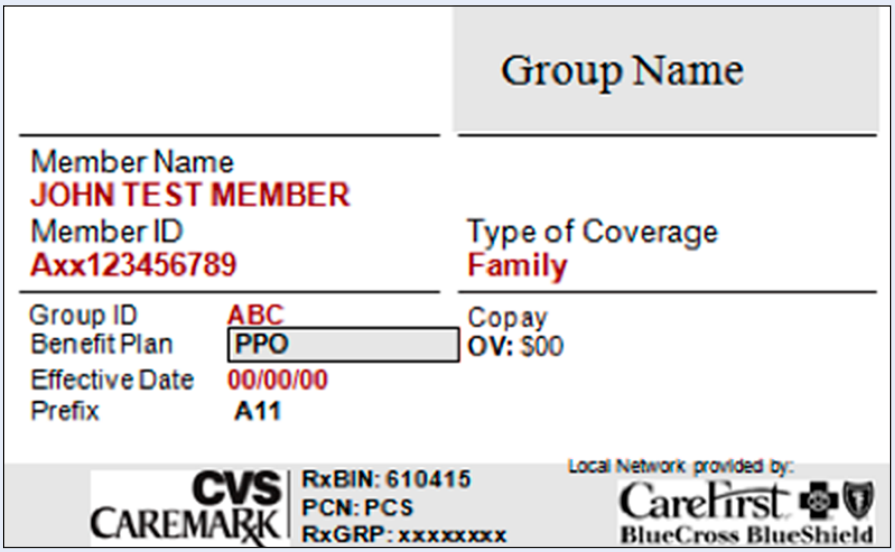
Do you have patients who receive benefits through a Third Party Administrator (TPA)? CareFirst administers benefits through TPAs to allow them access to our provider network.

Use the sample member ID card below to help identify these patients:

A few things to keep in mind:

- The CareFirst logo, Group logo and alpha prefix ("A") appear on the front of the card
- Claims submission instructions appear on the back of the card

For questions on patient benefits, refer to the telephone number on the back of the ID card.



New Requirements for Submitting Medicare Secondary Claims

Did you know that the Blue Cross and Blue Shield Association has implemented new submission regulations for Medicare Secondary Claims?

Make sure your claims are accurately processed for payment and follow the requirements below:

- Wait 30 days from the Medicare EOB date before submitting your secondary claim.
- If a secondary claim is submitted electronically, it must include the Medicare EOB or remittance advice date (**see below for specific information**).
- Out-of-area member claims for covered services are now rejected by the member's home plan. After receiving a rejection notification, providers 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 impacted by the 30 day requirement and do not require the inclusion of a Medicare EOB.

As a reminder:

- Always check CareFirst Direct or FirstLine for claim status *before* submitting a secondary claim.
- All professional providers should submit Medicare secondary claims electronically. ***Note:*** *If a paper claim is submitted, it must be accompanied by a copy of the Medicare EOB.*
- All institutional providers should submit Medicare secondary claims on paper with a copy of the Medicare EOB.

For additional information on claims filing rules for Medicare Secondary Claims, visit www.carefirst.com/electronicclaims > *Claims Filing* tab.

CLAIMS AND BILLING

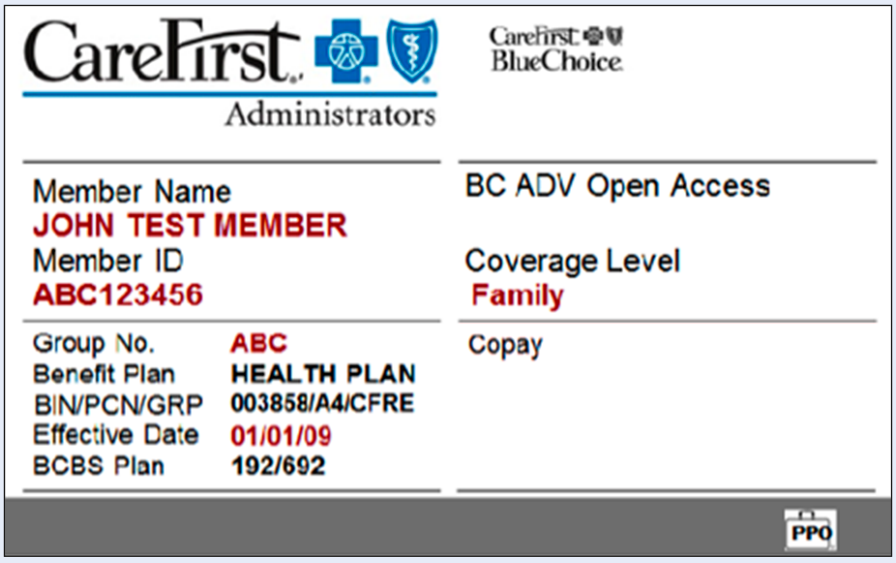
CareFirst Administrators BlueChoice Advantage Open Access Products

Effective Jan.1, 2014, the following accounts will have a CareFirst Administrators BlueChoice Advantage Open Access product:

- American Federation of Government Employees
- Burch Oil
- Bob Hall
- OriGene Technologies

Members will be identified by prefixes AFV, BUA, BNH and OGR on the front of their identification card. The back of the identification card contains the telephone number for Utilization Management.

