2024 Medicare Advantage

PROVIDER MANUAL

(formerly Medi-Pak® Advantage)

Please note: This document pertains to all Arkansas Blue Medicare Advantage networks and plans.

Arkansas Blue MEDICARE

An Independent Licensee of the Blue Cross and Blue Shield Association

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Welcome to the Medicare Advantage Provider Manual

Medicare Advantage Overview

Arkansas Blue Cross and Blue Shield is an authorized Medicare Advantage Organization that contracts with Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage and Part D prescription drug insurance plans in the market. Arkansas Blue Cross markets Medicare Advantage plans under Arkansas Blue Medicare. In 2024, Arkansas Blue Medicare will offer Medicare Advantage coverage to Medicare-eligible Arkansas residents.

Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single healthcare plan. This flexibility allows Arkansas Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit.

Disclaimer

Arkansas Blue Cross makes no representations or warranties with respect to the content hereof. Further, Arkansas Blue Cross reserves the right to revise this publication without obligation of the Medicare Advantage Organization to notify any person of such revision or changes.

Updates to any part of this manual may be made by Arkansas Blue Cross or by CMS at any time. Either Arkansas Blue Cross or CMS may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a letter to providers, publication in the Providers' News or other publications of Arkansas Blue Cross or CMS, or posting to either the Arkansas Blue Cross website, **www.arkansasbluecross.com**, Arkansas Blue Medicare website, **www.arkbluemedicare.com**, or the CMS website, **www.cms.gov** or through other forms of CMS-approved communications.

The Arkansas Blue Medicare Private Fee-for-Service (PFFS) Plan offered by Arkansas Blue Cross includes a network of doctors, other healthcare providers, and hospitals. In a PFFS Plan, members can see any of the network providers who have agreed to always treat plan members. Members can also choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but the member may pay more out-of-pocket for services provided out-of-network.

The Arkansas Blue Medicare Preferred Provider Organization (PPO) Plan offered by Arkansas Blue Medicare Plus includes a network of doctors, other healthcare providers and hospitals. In a PPO Plan, a member will pay less when using doctors, hospitals and other healthcare providers that belong to the plan's provider network. Members do have the flexibility to go to doctors, other healthcare providers or hospitals that are not in the plan's Medicare Advantage PPO network, but it will usually cost the member more out-of-pocket. Additionally, our PPO Travel Program enables Medicare Advantage PPO members traveling in certain states to use the networks of other participating Blue Cross and/or Blue Shield Medicare Advantage PPO plans.

The Arkansas Blue Medicare Health Maintenance Organization (HMO) Plans offered by Arkansas Blue Medicare, respectively, include a network of doctors, other healthcare providers and hospitals. In an HMO Plan, members generally must get your care and services from doctors, other healthcare providers or hospitals in the plan's network. Exceptions include emergency care, out-of-area urgent care or out-of-area dialysis.

Special Note: This manual is provided for the convenience of providers participating in any Medicare Advantage networks offered by Arkansas Blue Medicare. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs or supplies because coverage or noncoverage is always governed exclusively by the terms of the member's health benefit plan. Accordingly, in case of any question or doubt about coverage, providers should always review the member's particular health benefit plan.

Unless otherwise indicated, any reference in this manual to "company," shall be deemed to refer to Medicare Advantage plans offered by Arkansas Blue Medicare (HMO, PPO, PFFS) plan.

Regional Offices and Welcome Centers

The main office of Arkansas Blue Cross is located at Sixth and Gaines streets in downtown Little Rock. Arkansas Blue Cross operates full-service regional offices serving seven designated geographic areas of the state. The **Regional Offices** (headquartered in Fayetteville, Fort Smith, Hot Springs, Little Rock, Jonesboro, and Pine Bluff) offer sales and provider relations services to counties in their parts of the state. The Welcome centers are located in the aforementioned cities and also one located in Rogers, **https://www.arkansasbluecross.com/support/office-locations**.

Medical Directors

Office Location	Medical Director	Address	Phone
Arkansas Blue Cross Corporate Offices	Medicare Advantage Dr. Thomas Becker **tebecker@arkbluecross.com**	Arkansas Blue Cross 601 South Gaines St. Little Rock, AR 72203	(501) 396-4196
Arkansas Blue Cross Corporate Offices	Chief Medical Officer Dr. Mark Jansen **mtjansen@arkbluecross.com**	Arkansas Blue Cross 601 South Gaines St. Little Rock, AR 72203	(501) 378-2309

Medicare Network Specialists and Network Development Representatives

The **Medicare Network Specialists** serve as the dedicated Medicare Advantage provider relations representatives to assist with contracting, Star measures, risk training and education and support for the provider community.

The **Network Development Representative** (NDR) serves as the point of coordination for the provider network activities in the assigned region and supports on-going network operations. The NDR is accountable for maintaining a good effective working relationship with providers in the assigned regions, which includes contracting and education regarding Arkansas Blue Cross. The NDR is also responsible for assisting providers with specific inquiries and problems which have not been resolved by other inquiries.

How Members Contact Medicare Advantage

Need Insurance?

- If you are seeking individual or group insurance coverage, **contact us**.
- If you have any questions or comments about our website, you may contact us at 844-463-1088.

Contact Our Welcome Centers

Arkansas Blue Cross is committed to providing easy access to customers on the local level. We have seven full-service welcome centers to serve members.

- **Regional Offices:** Locate the regional office nearest you.
- **Welcome Centers:** Locate the welcome center nearest you.

Contact Us

Member Services	
CALL	Arkansas BlueMedicare: 844-463-1088 Calls to this number are free. Office hours are 8 a.m. to 8 p.m. CT Monday through Friday (April 1 through September 30), Sunday through Saturday, 8 a.m. to 8 p.m. CT (October 1 through March 31) and closed on Thanksgiving Day and Christmas Day. Customer Service also has free language interpreter services available for limited or non-English speakers.
TTY	711 This number is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Arkansas Blue Medicare P.O. Box 3648 Little Rock, AR 72203

To contact CMS directly:

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

The following list of telephone numbers is for physicians and medical practitioners:

Provider Services	Toll Free	TTY
Medicare Advantage Provider Service (Arkansas policies only) ID numbers begin with (example) XCX	1-800-287-4188	711 This number is only for people who have difficulties with hearing or speaking.
Member eligibility inquires • Benefits • Coordination of benefits information (if applicable) • Effective date of coverage • Effective date of termination (if applicable)	This information can also be accessed through: Availity https://apps.availity.com/availity/web/public.elegant.login	
Arkansas Blue Medicare: Arkansas Blue Medicare | P. O. Box 3648 | Little Rock, AR 72203-3648		

Contact Our Regional Offices

Arkansas Blue Cross is committed to providing easy access to customers on the local level. We have six full-service regional offices to serve you.

- **Regional Offices**: Locate the regional office nearest you.
- **Medicare Network Specialists**: Provide direct service and support for Medicare Advantage providers.
- **Network Development Representatives**: Service for healthcare providers.

In an effort to assist physician offices in obtaining proper eligibility, coverage and benefits information regarding Medicare Advantage members, a list of helpful reminders is provided below:

- When a member calls to schedule an appointment, please ask about insurance information.
- When a member arrives at your office, please ask to see their Medicare Advantage identification card.
- Maintain a current copy of the front and back of the member's identification card in their medical file.
- When possible, collect any copayments, coinsurance and deductibles the day services are rendered.
- File claims with Arkansas Blue Medicare within 365 days of the service even if Medicare Advantage is not the primary payer.

If a member does not have a valid identification card, providers may call our Customer Service department or access **Availity** to obtain the most current membership eligibility information available for Medicare Advantage member. However, to utilize Availity, the provider must have the member's name, date of birth and full Arkansas Blue Medicare member identification number including the three digit alpha numeric prefix.

Appointment standards

Arkansas Blue Cross have appointment standards for access and after-hours care to help ensure timely access to care for members, especially for PCP and Behavioral Health visits. Our standards and requirements are shown in the following table.

Types of Services	Standard Appointment Requirements
Regular/Routine Care	Within 30 calendar days
Preventive Care	Within 30 calendar days
Emergency Care	Immediately
Urgent Care	Same Day
After-Hours Care	24 hours/7 days a week

Availity

Arkansas Blue Medicare discourages the use of paper claims forms to submit professional and institutional claims. Providers are encouraged to enroll in **Availity** and submit claim files through one of the following methods:

- Secure file upload; directly sending claims from your practice management system to **Availity**
- Through a third-party clearinghouse
- Through direct data entry on the **Availity** portal

Note: Corrected claims can also be sent via these methods.

Availity is an industry-leading, HITRUST-certified healthcare information technology company that serves Arkansas Blue Medicare and its providers by offering a suite of dynamic products built on a powerful, intelligent platform. This portal helps to integrate and manage the clinical, administrative and financial claims data in real-time for Arkansas Blue Medicare in coordination and collaboration with their providers.

Claim Filing

Claims, including revisions or adjustments, that are not filed by a provider prior to the claim filing limit of 365 days from the date of service or the date of discharge will be the provider's liability.

The National Uniform Claim Committee approved a new version of the CMS-1500 Health Insurance Claim Form. Arkansas Blue Medicare currently accepts the revised CMS-1500 claim form. Professional claims must be submitted using the revised CMS-1500 Health Insurance Claim Form.

For more information, contact your **Medicare Network Specialist** or visit **NUCC.org**. The site includes instructions for completing the form.

Where to submit a claim

For paper claim submission, send claims to:

Arkansas Blue Medicare
P. O. Box 2181
Little Rock, AR 72203-2181

For electronic claim submission, please contact Availity Client Services representative at 800-AVAILITY (282-4548).

Availity

For questions, please contact an Availity Client Services representative at 800-AVAILITY (282-4548). Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m. (Eastern time zone).

Non-Arkansas providers bill your local Blue plan. Please see the Ancillary section of this manual (below) for more information. Report the alpha prefix to ensure correct routing of the claim.

If you have problems submitting claims to us or have any billing questions, contact our technical billing resources at:

Electronic and Paper Claims
Availity – Availity Client Services 800-AVAILITY (282-4548)
Non-Arkansas Providers – Contact your local Blue plan.
Paper Claims – P.O. Box 3648, Little Rock, AR 72203-3648
Arkansas Providers – Call Provider Customer Service at 800-287-4188
Non-Arkansas Providers – Contact your local Blue plan.

