BlueLink Provider Newsletter

December 2016 | Volume 22 | Issue 6

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WHAT'S HAPPENING?

Joining PCMH Means Better Care For Your Patients

Calling all Primary Care Providers: 4,200 of your colleagues have already joined PCMH…You should, too.

Watch this brief video to listen to Dr. Kevin Schendel, lead medical advisor and participating provider in PCMH, discuss the benefits this Program can have on *your* patients, in *your* practice.

And, visit www.carefirst.com/joinpcmh for more information on how to participate.

The Provider Portal Refresh – What You Can Expect

You might call it CareFirst Direct, you might call it iCentric, or you might just call it the CareFirst Provider Portal. Whatever you call it, we're making it better.

Enhanced security features, more self-service options and a more personalized user experience are all things you can look forward to with the implementation of the refreshed Provider Portal.

What does this mean for you?

Starting Dec. 19, Provider Portal users will have to complete a one-time account update that will require each User ID to have a unique email address (if you perform work for multiple Tax IDs you can use the same email address for each of your User IDs). Once your account has been updated, depending on your location or device, when you sign in to your account you may see an identity verification screen. This is an added layer of protection requiring you to confirm your identity either through email verification or by entering a security code sent to your mobile phone. This helps us protect your account from fraudulent access.

Professional, Institutional and Dental providers and office administrators who work in solely a clinical or both clinical and billing roles, will have personalized homepages based on practice role making it easier to access materials specific to your job, and Providers will receive pharmacy alerts on their homepages.

For our PCMH Providers and office administrators we're adding alerts and adjusting workflow navigation, making it easier for you to track the status and progress of patients in the Program.

As we move closer to implementation, sign up for email updates with user guides, helpful reference materials and training opportunities that will help explain the ins and outs of the enhancements for new and current users.

HEALTH CARE POLICY

Habilitative Policy Updates

As a result of Maryland legislation, updates have been made regarding coverage of habilitative services including:

- Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST),
- Applied Behavioral Analysis (ABA), and
- Oral (dental).

Beginning Jan. 1, 2017 and moving forward, you should **bill the SZ modifier** along with the procedure code when submitting claims for habilitiative services.

To view the updated medical policy associated with these services, refer to the Medical Policy Reference Manual at www.carefirst.com/medicalpolicy. Search for '8.01.011A' or 'Habilitative Services' for details.

For covered procedure codes associated with the services listed above, refer to the Medical Policy Update Chart in this issue.

Effective Dates, CPT® Codes and Policy Updates for December – Here's What You Need to Know

As a reminder, these medical policies are not intended to replace or substitute the independent medical judgment of a practitioner or other health professional for the treatment of an individual. As medical technology continues to change, CareFirst reserves the right to review and update its medical policy as necessary.

Refer to the latest Medical Policy Update chart below:

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
1.01.001 Durable Medical Equipment with Attached Table	Report service with appropriate HCPCS code. Refer to policy for details.	Periodic review and update. Effective 9/19/16
1.01.012 Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders	Under Policy Guidelines, added updated 2016 rationale statement. Report service with appropriate HCPCS code. Refer to policy for details.	No further review scheduled. Effective 9/19/16
1.01.071 Automated Oscillometer Blood Pressure Monitors for Home Use	Under Policy Guidelines, added updated 2016 rationale statement. Report service with appropriate HCPCS code. Refer to policy for details.	Periodic review and update. Effective 9/19/16
2.01.018 Sleep Disorders	Under Policy statement added revised medical necessity statement for home monitoring devices. Report service using appropriate CPT® category I code or HCPCS code. Refer to policy for details.	Revision Effective 9/19/16

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
2.01.027 Chelation Therapy	Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code or HCPCS code. Refer to policy for details.	Periodic review and update. Effective 9/19/16
2.03.010 Genetic Testing for Inherited Susceptibility to Colon Cancer	Under Policy statement added updated medical necessity indications. Policy Guidelines revised and added updated 2016 rationale statement. Report service using appropriate CPT® category I code. Refer to policy for details.	Periodic review and update. Effective 9/19/16
5.01.019 Palivizumab (Synagis®) for Immune Prophylaxis for Respiratory Syncytial Virus (RSV)	Under Policy statement and Policy Guidelines added revised medical necessity criteria. Under Policy Guidelines, added updated 2016 rationale statement. Report service using CPT® category I code 90378. Refer to policy for details.	Periodic review and update. Effective 9/19/16
6.01.027 Computed Tomography as a Screening Test for Lung Cancer	Provider Guidelines statement revised. Report service using HCPCS code G0297. Refer to policy for details.	Revision Effective 10/1/16
7.01.025 Spinal Cord and Deep Brain Stimulation	Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code or HCPCS code. Refer to policy for details.	Periodic review and update. Effective 9/19/16
7.01.117 Minimally Invasive Lumbar Decompression	Under Policy Guidelines, added updated 2016 rationale statement. Report service using CPT® category III code 0275T. Refer to policy for details.	Periodic review and update. Effective 9/19/16
7.03.004 Placental and Umbilical Cord Blood as a Source of Stem Cells	Report service using appropriate CPT® category I code 38205 or 38206 and HCPCS code S2140 or S2142. Refer to policy for details.	Revision Effective 9/19/16
11.01.002 Genetic Testing for Inherited BRCA1 or BRCA2 Mutations	Under Policy statement added revised medical necessity criteria. Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code. Refer to policy for details.	Periodic review and update. Effective 9/19/16