Please use CareFirst Direct to verify eligibility and benefits and to check the status of your claims.



HEALTH CARE REFORM

Reform Re-cap

Throughout 2013, we sent you emails, mailed postcards, made website updates and developed resources to help your practice get informed on health care reform.

This year, we resolve to help you *stay* informed with key Affordable Care Act (ACA) news. If you missed one of our updates so far, click the links below to catch up:

- Are You Ready for Health Care Reform?
- Health Care Reform Update: PPACA and Mobile App for Members
- Health Care Reform Update: Women's Preventive Services

Reform Resources

As a reminder, please continue to follow current procedures, review member ID cards and use CareFirst Direct or FirstLine to verify information and coverage prior to rendering care.

Check out the resources below to help answer any questions about all CareFirst products:

- Professional Provider Manual
- Institutional Provider Manual

HEALTH CARE REFORM

Grace Period Reminder

The Three Month Grace Period is a provision in ACA that only applies to CareFirst members who enrolled on 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 month.

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 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 second and third month of delinquency (except Maryland HMO members).

Upon receipt of the member's premium, CareFirst will automatically adjust a clean claim submitted in accordance with the member's contract in effect at the time of service rendered.

Verifying Member ID Cards

Many CareFirst members receive new identification cards at the beginning of the year. Due to our new Pharmacy Benefits manager and changes with respect to the Affordable Care Act, it is even more important to ask the member for the most current copy of their ID card at each visit.

Here are several helpful tips:

- Ask members for their current ID card at every visit. Since new ID cards may be issued throughout the year, this confirms that you have the most up-to-date information in your patient's file.
- Make copies of the front and back of the member's ID card and pass this key information to your billing staff.
- All Blue Cross and Blue Shield membership identification cards include a **three-digit alpha prefix** in the first three positions of the member's ID number.
- This alpha prefix identifies the member's Home Plan and is critical for eligibility/benefits verification and claims processing.
- Up to 14 additional characters, any combination of letters and numbers may follow this. When filing the claims, always enter the identification number exactly as it appears on the member's card, inclusive of the alpha prefix.
- Member ID numbers must be reported exactly as shown on the ID card. Do not add, omit or alter any characters from the member ID number.

HEALTH CARE POLICY

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 BLUECHOICE DETERMINATION
AlloMap assay	Gene expression assay for detection of rejection of heart transplant	Considered medically necessary for certain heart transplant patients CPT® reporting code 88299
Injection of bulking agents into anal sphincter to treat fecal incontinence, e.g. Solesta®	Hyaluronic acid with dextran polysaccharide is injected to build up anal sphincter	Considered experimental / investigational CPT® reporting code 46999

HEALTH CARE POLICY

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
2.01.009 Tilt Table Test	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 93660	Periodic review and update Effective 12/23/13
2.01.025 Erectile Dysfunction	Under Policy Guidelines, added 2013 rationale statement. Report services with appropriate Category I CPT® code and/or HCPCS code	Periodic review and update Effective 1/20/14
2.01.028 Neuropsychological Testing	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® codes 96116, 96118, 96119 or 96120	Periodic review and update Effective 1/20/14
2.01.053 Implantable Hormone Replacement Pellets	Medically necessary policy statement modified to include treatment of delayed male puberty. Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 11980 or HCPCS code S0189	Periodic review and update Effective 12/23/13
2.01.058 Monitoring of Regional Cerebral Blood Flow Using Implanted Cerebral Thermal Infusion Probe	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® codes 61107 or 61210	Periodic review and update Effective 1/20/14
2.02.009 Electrocardiographic Body Surface Mapping	Under Policy Guidelines, added 2013 rationale statement. Report service with Category III CPT® code 0178T, 0179T or 0180T	Periodic review and update Effective 12/23/13
2.03.005 Adoptive Immunotherapy	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 36511 or HCPCS code S2107	Periodic review and update Effective 1/20/14
2.03.006 Isolated Limb Perfusion	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 36823	Periodic review and update Effective 1/20/14
3.01.011A Autism Spectrum Disorders (Virginia Mandate)	Report service with appropriate Category I CPT® or HCPCS codes	No further review scheduled Effective 12/23/13
4.02.007 Preimplantation Genetic Testing	Under Policy Guidelines, added 2013 rationale statement. Report services with appropriate Category I CPT® code	Periodic review and update Effective 1/20/14