If you have questions about plan payments:

Arkansas Providers – Call Provider Customer Service at 800-287-4188. Non-Arkansas Providers – Contact your local Blue plan.

To perform a status inquiry on a Medicare Advantage claim you have two options:

1. Call Provider Customer Service at 800-287-4188; for 2020 claims, call 866-791-1342
2. Use **Availity**
3. Non-Arkansas providers – Contact your local Blue plan

Ancillary Claims

The Blue Cross and Blue Shield Association has clarified its rules pertaining to how independent laboratories, durable medical equipment suppliers and specialty pharmacies should submit claims in certain circumstances.

These rules also impact referring practitioners. Here are highlights:

- Independent labs should file claims with the plan in whose state the specimen was drawn (determined by where the referring physician is located).
- Durable medical equipment suppliers should file claims with the plan in whose state the equipment or supplies were shipped to (including mail order supplies) or purchased (if it was purchased at a retail store).
- Specialty pharmacies should file claims with the plan in whose state the ordering physician is located.

Rural Health Clinic Billing

If a service is performed at a Rural Health Clinic (RHC) and the service is payable to it as a RHC, the service should be billed to Arkansas Blue Medicare as a UB claim form.

If a service is performed at a RHC outside of its CMS all-inclusive rate, the service should be billed as a HCFA 1500 professional claim. Since there is not a cost settlement with Arkansas Blue Medicare, RHCs should bill the pneumococcal and influenza vaccine on as a HCFA professional claim.

The place of service code should represent where the actual service was performed. The following codes are examples of codes RHCs may utilize for the place of service:

72 - RHC (The service was performed in the RHC facility)
32 - Skilled Nursing Facility (SNF)
19 or 22 - Outpatient hospital
21 - Inpatient hospital

Coordination of Benefits

When Arkansas Blue Medicare is the secondary carrier, the benefits will be reduced by the amount paid by the primary carrier. The allowable expense is a service that is covered in full or in part by any of the plans covering the person. Non-covered expenses are not coordinated. Ultimately, it is the member's responsibility to ensure delivery of the EOB from the primary carrier to Arkansas Blue Medicare. However, if the provider receives the EOB from the primary carrier, he or she may forward it to Arkansas Blue Medicare for processing.

When Arkansas Blue Medicare is secondary, a provider has the right to collect the copayment deductible, or coinsurance and then coordinate benefits with the other carrier.

Please note: If Arkansas Blue Medicare is the secondary payer, providers should not submit a claim until they have received the primary payer's payment.

If the provider receives payment in excess of actual charges and has collected a copayment, deductible or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the copayment, deductible or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

If the provider contractually participates with other health plan(s), the privilege to collect a copayment may be affected by the agreement with the other health plan(s).

To file secondary claims electronically, reference the Electronic Claims section of this manual.

Corrected Claims

The Arkansas Blue Cross definition of a corrected claim is a claim that has been processed, whether paid or denied, and was refiled with additional charges, a different diagnosis or any information that would change the way that claim was originally processed. Placing the "Corrected Claim" indication on the claim form when it has not been previously processed will cause a delay in claim adjudication.

Claims returned requesting additional information are NOT to be refiled as corrected claims. These claims have been processed; however additional information is needed to finalize payment.

To submit an electronic corrected claim through Availity, use the Bill and Frequency Type codes listed below.

• 7 – Replacement of Prior Claim

If you have omitted charges or changed claim information (diagnosis codes, dates of service, member information, etc.), resubmit the entire claim, including all previous information and any corrected or additional information. Hospitals and facilities should include the seven in the third digit of the Bill Type. Physicians should submit with a Frequency Type code of seven.

• 8 – Void/Cancel of Prior Claim

If you have submitted a claim to Arkansas Blue Medicare in error, resubmit the entire claim. Hospitals and facilities should include the eight in the third digit of the Bill Type. Providers should submit with a Frequency Type code of eight.

Paper claims will follow the same as above, but the frequency code and the original claim number to be

replaced or voided should be entered into box 22 on the original CMS red and white claim form. If submitting unsolicited medical records for review, the Arkansas Blue Medicare records cover sheet is available by clicking the link **Medical Records Routing Form – MA** Medicare Advantage.

Paper Claims: Guidelines for Filing Paper Claims

Providers are encouraged to utilize the much faster, easier electronic claims processing capabilities available through **Availity** and EDI. However, if a provider must use paper claims, the following guidelines apply.

Guide to CMS-1500 Paper Claim Form for Professional Providers

These guidelines will help providers prepare claims for ImageNet scanning when filing paper claims for Arkansas Blue Medicare.

- **Align the form:** Please align the claim form carefully so that all data falls within the blocks on the claim form. The provider will be able to keep the form aligned if they center an "X" in the boxes at the top right and left corners of the claim. Please be sure that all line-item information appears on the same horizontal line. Claims will be returned if they are not properly aligned.
- **Dates:** Use an 8-digit format for all dates on the claim. For example, enter June 1, 2006 as 06012006. All dates must be valid dates. Some fields require an entry such as DOS, while others are optional.
- **Dollars and cents:** Please do not use dollar signs ($) in any block. Separate dollars and cents with a blank space. For example, enter $1,322.00 as 1332 00.
- **Forms:** Please do not fold, staple, or tape claims. Please separate all forms carefully.
- For providers using bursting equipment, adjust the splitters to precisely remove the pin feed edges. Claims must be submitted on the current CMS approved version of the CMS-1500 claim form printed with red "drop out" ink.
- Providers may obtain copies of the CMS-1500 claim form through various vendors such as the American Medical Association or the U.S. Government Printing Office.
- **Keep it clean:** Do not print, write or stamp extra data on the claim form. When correcting errors, use white correction tape only and not white correction fluid.
- **Lines of Service (Block 24):** Limit the lines of service to six lines on each claim filed. Placing information in the shaded areas as shown on the NUCC site should be as "FYI" only since the data may not image properly. Arkansas Blue Medicare does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.
- **Names:** For all blocks requiring names, please omit any titles, such as Mr. or Mrs. Enter the last name first, followed by a comma, and then the first name – Last Name, First Name. (For example: Doe, James).
- **Print quality:** Providers can help ensure that paper claims are accurately processed by checking the quality of the print carefully. Faint printing can cause scanning problems. Please replace printer ribbons or toner regularly and be sure to use the highest quality print setting available.
- **Ribbons and fonts:** Use only black ribbons in typewriters or printers and change the ribbons frequently. Although claims can be accepted using a 12-pitch setting, please use a 10-pitch setting. If software supports fonts, please use Courier 10 Monospace font.

By following these guidelines, providers will assist Arkansas Blue Medicare in meeting its goal of efficient and accurate claims processing.

Rejected Claims
As part of the change in claims processing, all paper claims are now processed through "front-end" edits that verify eligibility information. Claims that cannot be scanned by ImageNet will be returned to the provider with an accompanying explanation. Providers will receive a letter for claims that the ImageNet rejects. Please verify the information on the patient's insurance card prior to submission.

Submit the unacceptable claims as **new** claims. Do not resubmit unacceptable claims as "corrected claims." Unacceptable claims are rejected prior to acceptance into Arkansas Blue Medicare adjudication system, therefore there is no "original" claim to correct on the Arkansas Blue Medicare system.

Common Causes of Paper Claim Delays or Returns
- National Provider Identifier missing in blocks 17B, 32A and 33A
- Invalid Place of Service and Type of Service codes
- Invalid CPT or ICD–9/ICD-10 codes
- Misaligned information on the form. Make sure your information is inside the form blocks.
- Narrative text in numeric fields on the CMS-1500 (HCFA) form
- Handwritten claims
- Alpha characters in number fields
- Invalid member number

Reminder of Printing Guidelines for Paper Claims
Arkansas Blue Medicare encourage providers to file claims electronically since electronic claims are processed faster and more accurately than paper claims. However, if a paper claim form is used, certain guidelines must be followed before the paper claim can be accepted. To ensure the paper claim is accepted and the claims data is read accurately, providers should adhere to the following guidelines:

- Use only red Form CMS-1500 and red Form UB-04 that conform to CMS guidelines.
- Align the form carefully so that all data falls within the blocks on the claim form. Please be sure that all line-item information appears on the same horizontal line.
- Do not hand write claim information. Claim information must be printed or typed with black ink. Remember to regularly change your printer ribbon or ink cartridges.
- Keep the form clean by not printing, writing or stamping extra data on the form. Please refrain from using correction fluid or correction tape. If an error occurs while completing the claim, please complete a new, red claim form for submission.
- Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks or parentheses.
- The recommended font for Form CMS-1500 is 12-point Courier New set at 10 characters per inch (10-pitch), six lines per inch. The recommended font for Form UB-04 is 10-point Courier New set at 10 characters per inch (10-pitch) and six lines per inch.
- Please separate all forms carefully. Do not fold, staple or tape claims. Do not place any stickers on the claim form. Remove any pin-feed edges from any continuous feed forms.

Since ImageNet technology is used to convert paper claims to electronic data, paper claim forms that do not comply with these guidelines or are printed too light to be successfully read by ImageNet equipment may be rejected.

Paper Claims: Step-By-Step Instructions

The following information is designed to help providers complete the new CMS-1500 claim form which is mandated by the National Uniform Claim Committee (NUCC) to meet the requirement for all providers to have a NPI number. Only submit paper claims if electronic claim submission isn't possible.

Note: Effective January 1, 2007, all fields indicated as REQUIRED in the following guide must be completed or the claim will be returned to the provider.

Block 1A – Insured's I.D. Number (REQUIRED):

Enter the patient's current identification number exactly as it appears on their identification card, including the appropriate three letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in the processing or denial of the claim.

Block 2 – Patient's Name (REQUIRED):

Enter the patient's last name followed by a comma and the first name in all capital letters. An entry in this block is required. Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), titles (such as Mr. or Mrs.) or any other marks of punctuation besides the comma. For example, enter Mrs. Mary O'Hara as "OHARA, MARY."

Block 3 – Patient's Date of Birth and Sex (REQUIRED):

Enter the patient's birth date (MM DD CCYY) and sex. A space must be reported between month, day, and year. Entry in both the date of birth and sex is required.