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
11.01.043 Systems Pathology for Prediction of Recurrence of Prostate Cancer	Under Policy Guidelines, added updated 2016 rationale statement. Report service using CPT® category I code 88399. Refer to policy for details.	No further review scheduled Effective 9/19/16
11.01.050 Genetic Testing for Familial Cardiomyopathies	Under Policy statement added revised medical necessity criteria. Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code. Refer to policy for details.	Periodic review and update. Effective 9/19/16
2.01.001 Idiopathic Environmental Intolerances	Under Policy Guidelines, added updated 2016 rationale statement. Report service using CPT® category I code 95199. Refer to policy for details.	Periodic review and update. Effective 10/17/16
2.01.010 Quantitative Electroencephalogram / Topographic Brain Mapping	Under Policy Guidelines, added updated 2016 rationale statement. Report service using CPT® category I code 95957. Refer to policy for details.	Periodic review and update. Effective 10/17/16
2.01.031 Surface Electromyography	Under Policy Guidelines, added updated 2016 rationale statement. Report service using HCPCS code S3900. Refer to policy for details.	Periodic review and update. Effective 10/17/16
2.01.045 Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid	Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code or HCPCS code. Refer to policy for details.	Periodic review and update. Effective 10/17/16
2.01.075 High-intensity Focused Ultrasound for Treatment of Localized Prostate Cancer	High-intensity Focused Ultrasound is considered experimental/investigational. Report service with CPT® category I code 53899. Refer to policy for details	New Policy Effective date 8/1/16
2.02.010 Ultrafiltration for Fluid Overload in Decompensated Heart Failure	Policy statement updated to include medically necessary criteria. Under Policy Guidelines, added updated 2016 rationale statement. Report service using CPT® category I code 93799. Refer to policy for details.	Periodic review and update. Effective 10/17/16

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
2.02.011 Wearable External Cardioverter-Defibrillator	Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code or HCPCS code. Refer to policy for details.	Periodic review and update. Effective 10/17/16
2.02.016 Leadless Cardiac Pacemaker	Leadless Cardiac Pacemaker is considered experimental / investigational. Report service with appropriate CPT® category III code, 0387T, 0388T, 0389T, 0390T, or 0391T. Refer to policy for details.	New Policy Effective date 8/1/16
3.01.006 Pervasive Developmental Disorders (e.g., Autism)	Policy statement, Benefit Applications, and Provider Guidelines revised. Habilitative services should be reported using appropriate CPT® category I code appended with the HCPCS modifier SZ. Refer to policy for details.	Revision. Effective 1/01/17
4.01.005 Lactation Consultations	Under Benefit Applications and Provider Guidelines, removed visit limit. Refer to policy for details.	Revision Effective 10/17/16
4.02.008 Recurrent Pregnancy Loss (Recurrent Spontaneous Abortion)	Under Policy Guidelines, added updated 2016 rationale statement. Report services using appropriate CPT® category I code. Refer to policy for details.	Periodic review and update. Effective 10/17/16
5.01.013 Intravenous Immune Globulin (IVIG) Therapy	Policy Statement and Provider Guidelines revised. Under Policy Guidelines, added updated 2016 rationale statement. Report service using appropriate CPT® category I code or HCPCS code. Refer to policy for details.	Periodic review and update. Effective 10/17/16
7.01.022 Oral-Facial Pathology or Trauma	Policy statement, Benefit Applications, and Provider Guidelines revised. Habilitative services should be reported using appropriate CPT® category I code appended with the HCPCS modifier SZ. Refer to policy for details.	Revision Effective 1/01/17
8.01.001 Physical Therapy	Policy statement and Provider Guidelines revised. Habilitative services should be reported using appropriate CPT® category I code appended with the HCPCS modifier SZ. Refer to policy for details.	Revision Effective 1/01/17
8.01.004 Occupational Therapy	Policy statement and Provider Guidelines revised. Habilitative services should be reported using appropriate CPT® category I code appended with the HCPCS modifier SZ. Refer to policy for details.	Revision Effective 1/01/17