HEALTH CARE POLICY

MEDICAL POLICY AND/OR PROCEDURE	ACTIONS, COMMENTS AND REPORTING GUIDELINES	POLICY STATUS AND EFFECTIVE DATE
6.01.024 Ultrasound (Echography) of the Spinal Canal and Contents	Under Policy Guidelines, added 2013 rationale statement. Report service with appropriate Category I CPT® code 76800	Periodic review and update Effective 1/20/14
6.01.032 Positron Emission Tomography (PET)	Description updated. Under Policy, added brain, prostate (except for initial treatment strategy), all other solid tumors and all other cancers not listed to oncological indications. Specific guidelines added to indications for melanoma, breast and cervical cancer. Under Policy Guidelines, updated guidelines for oncological treatment using PET scans, and added 2013 rationale statement. Report service with appropriate Category I CPT® or HCPCS codes. Refer to policy for details	Periodic review and update Effective 12/23/13
7.01.076 Wireless Capsule Endoscopy (Enteral Camera)	Policy changed from experimental / investigational to medically necessary to evaluate the extent of involvement of diagnosed Crohn's disease and to evaluate other gastrointestinal diseases not presenting with gastrointestinal bleeding. Evaluation of disorders of the esophagus remains experimental / investigational. Refer to policy for details. Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® code 91110 or 91111	Periodic review and update Effective 12/23/13
7.01.100 Cervical Vertebral Disc Replacement	Under Policy Guidelines, added 2013 rationale statement. Report service with Category I CPT® codes 22856, 22861 or 22864	Periodic review and update Effective 1/20/14
7.01.121 Transanal Hemorrhoidal Dearterialization	Transanal hemorrhoidal dearterialization is considered experimental / investigational. Report service with Category III CPT® code 0249T. Refer to policy for details	New policy Effective 12/23/13
7.01.122 Percutaneous Left Ventricular Assist Device	Percutaneous left ventricular assist device is considered experimental / investigational. Report service with Category I CPT® codes 33990, 33991, 33992 or 33993. Refer to policy for details	New policy Effective 3/24/14
7.03.011 Ventricular Assist Devices and Associated Services	Description updated with "NOTE: This policy does not address the percutaneous left ventricular assist devices, such as the Impella™ or similar devices. See Percutaneous Left Ventricular Assist Device (pLVAD) (Medical Policy 7.01.122)"	Policy revision Effective 3/24/14
8.01.005 Speech Therapy	Under Provider Guidelines, added information regarding telemedicine services for speech therapy. Refer to policy for details	Periodic review and update Effective 1/20/14
11.01.015 Preconception Sex Selection Techniques	Under Policy Guidelines, added 2013 rationale statement. Policy remains experimental / investigational	No further review scheduled Effective 12/23/13

CPET CORNER

CPET Corner

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:

Health Care Exchange – An overview of what providers need to know about the Maryland, Virginia and District of Columbia Healthcare Exchanges established under the Affordable Care Act.

Update Provider Data Online (Institutional and Professional) – An overview of the tool that allows providers to update their information directly into the Provider Portal (CareFirst Direct.)

Visit www.carefirst.com/cpet

QUALITY IMPROVEMENT

Annual Criteria Review Complete

CareFirst's Medical Directors and a panel of regional practitioners met on Nov. 7, 2013, for the Annual Criteria Review. The panel, which included primary care physicians and multiple specialists, reviewed and approved the Modified Appropriateness Evaluation Protocol Criteria, 2011 Apollo Managed Care Physical Therapy, Occupational Therapy, Rehabilitation Criteria and the CareFirst Medical Policy Reference Manual.

The Magellan Behavioral Health 2014 Medical Necessity Criteria were also reviewed and approved. The criteria took effect Jan. 1, 2014. A copy of any of the above mentioned criteria can be obtained or reviewed by calling (410) 528-7041.

CareFirst makes available physician reviewers to discuss utilization management decisions. Physicians may call (410) 528-7041 or (800) 367-3387 x 7041 to speak with a physician reviewer. All cases are reviewed on an individual basis.

Important Note: CareFirst affirms that all Utilization Management (UM) decision-making is based only on appropriateness of care and service. We do not reward practitioners or other individuals conducting utilization review for denials of coverage or service. In addition, financial incentives for UM decision-makers do not encourage denials of coverage or service.