Block 4 – Insured's Name (REQUIRED):

Enter the last name of the policyholder or subscriber, followed by a comma and the first name. Please enter this name exactly as it appears on their card. Do not include any apostrophes, hyphens, suffixes (like Jr. or Sr.), titles (such as Mr. or Mrs.) or any other marks of punctuation besides the comma. For example, enter Mary O'Hara as "OHARA, MARY." Using the terms "same" or "self" may result in a claim being rejected.

Block 5 – Patient's Address:

Fill out this block only if the patient's address is different from the insured's address, in Block 7, and please enter no more than 28 characters in this field.

Block 6 – Patient's Relationship to Insured (REQUIRED):

Check the appropriate box for patient's relationship to the insured. Enter an "X" in one of the following boxes:

- Self – the patient is the subscriber or insured
- Spouse – the husband or wife or qualified partner as defined by the insured's plan
- Child – minor dependent as defined by the insured's plan
- Other – stepchildren, student dependents, handicapped children and domestic partners

Block 7 – Insured's Address and Telephone:

Enter the insured's address and telephone number.

Block 9 (A-D) – Other Insured's Name and Other Information (REQUIRED):

If the patient is covered under another health benefit plan including Arkansas Blue Medicare, please enter the full name of the policyholder and include all the following information in Blocks 9 (A-D).

- Other insured's Policy or Group Number (Note: Do not use a hyphen or space within the policy or group number)
- Other insured's Date of Birth and Sex
- Employer's Name or School Name
- Insurance Plan or Program Name

Block 10 (A-C) – Patient's Condition Related to?

For each category (employment, auto accident and other), insert an "X" in either the YES or NO fields. If any "YES" fields are selected, Block 14 must be populated with the accident date. The appropriate postal abbreviation for the STATE must be supplied if an AUTO ACCIDENT.

Block 11 – Insured's Policy, Group or FECA Number (REQUIRED):

Enter the insured's current identification number exactly as it appears on their identification card, including the appropriate three-letter alpha prefix. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in processing or denial of the claim.

Block 11A – Insured's Date of Birth, Sex (REQUIRED):

Enter the 8-digit date of birth (MM/DD/CCYY) of the insured and an "X" to indicate the sex of the insured.

Block 11D – Is There Another Health Benefit Plan?

Enter an "X" in the appropriate box. If marked "Yes," complete Block 9 and Block 9 (A-D).

Block 14 – Date of Current Illness, Injury or Pregnancy:

Injury - Enter date the accident occurred; if any YES fields are marked with an "X" in Block 10 (A-C) then Block 14 must populated with the accident date.

- Illness - Enter for acute medical emergency only and include onset date of condition;
- Pregnancy - Enter date of the last menstrual period (LMP) as the first date.

Block 17 – Name of Referring Physician or Other Source:

Enter the name (First Name, Middle Initial, and Last Name) and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas within the name.

Block 17B – National Provider Identifier (NPI) (REQUIRED):

Enter the NPI of the referring provider, ordering provider, or other source in 17B.

Note: Now required for claims filed May 23, 2007 or later.

Block 18 – Hospitalization Dates Related to Current Services:

Enter admission and discharge dates for inpatient hospitalization related services.

Block 19 – Reserved for Local Use.

Block 20 – Outside Lab Charges:
If laboratory work was performed outside a provider's office, enter the laboratory's actual charge to the provider. If the laboratory bills Arkansas Blue Medicare directly, enter an "X" in the "NO" box.

Block 21 (1-4) – Diagnosis and/or Nature of Illness or Injury (REQUIRED):
Enter the appropriate ICD-9/ICD-10 diagnosis code (up to five digits) for the services performed. Do NOT use any punctuation such as a decimal.

Block 22 – Medicaid Only.

Block 23 – Prior Authorization Number:
Enter any of the following as assigned by the payer for the current service:
- Prior authorization number
- Referral number
- Mammography pre-certification number

Block 24 – Supplemental Information:
The following are types of supplemental information that can be entered in the shaded areas of item number 24.

- National Drug Codes (NDC) for drugs – must have N4 qualifier followed by 11-digit NDC code – do not put a space between the qualifier and code; do not use hyphens in the code.
- Placing the following information in the shaded areas as shown on the NUCC site should be as "FYI" only since the data may not image properly. Arkansas Blue Medicare does not recommend the use of this free form line. However, if it is used, it is critical that the right qualifiers be used.
- Narrative description of unspecified codes must have a "ZZ" qualifier followed by the code description – do not put a space between the qualifier and the code.
- From the NUCC website:
- "To enter supplemental information, begin at Block 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code."

Block 24A – Date(s) of Service (REQUIRED):
Enter date(s) of service, from and to. If only one date of service, enter that date under "From." Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charges and individual provider for each line must be identical for that service line. Grouping is only allowed for services on consecutive days. The number of days must correspond to the number of units in 24G.

Block 24B – Place of Service (POS) Code (REQUIRED):
Enter the appropriate two-digit code from the "Place of Service" list from the CMS web site for each item used or service performed. The "Place of Service" identifies the location where the service was rendered. POS 11 = Office

Block 24C – EMG Emergency Indicator:
Enter "N" for NO and "Y" for YES in the bottom, unshaded area of this field.

Block 24D – Procedures, Services or Supplies (REQUIRED):
Enter the CPT/HCPCS code(s) and applicable modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers. The specific procedure code(s) must be shown without a narrative description unless it is an "unlisted" procedure code. If "unlisted" an NDC or description must be shown in the shaded area for that line.

Block 24E – Diagnosis Pointer (REQUIRED):
Enter the line-item diagnosis code pointer(s) referencing the appropriate diagnosis code(s) reported in Block 24D. Do not use a range, list primary diagnosis for the service line first. (1, 2, 3 not 1-3).

Block 24F – Charges (REQUIRED):
Enter the charge for each listed service.

Block 24G – Days or Units (REQUIRED):
Enter the units of service rendered for the procedure. Anesthesia services and "special" procedure codes require time in units format. **Note:** Must be whole number.

Claims submitted for anesthesia services by anesthesiologists or CRNAs must indicate the actual total number of minutes that anesthesia was administered. For example, if anesthesia was performed for one hour and 22 minutes, this would be indicated as 82 minutes in block 24G of the CMS-1500 claim form. If no units are indicated on the claim, the claim will be denied.

Block 24J – Rendering Provider ID Number (REQUIRED):
The individual provider rendering the service should be reported in Block 24J. The original fields for Block 24J and 24K have combined and re-numbered as Block 24J. Enter the NPI number in the unshaded area of the field. **Note:** NPI is required on claims filed on May 23, 2007 or later.

Block 25 – Federal Tax ID Number:
Enter the provider of service's or supplier's federal tax ID (employer identification number) or Social Security number. Enter "X" in the appropriate box to indicate which number is being reported. Only one box can be marked.

Block 26 – Patient's Account Number:
Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Block 27 – Accept Assignment? (REQUIRED):
Enter an "X" in the correct box. Only one box can be marked. "Accept Assignment" indicates the provider agrees to accept assignment under the terms of the Medicare program.

Block 28 – Total Charge (REQUIRED):
Enter the sum of all line charges.

Block 29 – Amount Paid:
Enter the total amount the patient or other payers paid on the covered services only. Attach a copy of the other insurer's explanation of benefits (EOB) and complete Block 9.

Note: If Arkansas Blue Medicare is the secondary payer, providers should not submit a claim until payment is received from the primary payer.

Block 31 – Signature of Physician/Supplier:
Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter the eight-digit date (MM/DD/CCYY), or alphanumeric date (e.g., January 1, 2022) the form was signed.

Block 32 – Service Facility Location:
Enter the name, address, city, state and zip code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, zip code and state when billing for purchased diagnostic tests. When more than one supplier is used, a separate CMS-1500 claim form should be used for each supplier.

Block 32A – National Provider Identifier (NPI):
Enter the National Provider Identifier (NPI) number of the service facility.

Block 33 – Physician's or Supplier's Billing Name, Address and Phone:
Enter the provider's or supplier's billing name, address, zip and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

- 1st line – Name
- 2nd line – Address
- 3rd line – City, State, and Zip Code

Block 33A – National Provider Identifier (NPI):
Enter the "pay to" National Provider Identifier (NPI) number of the billing provider in Block 33A.

UB-04 Processing Information
Arkansas Blue Medicare relies on the proper coding to process provider claims and adjudicates the member's benefits. The codes providers select and enter on claims are representations to us that the member's treatment (and your bill) was for the coded diagnosis, not others, and that the provider, in fact, performed the procedures as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Healthcare Procedural Coding System Manual (HCPCS). Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation or other remedial actions.

Claims Filing Information
Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at www.nubc.org.

Scanning UB 04 Claim Forms
Arkansas Blue Medicare is now scanning the UB 04 claim form (CMS-1450). From our experience with scanning, the following items commonly cause claims to be delayed or rejected on UB 04 claims:

- All data must be contained within its defined area
- All dollar fields should be blank or have real values
- Do not include $ or decimal points when reporting charges
- Do not handwrite or put comments on claims

Most Common Errors
This process has also allowed us to process UB 04 claims through edits on the front end before they enter the claim system. From our experience with scanning, we recommend the following based upon common reasons for claims to be rejected on UB04 claims:

- No Source of Admission code in Form Locator 15
- No Patient Status code in Form Locator 17
- No Provider Number in Form Locator 56 and 57

Form Instructions
The UB 04 manual is our guide for completing this form.

DATES – Box 6, 10, 12, 31-36, 45 and 74-74E. All date fields except Box 10 should be filled out as "MMDDYY." Do NOT use "/ -" or spaces to separate month, day or year. Always put a zero in front of single-digit days or months. Box 10 (birthday) should have a four-digit year.

BOX 1 – Provider's Name and Address: Do NOT type information above Box 1. Always place phone number as last line in this box. Format expected: Line 1 – provider's name; Line 2 – provider's street address; Line 3 – provider's city, state and zip (5 or 9 positions); Line 4 – provider's phone (7 or 10 positions).

BOX 3a – Patient Control Number: Should start on left side of box. Numbers next to bill type can become part of bill type.

