

News You Can Use

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Mental Health Medication Management

*CareFirst no longer requires a Magellan authorization for medication management, procedure code 90862. This affects claims submitted on or after 1/1/2009.

FEP Requires an Authorization for all NICU Services

CareFirst has received numerous inquiries from hospitals regarding authorization requirements for Federal Employee Program (FEP) babies who receive Neonatal Intensive Care Unit (NICU) services. To eliminate confusion, the FEP policy is listed below:

FEP Policy:

Benefits are available for routine nursery care newborns during the covered portion of the mother's maternity stay. **If the infant requires definitive treatment**, including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's admission, **the newborn is considered a patient in his or her own right**. As such, the infant will require an authorization for the hospital stay and medical or surgical benefits will apply rather than maternity benefits.

Billing requirements:

When billing for NICU services, please use the following codes, as appropriate:

- Revenue code 173 – intermediate care; requires six to 12 hours of nursing each day.
- Revenue code 174 - intensive care; severely ill neonate requires constant nursing and continuous cardiopulmonary and other support.

All charges related to the baby's care must be submitted on a separate claim from the mother.

Authorizations:

All authorizations for NICU services must be called into the CareFirst Precertification Department, 1-866-PRE-AUTH (773-2884). Because these are newborn babies, there is no enrollment information on file and iExchange cannot be used.

1 of 4

News You Can Use

FEP Requires an Authorization for all NICU Services (cont'd)

Eligibility:

CareFirst will provide an authorization for the newborn at the time of service. The policyholder has 30 days to add the baby to the policy. If the baby is not added to the FEP policy within 30 days, CareFirst will retract the money paid for the NICU claim. The policyholder will need to provide the hospital with the updated insurance information. All of the baby's charges should then be billed to the appropriate carrier.

Lab Vendors that Limit the Patient's Liability

Members with PPO and Indemnity products with co-insurance and high deductible plans may realize a lower out-of-pocket expense if their outpatient laboratory services are provided by either of CareFirst's participating national independent laboratory providers, Laboratory Corporation of America, Inc. (LabCorp) or Quest Diagnostics, Inc. (Quest), compared to other providers, labs and/or facilities.

To obtain a list of Patient Service Centers or for additional information regarding the services they provide you may access their Web sites at www.labcorp.com or www.questdiagnostics.com.

Requirements for CareFirst BlueChoice HMO members have not changed.

Orthotics not covered for a Chiropractor under the Federal Employee Program (FEP)

Benefits are only provided for those medically necessary services that are considered "covered" under FEP and that are performed by providers acting within the scope of their licensure. The FEP brochure defines covered chiropractic services as the initial office visit, initial set of x-rays, and spinal manipulations. Orthotics is not a covered benefit when dispensed or prescribed by a chiropractor.

News You Can Use

Claims Adjudication Policy Updates

CareFirst and CareFirst BlueChoice should not usually receive claims with procedure codes specific to Medicare and Medicaid, or "Temporary National Codes" (Non-Medicare). Therefore, unless otherwise directed through [BlueLink](#) or other means of communication, providers should report services for our members using the standard CPT® codes instead of comparable Level II HCPCS codes. This includes, but is not limited to Medicare temporary G-codes; H and T codes which are specific to Medicaid; and non-Medicare "S" codes.

PLEASE NOTE: this policy does **not** apply to:

- Crossover claims which are reimbursed by CareFirst as secondary to Medicare
- Claims for DME, supplies, equipment, or drugs for which there is no comparable CPT® code

Reporting ICD-9-CM Diagnosis Codes

Adhere to coding guidelines as outlined in the most current ICD-9-CM coding book. Of particular importance are the following:

- Code to the highest level of specificity, to include 4th and 5th digits, as appropriate
- List the primary, or most important diagnosis for the service or Procedure, first
- Code chronic complaints only if the patient has received treatment for the condition
- When referring patients for laboratory or radiology services, code as specifically as possible and list the diagnosis that reflects the reason for requesting these services.

Claims that are not coded properly may be returned to the reporting provider, which will delay adjudication.

Additional information on claims adjudication and related policies is available in the CareFirst General Information Manual at www.carefirst.com

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Mental Health Seminars

The following new seminars are listed for mental health professionals. The material that we will cover is related strictly to professional mental health providers. Registration is required at www.carefirst.com in the provider and physician section under resources and seminars.

Date	Location	Room and Time
Wed., April 22, 2009	Providence Hospital 1150 Varnum St. N.E. Washington, D.C. 20017	Ross Auditorium - 10:00 a.m. to 1:00 p.m.
Tues., April 28, 2009	Holiday Inn Express- Hagerstown	Conference room - 10:00 a.m. to 1:00 p.m.

***Note:** For ease of communication, all references to “CareFirst” will refer to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., unless specified otherwise.