Medical Policy and/or Procedure	Actions, Comments and Reporting Guidelines	Policy Status and Effective Date
8.01.005 Speech Therapy	Policy statement and Provider Guidelines revised. Habilitative services should be reported using appropriate CPT® category I code appended with the HCPCS modifier SZ. Refer to policy for details.	Revision Effective 1/01/17
8.01.011A Habilitative Services (MD and DC Mandates)	Description, Benefit Applications, and Provider Guidelines revised. Habilitative services should be reported using appropriate CPT® category I code appended with the HCPCS modifier SZ. Refer to policy for details.	Revision Effective 1/01/17
6.01.041 Carotid Intima-Media Thickness Measurement to Assess Risk for Coronary Artery Disease	Policy Statement remains unchanged. Report service using Category I CPT® code 93895 or Category III CPT®® code 0126T. Refer to Policy for details.	Revision Effective 2/1/2017

Five New Medical Technology Updates

Our Technology Assessment Unit evaluates new and existing technologies to apply to our health 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 BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (CareFirst BlueChoice) criteria for coverage. Policies for non-local accounts like NASCO and Federal Employee Program (FEP) may differ from our local determinations. Please verify member eligibility and benefits prior to rendering services via CareFirst on Call (Professional and Institutional) or CareFirst Direct.

The Technology Assessment Unit recently made the following determinations:

Technology	Description	CareFirst and CareFirst Blue Choice Determination
Noninvasive prenatal testing for fetal aneuploidies	Circulating fetal DNA is tested on maternal blood to identify aneuploidies such as trisomy 21, 18, and 13.	Considered medically necessary for women with singleton pregnancies Considered experimental / investigation in cases of twin or multiple pregnancies. Testing for additional trisomies beyond 21, 18, and 13 is considered experimental / investigational. Testing for microdeletions is considered experimental / investigational. CPT® reporting code 81420 or 81507

Technology	Description	CareFirst and CareFirst Blue Choice Determination
DecisionDx gene expression test for uveal tract melanoma	A genomic based test for patients with uveal tract melanoma, to assess risk for metastasis	Considered experimental / investigational. CPT® reporting code 81479
Carotid artery angioplasty and stenting	Percutaneous treatment for symptomatic carotid stenosis as an alternative to carotid endarterectomy	Considered medically necessary as an alternative to carotid endarterectomy in patients meeting specified criteria. CPT® reporting code 61635
Mechanical thrombus removal in acute ishemic stroke	Thrombectomy procedure that attempts to reduce stroke-related disability	Considered medically necessary when used in conjunction with fibrinolytic medications CPT® reporting code 61645
Cervical disc arthroplasty	Replacement of cervical intervertebral disc(s) with prosthetic device(s)	Considered medically necessary at one or two adjacent levels when using a device approved by the FDA for the indication. CPT® reporting code(s) 22856, 22858

Category II CPT® Codes – Effective January 1, 2017

Code	Status
0446T-0448T	Experimental / investigational
0449T-0450T	Experimental / investigational
0451T-0463T	Experimental / investigational
0464T	Experimental / investigational
0465T	Experimental / investigational
0466T-0468T	Experimental / investigational

CLAIMS & BILLING

Attention Hospital Billing Administrators: We're Improving Efficiencies for Hospital Billing Audits

CareFirst has been working with our hospital billing audit vendor, Carewise Health, and our credit balance audit vendor, CDR, to improve the recovery process for credit balances. Why? To continue our efforts of minimizing the impact of audits and create a more streamlined billing process.

What does this mean for you?

Carewise Health can now roll any credit balances into their hospital audits as long as CDR has not already initiated a credit balance audit on that account.

If Carewise Health initiates a hospital bill audit and CDR is already working the credit balance, CDR will continue to handle the credit balance audit on behalf of CareFirst.

This new process will reduce the number of times a claim will have to be reviewed in order to reconcile the credit balance.

Have questions? Call the appropriate Provider Relations Representative for your area.

Submitting Voluntary Refund Requests

When reviewing patient accounts, if you find that CareFirst is due a refund, you may submit your refund to CareFirst using the Provider Refund Submission Form Using this form ensures that all needed information is provided to our finance team and the item is posted correctly.

The type of claim, entity and where the payment was sent from will determine the address where you should submit your refund to CareFirst.

CareFirst Host and CareFirst Administrators Claim Refund Requests

Refund requests for claims mailed from P0 Box 981608, El Paso, Texas, 79998 should be submitted to CareFirst Administrators at 1501 South Clinton Street Baltimore, Md. 21224-5730. Include the ID number, which will start with an A, and the 13 digit claim number with your refund submission.