BOX 8 a and b – Patient's Name/ID: Enter in 8a the patient's ID and in 8b the patient's last, first and middle initial. No commas, periods or titles.

BOX 9 a-e – Patient's Address: Enter the patient's street address (9a), city (9b), state (9c), zip codes (5 or 9 digits) (9d), and country (9e). Do not use separators such as semi-colons, use spaces.

BOX 38 – Responsible Party's Name and Address: Line 1 – Name (last name, first name) and initial. No periods, commas or titles. Line 2 – Address (street or apt, etc.) Line 3 – Can be a second street, box etc. Line 4 – City, state and zip (5 or 9). Do not enter phone numbers. Phone numbers distort OCR and there is no place to store them on the NSF records.

BOX 46 – Service Units: Enter whole numbers only up to seven numeric digits. Fractions and decimals are not allowed.

BOX 50 – Payer Name: Enter payer's name, left-justified. If Medicare is the primary payer, enter "Medicare" on the line. (Line A – Primary Payer, Line B – Secondary Payer, and Line C – Tertiary Payer)

BOX 56 – National Provider Identifier (NPI): Please left-justify.

BOX 58 – Insured's Name: Enter the last, first and middle initial of the insured. Do not use periods, commas or titles. (Line A – Insured's Name Primary, Line B – Insured's Name Secondary, and Line C – Insured's Name Tertiary)

For complete **instructions on the UB-04 form**, visit the CMS web site at **www.cms.hhs.gov**.

Black UB-04 Claim Forms No Longer Accepted

Beginning October 1, 2012, paper claims submitted on black UB-04 (CMS-1450) claim forms will be returned to the provider. Paper facility claims should be submitted on the standard UB-04 claim form with red "drop out" ink. These may be obtained through various print vendors that comply with National Uniform Billing Committee (NUBC) specifications. Arkansas Blue Medicare recommends providers to submit claims electronically and avoid using paper claim forms whenever possible.

UB-04 Claim Data Element Specifications

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at **www.nubc.org**.

Timely Filing Requirement

Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis (including those services for which the charge is related to cost). The timely filing period for both paper and electronic Medicare claims, is one calendar year (365 days) from the date on which the services were provided.

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, Federal non workday or legal holiday, the claim will be considered filed timely if it is filed on the next workday. Also note that a claim received by the contractor more than one year after the service has been rendered is subject to a 10 percent reduction. The 10 percent reduction amount may not be charged to the beneficiary. When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination." As such, the determination that a claim was not filed timely is not subject to appeal.

Proof of Timely Filing

Documents submitted as proof of timely filing will only be accepted if computer-generated and contain the following information (additional information may be required on a case by case basis):

- Physician or facility name
- Patient's name and member ID#
- Date of service
- Charged amount
- CPT code
- Date claim was originally filed/resubmitted
- Insurance filed is listed as Arkansas Blue Medicare (Insurance codes are not acceptable unless a memo accompanies the printout describing the code)
- If the insurance filed shows a plan other than Arkansas Blue Medicare, a memo should be attached indicating when the provider was notified that the member had other insurance and any circumstances that caused the delay in filing with the correct or the delay in checking the status of the claim. These cases will be reviewed. If the member did not notify the provider of the correct insurance plan, the claim should not be filed and the member can be billed.

If a provider attached a claim correction form to the claim with proof of timely filing, this can expedite the process since the scanning system should halt the claim for review.

The following will not be accepted as proof of timely filing

- Handwritten notes indicating date the claim was filed
- Computer notes with incomplete information

- Insurance codes with no explanation
- Proof of timely filing with a date of service past the required filing period; (Extenuating circumstances may be reviewed by attaching a memo)
- Dates on the bottom of the claim submitted as proof

If Arkansas Blue Medicare is secondary, the timely filing starts from the primary carrier's Remittance Advice date of payment or denial.

Examples of High Claims Rejections
Box 9a and Box 1a should not contain the same contract number or Box 9 contained a name but the policy number in box 9a was missing or was only 1 character long.

Patient and Subscriber information matched but relationship code was not marked as self.

Rendering Provider NPI (National Provider Identification number) is missing, not valid or is not registered with Arkansas Blue Cross and Blue Shield.

Please resubmit with a valid diagnosis code. Patient and Subscriber are the same but Dates of Birth are different.

A valid identification number for this patient is invalid/missing or was blank.

Please resubmit with a date of accident, first symptom or pregnancy LMP for each service.

Date – Admission is missing. It is required on all inpatient claims and some outpatient claims as defined by NUBC.

The Claim resubmission code was blank or "1" but contained an original REF (claim) number.

Please verify that the information on the service line is correct (e.g., date of service, type of service, place of service, procedure codes, diagnosis codes, charges, days/units and reserved for local use).

A valid identification number for this patient is invalid/missing or was blank.

Please resubmit with a valid diagnosis code.

Box 17 Referring Provider Name was completed but Referring Provider NPI (National Provider Identification number) is missing in box 17b.

When place of service is 41 or 42 the pickup and drop off locations are required in box 32.

Other Insurance Last Name is blank but Policy/Group Number was populated.

Reimbursement Methodology

Arkansas Blue Medicare reimburses network providers at the reimbursement level stated in the provider's Provider Participation Agreement minus any member-required cost sharing, for all medically necessary services covered by Original Medicare or an enhanced Arkansas Blue Medicare benefit.

Arkansas Blue Cross processes claims in accordance with Original Medicare guidelines. Providers must bill Arkansas Blue Cross in the same manner they bill Original Medicare (e.g., if an RHC or FQHC with original Medicare, you must file Arkansas Blue Cross as an RHC or FQHC). Arkansas Blue Cross will not reimburse providers for services that are not covered under Original Medicare, unless such services are specifically listed as covered services under the member's particular Medicare Advantage health benefit plan.

Arkansas Blue Cross must also comply with all applicable CMS Original Medicare manuals, instructions, directives and guidance, including Medicare national coverage determinations, Medicare local coverage determinations, general coverage guidelines and written coverage decisions of the local Medicare administrative contractor.

Providers should follow all applicable Original Medicare guidelines and include the following on all claims:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, you must supply all applicable digits.
- National coding guidelines are accessible **here**.
- Medicare Part B supplier number, national provider identifier and federal tax identification number.
- The member's Medicare Advantage number, including the alpha prefix, found on the member's ID card.
- For paper claims, the provider's name should be provided in Box 31 of the CMS-1500 claim form.

Member Financial Obligations

In most situations, Medicare Advantage members will be responsible for part of a provider's bill for services; and, as the provider agreement with Arkansas Blue Medicare outlines, providers will not waive these member financial responsibilities, (e.g., the member copayment, coinsurance and deductible) as specified in the member's health plan or contract.

Non-Covered Services

Members will generally be exclusively responsible for any non-covered services provided. As specified in the provider agreement, providers may not bill members for services that do not meet Medicare Coverage criteria (e.g., experimental/investigational).

Please note that except for applicable copayment, coinsurance or deductible, providers are **not** permitted to request or require payment in advance by any of Medicare Advantage members or from anyone else as a condition of providing services to members.

Billing

Providers are **not** permitted to "balance bill" a member for amounts in excess of the Medicare allowance (member copayment, coinsurance and deductible are deemed part of the allowance for this purpose and should be billed to the member) for covered services. Providers are also responsible for any billing or collection service activities that they may engage, or to whom a provider may assign any accounts

receivable or other claims against Medicare Advantage members.

If Arkansas Blue Medicare finds that a provider, billing service, collection agency or other agent engaged by a provider has improperly attempted to bill any member or collect any amounts from members in violation of the provider agreement or the guidelines in this Provider Manual, providers are obligated to promptly take all necessary steps to halt any such activity, to ensure that it is not repeated and to reimburse Arkansas Blue Medicare and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency or other agent. Providers may also be excluded or removed from the network for failure to adhere to the member "hold harmless" agreement.

CMS prohibits billing members in the **Qualified Medicare Beneficiary (QMB) Program**. The QMB Program serves members enrolled in Original Medicare or a Medicare Advantage plan with a supplemental State Medicaid plan covering Medicare deductibles, coinsurance and copayments under certain circumstances. Federal law prohibits Medicare Advantage (MA) providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program.

Copays
The Centers for Medicare and Medicaid Services (CMS) Medicare managed care manual provides guidance on acceptable cost-sharing. The following indicates benefits and beneficiary protections:

- The 50% cap on Original Medicare services: For an Original Medicare in-network or out-of- network item or service category to be considered a plan benefit, plans may not pay less than 50% of the contracted (or Medicare allowable) rate and cost-sharing for services cannot exceed 50% of the total MA plan financial liability for the benefit. Consequently:
  1. If a plan uses a coinsurance method of cost-sharing, then the coinsurance for an in-network or out-of-network service category cannot exceed 50%.
  2. If a plan uses a copay method of cost-sharing, then the copay for an out-of-network original Medicare service category cannot exceed 50% of the average Medicare rate in that area.

Refunds

While all parties strive for accurate claim adjudication on the first pass, occasionally adjudication mistakes are detected that result in the need to adjust the amount paid.

In order to "close" patient accounts timelier, Arkansas Blue Cross, Arkansas Blue Medicare will initiate the recovery within approximately 10 days assuming the provider has claims payments to cover any, or all, of the overpaid amount. If the provider does not have claim payments sufficient to cover the overpayment during a 90-day period, Arkansas Blue Cross, Arkansas Blue Medicare will send a follow-up letter requesting a check for the overpaid amount.

Please note that if Arkansas Blue Cross, Arkansas Blue Medicare must offset to recoup duplicate or erroneous payments (overpayments) made to providers, providers are not allowed to pursue collection of such offset amounts from the members against whose claims such offsets are made.

Minimize the Time Required to Process a Claim Refund

To minimize the time required to process a claim refund and to ensure that your 1099 earnings are adjusted accurately:

- When sending us a requested refund: Please return the remittance copy of the refund request letter

along with the check.

- When sending us an unrequested refund: It is not necessary to return the original check and the entire explanation of payment if just one or two patient claims are paid incorrectly.