Members Rate Their Experience

Each year, CareFirst participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This survey measures members' satisfaction with their experience with their practitioner offices, health care and health plan. The survey is a standardized tool that allows results to be publicly reported so individuals have an objective means of comparing health plans. The results assist CareFirst in identifying opportunities for improvement and tracking progress toward its goal of meeting the national 90th percentile for each measure. The 2013 (experience from 2012) CAHPS survey results revealed the following opportunities:

MEASURE	GOAL (NATIONAL 90TH PERCENTILE)	CAHPS 2013 BLUECHOICE RESULTS	CAHPS 2013 BLUEPREFERRED RESULTS
Claims Processing	93.2%	90.2%	87.9%
Customer Service	92.0%	84.6%	84.2%
Getting Care Quickly	90.2%	83.3%	86.3%
Getting Needed Care	91.6%	86.0%	87.4%
How Well Doctors Communicate	96.6%	92.5%	95.0%
Rating of Personal Doctor	87.9%	80.9%	83.6%
Rating of Specialist Seen Most Often	88.3%	85.2%	84.6%
Rating of All Health Care	82.2%	74.4%	74.2%
Rating of Health Plan	75.6%	64.80%	66.2%

Claims Processing for BlueChoice and Customer Service for both BlueChoice and BluePreferred experienced improvement of satisfaction between 2012 and 2013.

Interventions are developed to improve members' satisfaction based on the outcomes from this survey as well as real-time surveys that measure members' recent experience with claims payment and customer service.

QUALITY IMPROVEMENT

2013 Appointment Access

CareFirst annually valuates members' access to primary care against its preferred appointment wait times. These desired appointment times are found in the Practitioner Office Standards on the CareFirst website.

Preferred Times for Appointments

TYPE OF APPOINTMENT	PREFERRED APPOINTMENT TIMES
Non-symptomatic (Preventive Care)	30 days
Symptomatic Non-urgent (Routine Care)	14 days
Urgent Care	24 hours
After-hours Care Call back to member	Responds to caller within 30 minutes

The findings are as follows:

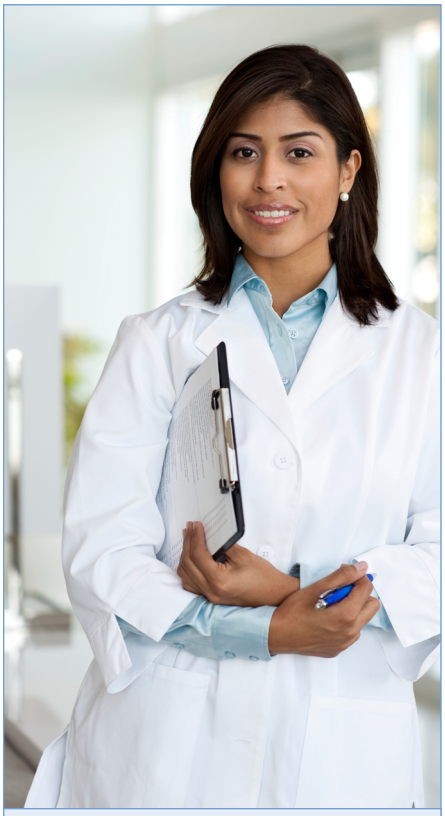
2013 Accomplishments

BlueChoice member satisfaction results exceeded the 95 percent goal for waiting to get an appointment within 30 days for preventive care.

2013 Opportunities for Improvement (Results falling below the 90 percent goal)

- Obtaining an appointment within 30 days for preventive care (BluePreferred-slightly below 95 percent)
- Obtaining an appointment within 14 days for routine care (BlueChoice and BluePreferred)
- Obtaining an appointment within 24 hours for urgent care (BlueChoice and BluePreferred)
- Receiving a return call within 30 minutes when calling a practitioner after office hours (BlueChoice and BluePreferred)
- Receiving the advice or help needed when calling a practitioner after office hours (BlueChoice and BluePreferred)
- Obtaining an appointment with a behavioral health practitioner within 10 business days for routine care (BlueChoice and BluePreferred)

Expectations for fast and immediate service are higher than ever. Long wait times for getting an appointment and waiting to see the doctor once in the office influences members' satisfaction with their physician and, in some instances, determines if they will continue with your practice. Members' perception of convenience can affect their satisfaction with obtaining an appointment, even when it is within the preferred time.



How Are We Doing?

How does *BlueLink* help you do your job? Let us know how *BlueLink* has made an impact on the way that you do business with CareFirst. Tell us what you think – what we're doing right and what we could do better. Your feedback helps us deliver timely, engaging news that will help you have more time to care for our members.

Our goal is to provide you with the best articles possible and your feedback is vital. Email your comments to newsletter.editor@carefirst.com and you will be entered to win a free gift.

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CareFirst
The CareFirst BlueCross BlueShield family of health care plans