Refund Requests for Members Whose Claims are Processed Using a Coordination of Benefits Method

CareFirst's NASCO claim processing system offers several Coordination of Benefits (COB) methods. Each account has the option to select their preferred COB method from the list below, which impacts how the claim is paid.

Methods of COB:
Aggregate
Regular
Carve-out
Non Duplication
Modified-Aggregate

For claims paid by CareFirst and another insurance carrier, you will need to verify the member's type of COB coverage. You can obtain the member's COB coverage by calling Provider Services at 800-313-2223. If you confirm the member has Modified-Aggregate coverage, please apply the examples below to determine if correct secondary payment was received from CareFirst. You will also be able to confirm by matching up the payment from the primary insurance carrier with the CareFirst payment.

Example 1 - CareFirst allowed is the higher of:		Primary carrier paid:	40.00
Charge:	$100.00	CF Allowed benefit:	50.00
Primary carried allowed	40.00	Secondary payment:	10.00

Total combined payment:	50.00	Primary carrier paid:	80.00
Subscriber liability:	0.00	CF Allowed benefit:	50.00
Example 2 - <u>Other Insurance allowed</u> <u>is the higher of:</u>		Secondary payment:	20.00
		Total combined payment:	100.00
Charge:	$100.00	Subscriber liability:	0.00
Primary carrier allowed:	100.00		

Questions?

Please contact Provider Services at 800-313-2223 with any refund related questions.

PROVIDER REMINDERS

Behavioral Health Programs and Services – Your Patients Want to Hear From You

When we asked your patients, our members, to describe in one word their thoughts on behavioral health resources and programs, this is what they said[1]:

And, when we asked these same patients to tell us who their **#1 source** would be for more information on behavioral health resources and programs, they said YOU, their Primary Care Provider (PCP) [1].

With one in five Americans experiencing a behavioral health illness or substance abuse disorder each year, demand is growing for behavioral health and substance abuse services[2] for helping to manage the following: depression, drug or alcohol dependence, stress, work-life balance, eating disorders and more.

Together with Magellan Healthcare Provider Group[3], CareFirst offers specialized services and programs that you can recommend when your patients come to you for assistance. Through a variety of programs and one-

on-one support, Magellan's clinical and administrative resources can help your patients get the services and assistance they need to successfully follow your treatment plan to improve their health and quality of life.

Check out this flyer for specific Program details.

Have a patient who needs help now? There are two easy ways to refer:

CALL: 1-800-972-0718
EMAIL: mhpgpcp@magellanhealth.com

[1]*Responses taken from a CareFirst member survey conducted in August 2016.*

[2] *Mental Health By The Numbers (n.d.) Retrieved July 2016 from http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers*

[3]*Magellan HealthCare Provider Group is an independent medical group providing behavioral health services to CareFirst BlueCross BlueShield members.*

Medical Record Outreach – Can't Charge for Copies

CareFirst is Not Responsible for Associated Costs Related to Medical Record Retrieval

As we've shared in previous issues of BlueLink, CareFirst is conducting medical outreach for chart reviews in order to help validate health status for the purposes of the Affordable Care Act (ACA) Risk Adjustment Program.

The chart review process allows CareFirst to confirm that all medical records are documented completely and accurately, and that this information has correctly flowed through submitted medical claims. The chart review also helps us acknowledge that we are submitting complete and accurate data to Health and Human Services as required by the ACA Risk Adjustment Program.

Although you will not need dedicated office staff to support this effort, some of your staff will be required to retrieve the records for the purposes of this review. There will be no specific cost to you for this process; however, the retrieval process may require time from some of your office staff and you will be responsible for any associated costs that accompany the copying and/or mailing of medical records.

As a reminder, CareFirst provider contracts allow access to these records for this purpose at no cost to CareFirst. Therefore, CareFirst will not pay for copies of medical records or postage.

We thank you in advance for your help with these outreach efforts.

Translation Services Available to Assist with Effective Patient Communication

Do you have a patient in your office whose primary language is not English?

CareFirst now provides translation services through the AT&T Language Line at no charge for our practitioners and members. The AT&T Language Line provides assistance with languages ranging from Albanian to Vietnamese. If your patient requires interpretation services, contact CareFirst's Provider Services department to connect your office to the AT&T Language Line. The AT&T Language Line interpreters will analyze the

original message and select words that most accurately convey the true meaning of what is said[1]. Your office staff remains on the line during the call to take the lead and provide subject matter expertise.

[1] *Interpreters do no interpret word-for-word, but meaning-for-meaning.*

IN CASE YOU MISSED IT

- **Nov. 14, 2016 –** Learn about the updates before submitting your claims
- **Nov. 10, 2016** – New Modifiers Help Identify Claims Associated with Gender Dysphoria