Please enclose copies of the remittance advice/explanation of payment pages with the claims paid in error highlighted and a notation of the reason for the refund or enclose the following information for each claim paid in error:

1. Reason for the refund
2. Patient name
3. Patient ID number
4. Date of service
5. Amount 6. Provider name (pay to)
6. NPI (pay to)
7. TIN (pay to)

If the provider is not returning the original check, a separate refund check for each line of business is preferred. A provider's 1099 earnings can only be corrected if Arkansas Blue Cross has the specific provider name, NPI, and EIN. If a provider uses the services of a third party for these financial transactions, please instruct the third party administrator to provide this information on each refund.

The following are the correct addresses to use for claim refunds:

Arkansas Blue Cross and Blue Shield
Medicare Advantage
P.O. Box 2099
Little Rock, AR 72203

Remittance Advice

A Remittance Advice will accompany the reimbursement from Arkansas Blue Cross and/or Arkansas Blue Medicare for services rendered to our members. The standard Remittance Advice also provides line-by-line detail. If a provider uses a billing service, please send copies of the Remittance Advice to the billing company. Most of the column headings on the Remittance Advice are self-explanatory.

Medical Policy

Arkansas Blue Medicare Medical Policies identify the clinical criteria for determining when services are considered 'medically reasonable and necessary.' CMS requires Arkansas Blue Medicare Coverage to provide the same medical benefits to Medicare Advantage members as Original Medicare. As such, whenever possible, Arkansas Blue Medicare Coverage Medical Policies are based on Medicare coverage manuals, National Coverage Determinations (NCDs), and/or Local Coverage Determinations (LCDs). If there is no applicable NCD or LCD for the service under review, then other evidence-based criteria may be applied. Medical Policy applies to Medical and Part B medication services requiring prior authorization, medical policies may be made available to providers upon request.

Policy Hierarchy

The following hierarchy is used to determine Arkansas Blue Medicare Medical Policy (some services may require references from more than one tier of the hierarchy):

CMS Coverage Manuals or other CMS-based Resource

Arkansas Blue Medicare is expected to stay apprised of new and/or changing Medicare Part A and Part B coverage policies, which include various CMS sources. Examples include the Medicare Managed Care Manual, outlining statutory provisions governing the MA and Part D program requirements.

National Coverage Determinations (NCD)

For some services, procedures, and technologies, CMS has developed an NCD, which is to be applied on a national basis for all Medicare beneficiaries. NCDs are binding on all Medicare Advantage plans.

Local Coverage Determinations (LCD)

When there is no NCD or other coverage provision outlining medical necessity criteria within a Medicare manual, or when there is a need to further define an NCD, then the Medicare Administrative Contractor (MAC) for a service area may develop a policy (LCD) or article (LCA).

Arkansas Blue Medicare utilizes Novitas Solutions, Inc., (Novitas) as the Medicare Administrative Contract (MAC) Jurisdiction H (JH), which spans Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas and includes Indian Health Service (IHS) and Veterans Affairs (VA) nationally.

Novitas may provide coverage or non-coverage guidance in a Part B News Article published on the **https://www.novitas-solutions.com/webcenter/portal/NovitasSolutions** website. Thus, these articles may be used in Medicare Advantage medical policy development, even though they are not in the form of an LCD or an LCA.

Medicare Part B Step Therapy

The Arkansas Blue Medicare Preferred Drug List encourages utilization of clinically appropriate and lower net cost products within the following therapeutic drug classes. The Preferred Drug List applies to the listed products only and other products may be available under the plan's medical benefit.

The listed preferred products must be used first. An exception process is in place for specific circumstances that may warrant a need for a non-preferred product. For example, this step therapy requirement does not apply to the plan's members who are actively receiving treatment with non-preferred products.

This list can also be found at: Medicare Part B Prior Drug Authorization Policies - Arkansas Blue Cross and Blue Shield - **https://www.arkansasbluecross.com/providers/medical-providers/medicare/part-b-prior-authorization-policies**

Drug Class	Non-Preferred Products(s)	Preferred Product(s)
Alpha-1 Antitrypsin Deficiency	Aralast Glassia Zemaira	Prolastin-C
Antimetabolites	Alimta Pemfexy	Pemetrexed
Autoimmune Infused/Infliximab	Infliximab Remicade	Avsola Inflectra Renflexis
Autoimmune Infused/Other	Actemra Cimzia Ilumya Orencia Stelara	Entyvio Simponi Aria
Avastin/Biosimilars (Oncology)	Alymsys Avastin Vegzelma	Mvasi Zirabev
Botulinum Toxins	Botox Myobloc	Dysport Xeomin
Breast Cancer Mab	Perjeta	Phesgo
Complement Inhibitors (aHUS, gMG, PNH)		Soliris Ultomiris
Complement Inhibitors (NMOSD)	Uplizna	Soliris
Hematologic, Erythropiesis - Stimulating Agents (ESA)	Epogen Mircera Retacrit	Aranesp Procrit

Drug Class	Non-Preferred Products(s)	Preferred Product(s)
Hematologic, Neutropenia, Colony Stimulating Factors - Long Acting	Fylnetra Nyvepria Rolvedon Stimufend Udenyca Ziextenzo	Fulphila Neulasta
Hematologic, Neutropenia, Colony Stimulating Factors - Short Acting	Granix Leukine Neupogen	Nivestym Releuko Zarxio
Hematopoietic Agents - Iron	Feraheme Injectafer Monoferric	Ferrlecit Infed Sodium Ferric Gluconate Venofer
Hemophilia Factor VIII - Recombinant	Advate Afstyla Kogenate Novoeight Nuwiq Recombinate Xyntha Xyntha Solofuse	Kovaltry
Hemophilia Factor IX - Recombinant		Alprolix Idelvion
Immune Globulin - IV	Asceniv Bivigam Gammagard Liq. Gammaplex Panzyga	Flebogamma Gammaked Gamunex-C Octagam Privigen
Immune Globulin - SC	Cutaquig Cuvitru HyQvia Xembify	Hizentra
Lysosomal Storage Disorders - Gaucher Disease	VPRIV	Cerezyme Elelyso
Mitotic Inhibitors	Abraxane	Docetaxel Paclitaxel
Multiple Myeloma Proteasome Inhibitors	Empliciti Kyprolis Sarclisa Velcade	Bortezomib
Multiple Sclerosis (Infused)	Briumvi Lemtrada	Ocrevus Tysabri

Drug Class	Non-Preferred Products(s)	Preferred Product(s)
Osteoarthritis Viscosupplements - Multiinjection	Euflexxa Gelsyn-3 GenVisc Hyalgan Hymovis Supartz FX Triluron TriVisc Visco-3	Orthovisc Synvisc
Osteoarthritis Viscosupplements - Single Injection	Gel-One Monovisc	Durolane Synvisc-One
Osteoporosis - Bone Density	Evenity	Prolia Zoledronic Acid
Osteoporosis - Hypercalcemia of Malignancy	Xgeva	Pamidronate Zoledronic Acid
PD1/L1 Immune Checkpoint Inhibitors - Basal Cell & Squamous cell	Keytruda	Libtayo
PD1/L1 Immune Checkpoint Inhibitors - NSCLC	Imfinzi Keytruda Opdivo Tecentriq	Libtayo
Prostate Cancer - Luteinizing Hormone Releasing Hormone (LHRH) Agents	Camcevi Lupron Depot Trelstar Zoladex	Eligard
Prostate Cancer - Luteinizing Hormone Releasing Hormone (LHRH) Antagonists Agents		Firmagon
Retinal Disorders Agents - (ARMD) Age-Related Macular Degeneration	Beovu Cimerli Eylea Susvimo Vabysmo	Avastin Byooviz Lucentis
Rituximab	Riabni Rituxan Rituxan Hycela	Ruxience Truxima
Severe Asthma	Cinqair Nucala Tezspire	Fasenra Xolair
Somatostatin Analogues	Signifor LAR Somatuline Depot	Lanreotide Acetate Sandostatin LAR Depot
Trastuzumab	Herceptin Herceptin Hylecta Herzuma Ontruzant	Kanjinti Ogivri Trazimera

Step therapy prior authorization process

The step therapy prior authorization process evaluates whether the drug is appropriate for the individual member, taking into account:

- Applicable Medicare coverage determination guidance
- Dosage recommendation from the FDA-approved labeling
- Terms of the member's benefit plan
- Trial and failure of preferred products
- The member's treatment history

For Medical Non-Oncology Indications or for Non–EviCore Delegated Oncology Reviews:

Providers request precertification or step therapy review by:

- Accessing **https://www.arkansasbluecross.com/providers**
- Click **Forms tab**
- Scroll down to **Medicare Advantage Prior Authorization for the PA form**.
- Fax Part B Medication prior authorization form to **816-313-3015**

Providers requiring help may contact the Precertification Team at **833-732-1105**.

For Medical Oncology Indications or for EviCore–Delegated Reviews:

Providers request precertification or step therapy review by:

- Accessing the precertification list at **https://www.evicore.com/resources/healthplan/arkbluecross**
- Submitting a request via Providers Hub at **https://www.evicore.com/provider** or calling **800-646-0418** (option #4) (encouraged for urgent treatment requests)

Determination and review timeline

We will complete our review of prior authorization or pre-service coverage determination requests for Part B drugs within 72 hours for standard requests or within 24 hours for expedited requests. Notifications of the case determination, including appeal rights when applicable, will be provided within the required time frame.

We'll issue a denial decision if we don't receive sufficient clinical information to complete the review. To prevent denials due to a lack of information, please submit all relevant clinical information when you submit a Part B drug prior authorization request.

Critical Access Hospitals

Reimbursement for inpatient and outpatient services will be based on the critical access hospital's most recent interim rate letter from their A/B Medicare Administrative contractors. In order to ensure appropriate reimbursement, we request that you provide that letter to Arkansas Blue Medicare.

Member Discharge Appeal Rights

Hospitals must notify Medicare beneficiaries, including Arkansas Blue Medicare beneficiaries enrolled in one of our Medicare Advantage HMO/PPO/PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the normal time frames for delivery. For copies of the notice and additional information regarding this requirement, visit **http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp**.

SECTION 7: Medical Records Request

Medical Records

Patient medical records and health information shall be maintained in accordance with current federal and state regulations.

Arkansas Blue Medicare providers must maintain timely and accurate medical, financial and administrative records related to services they render Medicare Advantage members, unless a longer time period is required by applicable statutes or regulations. The provider shall maintain such records and any related contracts for 10 years from date of service.

The provider shall give without limitation, Arkansas Blue Cross, U.S. Department of Health and Human Services, U.S. General Accounting Office, or their designees, the right to audit, evaluate and inspect all books, contracts, medical records and patient care documentation, maintained by the provider, which will be consistent with all federal, state and local laws. Such records will be used by CMS and Arkansas Blue Cross to assess compliance with standards which includes, but not limited to:

1. Complaints from members and/or providers
2. HEDIS, Stars and other reviews, quality studies/audits or medical record review audits
3. CMS and Arkansas Blue Medicare reviews of risk adjustment data
4. Post-pay reviews to determine whether services are reasonable and medically necessary and billed correctly to the plan
5. Pre-service organization determinations, and appeals decisions
6. Medical, disease and utilization management specific medical record reviews
7. Suspicion of fraud, waste and/or abuse
8. Periodic office visits for contracting purposes; and other reviews deemed appropriate and/or necessary

Medical record content and requirements for all practitioners (for behavioral health practitioners see below) include but may not be limited to:

- **Clinical Record**
  - Patient name, identification number (name and ID number must be on each page), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.

- **Medical Documentation**
  - History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services and other risk screening.
  - Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
    - Past medical, surgical and behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age and sex specific risk screening exam, relevant review of systems including depression and alcohol screening.
  - Documentation of patient education (age and condition specific), if applicable: injury prevention, appropriate dietary instructions, lifestyle factors and self-exams.

- **Clinical Record — Progress Notes**
  - Identification of all providers participating in the member's care and information on services furnished by these providers.
  - Reason for visit or chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, follow-up plans from previous visits have been addressed and follow-up report to referring practitioner (if applicable).
- **Clinical Record — Reports Content** (all reviewed, signed and dated within 30 days of service or event)
  - Lab, X-ray, referrals, consultations, discharge summaries, consultations and summary reports from healthcare delivery organizations, such as skilled nursing facilities, home healthcare, free-standing surgical centers and urgent care centers.

For Behavioral Health Practitioners

- Chief complaint, review of systems and complete history of present illness
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history
- Past medical history
- A medication list including dosages of each prescription, the dates of the initial prescription and refills
- At least one complete mental status examination, usually done at the time of initial evaluation and containing each of the items below:
  - Description of speech
  - Description of thought processes
  - Description of associations (such as loose, tangential, circumstantial or intact)
  - Description of abnormal or psychotic thoughts
  - Description of the patient's judgment
- Complete mental status examination
- Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content (including any thoughts of harm), mood, affect and other information relevant to the case
- A DSM-IV diagnosis, consistent with the presenting problems, history, mental status examination and other assessment data
- Thorough assessment of risk of harm to self or others
- Informed consent indicating the member's acceptance of the treatment goals. Formal signed consent is not required except where required by law.
- To ensure coordination of the member's care, the treatment records shall reflect continuity and coordination of care with the member's primary care practitioner and as applicable; consultants, ancillary practitioners and healthcare institutions involved in the member's care
  - Where it is required by law, proper documented written and signed consent for any release of information to outside entities has been obtained
  - Progress notes shall describe the member's strengths and limitations in achieving the treatment goals and objectives
  - Evidence that members who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care

Other Medical Record Requirements
The provider of service for all face-to-face and telemedicine encounters must be identified on the medical record, which includes signature and credentials (can be located anywhere on record, including stationery) for each date of service. Documentation of Telemedicine visits require notification of audio only or audio-visual encounter.

Stamped signatures are not acceptable. Acceptable signatures include handwritten (initials can be used if the full name and credentials appear somewhere in the record or on stationery) or an electronic signature on electronic records if authenticated at the end of each note in accordance with CMS authentication requirements (examples include – "electronically signed by," "authenticated by," "approved by," "completed by," "finalized by" or "validated by" and includes practitioner's name, credentials, date and signature).

Claims Processing when Medical Records are Required

Arkansas Blue Medicare *providers will notice a change from the previous processes that pended claims when waiting on record submission.* This manual provides new instruction to providers for handling services requiring medical documentation.

When medical records are needed to make a determination for the claim, providers are sent a letter requesting the necessary documents. If medical records are not received within thirty (30) days, claims will be denied as medical records not received. Providers should submit the medical record request letter along with the documents to the listed address. If records are received after the thirty (30) days, the claim will be reviewed as a redetermination.

Arkansas Blue Cross and Blue Shield
Medical Records Department
P.O. Box 3648
Little Rock, AR 72203-3648

To expedite processing and ensure a prompt and accurate response, please find our recommendations to make your submission as seamless as possible:

- Use the Arkansas Blue Medicare records cover sheet for all submissions
- Include the member's ID number on all correspondence
- Include provider information such as provider name, address and NPI on all correspondence
- Document the claim number related to records
- Distinguish between records if submitting for multiple members in the same mailing using the published Arkansas Blue Medicare records coversheet

To access the Arkansas Blue Medicare records cover sheet, click on the link **Medical Records Routing Form – MA**. The appropriate form should be attached as the cover sheet to expedite the review process by linking the appropriate claim(s) for dates of service on or after 1/1/2016.

Confidentiality of Member Information

In accordance with the highest standards of professionalism, and as a requirement of each provider's contract with Arkansas Blue Medicare, providers are obligated to protect the personal health information of their Medicare Advantage members from unauthorized or inappropriate use. All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements with Arkansas Blue Medicare.

Routine Needs for Member Information
At the time of enrollment, Arkansas Blue Medicare members who enroll electronically or by paper, permit Arkansas Blue Medicare to use and disclose their personal health information for routine needs such as:

- Bona fide research purposes
- Claims processing (payment, denial and investigation)
- Post service pre-pay review for medical necessity
- Coordination of care
- Customer service
- Data processing
- Fraud/abuse investigations or reports
- Healthcare operations
- Medical management
- Performance measurement
- Provider credentialing or quality evaluation
- Quality assessment and measurement
- Regulatory audits or inquiries, subpoenas, or other court or law enforcement procedures
- Required regulatory reports
- Risk adjustment and HEDIS
- Routine audits
- Utilization review

If Information is Needed for Other Reasons
If member-specific and identifiable information is needed for reasons other than those listed above under "routine needs," the member must sign specific authorization to release the information. If a member is unable to give preauthorization personally, Arkansas Blue Medicare have a process to obtain this consent through a parent's or legal guardian's signature, signature by next of kin, or attorney-in-fact. While specific authorizations are issued, the member has the right to limit the purposes for which the information can be used, and all concerned are obligated to respect that expressed limitation.

Members Rights to Medical Records
Members have the right to access their medical records; therefore, each practitioner must have a mechanism in place to provide this access. Members must not be interviewed about medical, financial or other private matters within the hearing range of other patients. Practitioners must have procedures in place for informed consent, storage and protection of medical records. Arkansas Blue Medicare may verify that these policies/procedures are in place as part of an on-site review process.

Medicare Advantage Employees
As a condition of employment, all Medicare Advantage employees must sign a statement agreeing to hold member information in strict confidence. Physicians and all other Arkansas Blue Cross participating providers also are bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information.

SECTION 8: Network Terms and Conditions

Network Participation Guidelines

Practitioners requesting participation in the Arkansas Blue Medicare network must agree to follow the CMS and the network Policies and Procedures and Terms and Conditions and meet applicable credentialing standards.

Providers who have questions about participation should contact their region's **Medicare Network Specialist** or **Network Development Representative**.

Provider Network Operations provides administrative support for the Arkansas Blue Medicare Advantage networks.

Provider Network Operations
P.O. Box 2181
Little Rock, Arkansas 72203-2181
Telephone: 501-210-7050
Fax: 501-378-2465
E-mail: **providernetwork@arkbluecross.com**

I. Introduction

BlueMedicare PFFS is a Private Fee-for-Service Medicare Advantage plan offered by Arkansas Blue Medicare. BlueMedicare PFFS allows members to use any provider, such as a physician, health professional, hospital or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, if the provider is eligible to provide healthcare services under Medicare Part A and Part B (also known as "Original Medicare") or eligible to be paid by Medicare Advantage for benefits that are not covered under Original Medicare.

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a Medicare Advantage member, you will be "deemed" to have a contract with the Medicare Advantage Organization. Section 2 explains how the deeming process works. Any provider in the United States that meets the deeming criteria in Section 2 is deemed to have a contract with the Medicare Advantage Organization for the services furnished to the PFFS member when the deeming conditions are met. No prior authorization, prior notification or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member. However, a member or provider may request an advanced organization determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Section 7 describes how a provider can request an advanced organization determination from the plan.

Arkansas Blue Medicare has signed contracts with some providers. These providers are our network providers. Our Arkansas Blue Medicare members can still receive services from non-network providers who do not have a signed contract with us, if the provider meets the deeming criteria described in Section 2. These deemed contracting providers are subject to the terms and conditions of payment described in this document.

To access the list of providers who participate with Arkansas Blue Medicare, visit **Find Care** and then select the "Search Medicare Networks" directory to search the complete listing of Medicare Advantage network providers. The amount of cost sharing a member pays a provider who is not participating in the member's specific network may be more than the cost sharing the member pays a network provider. We indicate the services for which the cost sharing amount differs between network providers and non-network providers in the Medicare Advantage member Evidence of Coverage (EOC).

II. When a Provider is Deemed to Accept the Medicare Advantage PFFS Terms and Conditions

A provider is deemed by law to have a contract with Arkansas Blue Medicare when the following criteria is met:

1. The provider is aware, in advance of furnishing healthcare services, that the patient is a member of Arkansas Blue Medicare, Blue Medicare (PFFS). All Blue Medicare PFFS members receive a member ID card that includes the Arkansas Blue Cross logo and clearly identifies them as a Blue Medicare PFFS member. The provider may validate eligibility by calling customer service at 800-287-4188. In addition, providers may check Availity to verify member eligibility.
2. The provider either has a copy of, or has reasonable access to, the Blue Medicare (PFFS) terms and conditions of payment (this document). The terms and conditions are available on our website at: **www.arkansasbluecross.com**. The terms and conditions may also be obtained by calling customer service at 800-287-4188.
3. The provider furnishes covered services to a Blue Medicare (PFFS) member.

If these conditions are met, the provider is deemed to have agreed to the Blue Medicare (PFFS) terms and conditions of payment for that member specific to that visit. For example: If a Blue Medicare (PFFS) member shows you an identification card identifying him/her as a member the Blue Medicare (PFFS) plan and you provide services to that member, you will be considered a deemed provider.

Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of urgent or emergency services (see below).

Note: You, the provider, can decide whether or not to accept the Blue Medicare (PFFS) terms and conditions of payment each time you see a Blue Medicare (PFFS) member. A decision to treat one plan member does not obligate you to treat other Blue Medicare (PFFS) members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you DO NOT wish to accept the Blue Medicare (PFFS) terms and conditions of payment, then you should not furnish services to a Blue Medicare (PFFS) member, except for urgent or emergency services. If you nonetheless do furnish non-urgent or non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing urgent or emergency services will be treated as non-contracted providers and paid at the payment amounts they would have received under Original Medicare.

III. Provider Qualifications and Requirements

In order to be paid by Arkansas Blue Medicare for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Arkansas Blue Medicare, in accordance with HIPAA requirements.
- Submit all claims (electronic or paper) to your local Blue plan.
- Furnish services to a Medicare Advantage member within the scope of your licensure or certification.
- Provide only services that are covered by the Arkansas Blue Medicare plans and that are medically necessary by Medicare definitions.

- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider list and not on the CMS Preclusion list.
- Not be a federal healthcare provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable federal healthcare program laws, regulations and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Arkansas Blue Medicare to resolve any member grievance involving the provider within the time frame required by CMS.
- For providers who are hospitals, home health agencies, skilled nursing facilities or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements).
- Not charge the member in excess of cost sharing allowed under these terms and conditions under any condition, including in the event of plan bankruptcy.

IV. Payment to Providers

Plan Payment

- Arkansas Blue Medicare reimburses deemed providers at the amount they would have received under Original Medicare for Medicare-covered services, minus any member required cost sharing, for all medically necessary services covered by Original Medicare.
- Arkansas Blue Medicare will process and pay clean claims within 30 calendar days of receipt. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. View the **Payment Methodology** for more detailed information.
- Services covered under Medicare Advantage that are not covered under Original Medicare are reimbursed using the Arkansas Blue Medicare fee schedule. Call us at 800-287-4188 to receive information on our fee schedule.
- Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

Member Benefits and Cost Sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. *You can only collect from the member the appropriate Medicare Advantage deductible, co-payment or coinsurance amounts described in these terms and conditions.* After collecting cost sharing from the member, the provider should bill Arkansas Blue Medicare for covered services. Section 5 provides instructions on how to submit claims to us. Please note, however, that Arkansas Blue Medicare will not hold members accountable for any cost sharing (deductibles, copayments, coinsurance) for Medicare-covered preventive services that are subject to zero-dollar cost sharing.

If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in the Medicare Advantage plan and a State Medicaid program), then the provider cannot collect any cost sharing for Medicare Part A and Part B services from the member at the time of the service when the State is

responsible for paying such amounts (nominal copayments authorized under the Medicaid State plan may be collected). Instead, the provider may only accept the Arkansas Blue Medicare plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate State source.

Services covered by BlueMedicare PFFS (Standard PFFS), Service Area A, C, D, F and G

To view a complete list of covered services and member cost sharing amounts under Arkansas Blue Medicare, visit **https://www.arkansasbluecross.com/medicare/medicare-forms.**

You may call us at 1-800-287-4188 to obtain more information about covered benefits, plan payment rates and member cost sharing amounts under Medicare Advantage. Be sure to have the member's ID number including the 3-character alpha prefix (on the ID card) when you call.

BlueMedicare (PFFS) follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by BlueMedicare (PFFS), unless specified by the plan. Information on obtaining an advanced coverage determination can be found in Section 7. BlueMedicare PFFS does not require members or providers to obtain prior authorization, prior notification or referrals from the plan as a condition of coverage. There are no prior authorization and prior notification rules for BlueMedicare (PFFS) members.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including BlueMedicare PFFS). All cost sharing is the member's responsibility.

Balance Billing of Members

There are two different PFFS balance billing scenarios:

- If the provider is deemed and a non-participating provider under Original Medicare rules, up to 15% balance billing is permitted. However, the plan – not the beneficiary – must pay the 15%.
- If the provider is deemed or contracted, and the balance billing is explicitly included in the BlueMedicare (PFFS) contract with the provider or in the terms and conditions of payment, it may balance bill up to 15% of the total plan payment amount for services, for which the beneficiary is responsible. A provider may collect only applicable plan cost sharing amounts from BlueMedicare (PFFS) members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to BlueMedicare (PFFS) members.

Hold Harmless Requirements

In no event, including, but not limited to non-payment by Medicare Advantage, insolvency of Medicare Advantage, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, copayments or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

V. Filing a Claim for Payment

- You must submit a claim to Arkansas Blue Medicare for an Original Medicare covered service within the same timeframe you would have to submit under Original Medicare, which is within one calendar year after the date of service. Failure to be timely with claim submissions may result in non-payment. The rules for submitting timely claims under Original Medicare can be found at: **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf**.
- Prompt payment – Arkansas Blue Medicare will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Arkansas Blue Medicare will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Arkansas Blue Medicare will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04) or the appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.
- Include the following on your claims:
  - National Provider Identifier.
  - The member's ID number, including the 3-digit prefix.
  - Date(s) of service.
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.
- Coordination of benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer manual located at: **https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer**.
- Providers should identify primary coverage and provide information to Arkansas Blue Medicare at the time of billing.
- Where to submit a claim:
  - For electronic claim submission, submit to your local Blue Plan.
  - For paper claim submission, submit to your local Blue Plan.

VI. Getting an Advance Organization Determination

Providers may choose to obtain a written advance coverage determination (known as an organization determination) from Arkansas Blue Medicare before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Arkansas Blue Medicare. To obtain an advance organization determination, call us at 800-287-4188 or send by fax to 816-313-3014. Arkansas Blue Medicare will make a decision and notify you and the member within 14 calendar days of receiving the request, with a possible 14-day extension either due to the member's request or an Arkansas Blue Medicare justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 800-287-4188 or send by fax to 816-313-3013. We will notify you of our decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-day extension either due to the member's request an Arkansas Blue Medicare justification (for example, the receipt of additional medical evidence may change Arkansas Blue Medicare decision to deny) that the delay is in the member's best interest. In the absence of an advance organization

determination, Arkansas Blue Medicare can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights (see the federal regulations at 42 CFR Part 422, subpart M, or Chapter 13 of the Medicare Managed Care Manual).

VII. Member and Provider Appeals and Grievances and Contracting Provider Dispute Resolution

A. Member and Provider Appeals and Grievances Under Member Appeal Process

Arkansas Blue Medicare members have the right to file appeals and grievances with Arkansas Blue Medicare when they have concerns or problems related to coverage or care. Members may appeal a decision made by Arkansas Blue Medicare to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints not related to the provision or payment for healthcare.

Providers and/or physicians also have certain appeal opportunities under the Member Appeal process. These opportunities are set forth below.

1. Pre-Service Appeal Request

A physician who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan on behalf of the member without submitting an Appointment of Representative form or Waiver of Liability form. Arkansas Blue Medicare is required by Medicare to verify that the member has been notified and approves of the physician's appeal request. If it is not evident that the member is aware of the appeal request, Arkansas Blue Medicare will reach out to the physician to gather this information. If Arkansas Blue Medicare verifies the member's knowledge of the physician's appeal request, it will be processed according to the Medicare Advantage five-level member appeal process.

Arkansas Blue Medicare automatically grants an expedited appeal if any physician or other provider, whether participating with Arkansas Blue Medicare or not, asks for one on the grounds that waiting for a standard appeal could seriously jeopardize the member's life, health or ability to regain maximum function or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment being requested. An expedited appeal will not be granted for a service that has already been provided.

2. Post-Service Appeal Request

A contracting physician or contracting provider may also request review of a post-service organization determination denial as a representative using the member appeal process. To do so, the physician should include an Appointment of Representative form with the appeal submission.

A non-contracting physician or provider may appeal a post-service determination using the appeal process by signing and submitting a Waiver of liability form. This form can be found at **Waiver of liability statement**. When the physician or other provider signs the form, he or she agrees not to bill the member regardless of the outcome of the appeal. The Waiver of liability form must be included with the appeal submission. Medicare regulations prohibit Arkansas Blue Medicare from considering the appeal until the signed Waiver of Liability form is received. When Arkansas Blue Medicare receives the appeal request and signed form, the

appeal is processed according to the Arkansas Blue Medicare five-level appeal process.

If a physician or provider uses the appeals process, the provider agrees to abide by the status, regulations, standards, and guidelines applicable to the Medicare appeals processes. Included in these regulations is the requirement that the appeal and Waiver of Liability form be submitted within 60 days from the date on the Remittance Advice notice.

The physician or provider should consider including the following documentation with the appeal submission:

- Provider or supplier contact information, including name, address, e-mail address, fax number, and phone number
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered and physician specialty
- Reason for dispute and a description of the specific issue being appealed
- Documentation of any correspondence and/or records that supports your position that the plan's denial was incorrect (including clinical rationale, Local Coverage Determination, and/or National Coverage Determination
- Appointment of Representative Form or Waiver of Liability form, where applicable
- Name and signature of the provider or provider's representative

The Arkansas Blue Medicare Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. Each plan's EOC is posted under the Arkansas Blue Medicare link on the website located at **https://www.arkansasbluecross.com/medicare/medicare-forms**.

You can call customer service by using the phone number listed on the back of the Members identification card for more information on our member appeals and grievances policies and procedures.

B. Contracting Provider Claim Adjudication Review Request (Non-Member Appeal Review Requests)

Contracted providers with Arkansas Blue Medicare have dispute resolution rights separate from the member appeals process. Specifically, a Contracted Physician or Contracted Provider may request a review of a post-service denial related to medical necessity or medical appropriateness. A Contracted Physician or Provider may also request a review of administrative denials. Administrative denials are determinations made by Arkansas Blue Medicare in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness. Examples of administrative denials include, but are not limited to: (1) Provider noncompliance with clinical review requirements for elective procedures requiring Arkansas Blue Medicare approval; and (2) Provider noncompliance with providing clinical information needed to render a decision for inpatient admissions within 48 hours of Arkansas Blue Medicare's request. Finally, a contracting provider may request a review when he or she believes that the payment amount made by the Arkansas Blue Medicare plan to the contracted provider is less than the payment amount that would have been paid under the Original Medicare fee schedule.[1]

Arkansas Blue Medicare assumes that the physician or provider is acting on his or her own behalf. Submission of an Appointment of Representative form is not required for these review

[1]This is in the current provider manual ("Payment level appeals") section.

requests as they are not considered a part of the CMS regulated member appeal process.

These post-service review requests will be reviewed based on:

- Review of pertinent medical information
- Consideration of the member's benefit coverage
- Information from the attending physician and primary care physician
- Clinical judgment of the medical director, when applicable/appropriate

A single level of review will be provided. This review process is designed to be objective, thorough, fair and timely.

At any step in the review process, a plan medical director may obtain the opinion of a same specialty, board-certified physician or an external review board.

When a Provider Claim Adjudication Review Request is received and a member appeal is in process, the member appeal takes precedence.

The request must be submitted to Arkansas Blue Medicare within 60 calendar days of the date noted on the written RA notification. If the review request is received by Arkansas Blue Medicare outside the designated time frame, Arkansas Blue Medicare is not obligated to review the case. A letter will be sent to the requesting provider either advising that the request was not reviewed or notifying the provider of the outcome of the request if the plan has chosen to review the case.

Requests are to be submitted in writing and must include any additional clarifying clinical information to support the request. Please identify the submission as a Provider Claim Adjudication Review Request. Appropriate documentation needed for a medical necessity review includes:

- Provider or supplier contact information, including name, address, e-mail and fax number
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers)
- ZIP code where services were rendered
- Physician specialty
- Reason for dispute
- Documentation and any correspondence that supports your position that the plan's denial was incorrect (include clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation), when appropriate
- Documentation and any correspondence that supports your position that the plan's reimbursement was incorrect (including interim rate letters), when appropriate
- Name and signature of the provider or provider's representative

Arkansas Contracting Provider/Physician Post-Service Review Requests should submit these requests to:

Arkansas Blue Medicare Legal Appeals Department
Attn: Contracting Provider Claim Adjudication Review Request
P.O. Box 2181
Little Rock, AR 72203
Fax: 501-378-3366
E-mail: **appealscoordinator@arkbluecross.com**

Arkansas Blue Medicare will notify the provider of the decision within 30 calendar days of receiving all necessary information.

Only one level of review will be provided. The decision regarding the review is final.

VIII. Member Appeals and Grievances and Provider Appeals

Arkansas Blue Medicare members have the right to file appeals and grievances with Arkansas Blue Medicare when they are dissatisfied with or have concerns or problems related to their medical coverage or care. Members may appeal a decision made by Arkansas Blue Medicare to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints not related to the provision or payment for healthcare.

A contracted physician who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan when acting on behalf of the member. The physician may also appeal a post-service organization determination denial using the member appeal process by submitting a completed Appointment of Representative form. There must be potential member liability (e.g., an actual claim for services already rendered as opposed to an advance organization determination) for a provider to appeal utilizing the member appeal process.

A non-contracting physician provider may appeal organization determinations on behalf of the member as a representative. A non-contracting provider may also appeal post-service organization determinations (e.g. claims) using the member appeal process by submitting a signed waiver of liability (promising to hold the member harmless regardless of the outcome).

If a provider appeals using the member appeal process, the provider agrees to abide by the statutes, regulations, standards and guidelines applicable to the BlueMedicare Member appeals and grievance processes.

The Arkansas Blue Medicare Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is posted under the Medicare Forms link on the website located at: **https://www.arkansasbluecross.com/medicare/medicare-forms** by choosing the appropriate county and plan that the Medicare Advantage member holds.

For more information regarding the appeals process, you can contact the Appeals Department at 501-378-2025.

IX. Providing Members with Notice of Their Appeal Rights – Requirements for Hospitals, SNFs, CORFs and HHAs

Hospitals must notify Medicare beneficiaries, including Medicare Advantage beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the normal time frames for delivery. For copies of the notice and additional information regarding this requirement, visit **http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp**.

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries, including Medicare Advantage beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing the *Notice*

of Medicare Non-Coverage (NOMNC), including complying with the normal time frames for delivery. For copies of the notice and the notice instructions, visit **CMS Advance Beneficiary Notice Link**.

As directed in the instructions, the *NOMNC* should contain the Medicare Advantage contact information somewhere on the form (such as in the additional information section on page 2 of the *NOMNC*).

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge (*Detailed Notice of Discharge*) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (*Detailed Explanation of Non-Coverage*) within the time frames specified by law. For copies of the notices and the notice instructions, visit **https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices**.

X. If You Need Additional Information or Have Questions

If you have general questions about the Medicare Advantage terms and conditions of payment, contact us at 877-233-7022, Monday – Friday, 8 a.m. to 8 p.m. or mail us at Arkansas Blue Medicare Advantage, P.O. Box 2181, Little Rock, AR 72203-2181.

- If you have questions about submitting claims, call 501-378-2336.
- If you have questions about plan payments, call 877-233-7022.

Pharmacy

Pharmacy Directory & Pharmacy Formulary

Providers may search the Arkansas Blue Medicare Advantage pharmacy directory and formularies. Please use the following link:

2024 Pharmacy Directory | Arkansas Blue Medicare (arkansasbluecross.com)

Medicare Part D Prescriber Requirements

CMS has requirements for any physician or other eligible professional (collectively referred to as "Providers") who prescribe Medicare Advantage (Part D) covered drugs. Providers must either enroll in the Original Medicare program or "opt out" in order to prescribe covered medications to their patients who have a Part D prescription drug benefit plan. Providers who are not enrolled must do this to allow for the processing of applications and to ensure enrollees will continue to receive their Part D covered prescriptions.

Note: Part D benefit plans will not be allowed to cover drugs that are prescribed by Providers who have not enrolled with or have not opted out of the Medicare program.

To comply with the CMS change Arkansas Blue Cross will require all providers to be enrolled in Original Medicare before they can be considered for participation in any of its Arkansas Blue Medicare Advantage networks, including the Private Fee For Service (PFFS), Local Preferred Provider Organization (LPPO) or Health Maintenance Organization (HMO).

Utilization Management

Certain drugs must undergo a criteria-based approval process prior to a coverage decision. Arkansas Blue Medicare Advantage's Utilization management program is managed by CVS Caremark. The CVS Caremark Pharmacy and Therapeutics committee reviews medications based on safety, efficacy and clinical benefit and may make additions or deletions to the list of drugs requiring prior authorization and to the list of drugs which have quantity limits.

For information on utilization management and to view specific prescription drug criteria, please visit the Prior Authorization section on our website. Please use the following link to view criteria, forms or submit a prior authorization request:

Arkansas Blue Medicare Advantage Plans, for prescription drugs:

CVS Caremark Prior Authorization Forms | Cover My Meds

Excluded Medications

Arkansas Blue Medicare Advantage does not cover all prescription drugs. Here are three general rules about drugs that Medicare drug plans will not cover under Part D.

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B
- Our plan cannot cover a drug purchased outside the United States and its territories
- "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration

- Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law these categories of drugs are not covered by Medicare drug plans.

- Non-prescription drugs
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction. Some medications for the treatment of weight loss and erectile dysfunction may be covered by your plan. Also, by law these categories of drugs are not covered by Medicare drug plans.
- Drugs when used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Note: Specific plans may provide coverage for generic medications used for weight loss or sexual or erectile dysfunction. These are disclosed in the members' Explanation of Benefits.

Technical Guidance
Arkansas Blue Medicare Advantage technical guidance is available to Part D sponsors and their pharmacy benefit managers applying for Part D prescriber Enrollment, enforced June 1, 2016. This guidance from the Centers for Medicare and Medicaid Services, CMS, is available at **Part D Technical Guidance**.

For More Information
For more information about an Arkansas Blue Medicare Advantage member's prescription drug coverage, please call one of the phone numbers below depending on the plan:

Pharmacy Help Desk: **1-844-280-5833**

Fraud, Waste and Abuse

Fraud is the intentional misrepresentation that an individual makes that could result in some sort of unauthorized benefit to himself or herself, or another person. The most frequent kind of fraud arises from a false statement or misrepresentation regarding entitlement or payment under Medicare. Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Anti-Fraud, Waste and Abuse Policy Statement

As an integral part of the compliance plan, Arkansas Blue Medicare supports and maintains provisions for the prevention, detection and correction of fraud, waste and abuse related to all benefits of the plan, including Medicare operations. Under the direction of the Board, CEO, compliance officer and compliance committees, comprehensive written policies, procedures and standards of conduct are implemented to comply with all applicable federal and state standards.

Provider Training

Fraud, Waste and Abuse Training

Arkansas Blue Medicare strongly encourages all providers to make every effort to detect report and prevent fraud, waste and abuse. While fraud, waste and abuse training are deemed for Medicare providers, awareness and prevention materials are provided on the website, in the Provider Welcome Kit, in the Provider Network Directory and in articles published periodically by Arkansas Blue Medicare. These materials contain the Arkansas Blue Medicare and/or Arkansas Blue Cross Fraud and Abuse Reporting Procedures as well as potential indicators of fraud, waste and abuse relevant to the provider's setting. Toward that end, Arkansas Blue Medicare provides materials to providers on our Code of Conduct annually in addition to other required CMS training requirements listed under Annual Compliance Training for Providers in this section.

If you suspect fraud is being committed by a member or another provider, please contact our fraud hotline at 800-FRAUD21. All callers will remain confidential and can be anonymous if desired.

Annual Compliance Training for Providers

As a contractor for the Centers for Medicare and Medicaid Services (CMS), Arkansas Blue Cross is required by the Medicare Managed Care Manual (42CFR Parts 422 and 423) Chapter 21: Compliance Program Guidelines and Chapter 9: Prescription Drug Manual to communicate information, including annual compliance training information to all first-tier, downstream and related entities (FDRs). As a contracted provider (FDR) that provides a service to our BlueMedicare HMO/PPO/PFFS and BlueMedicare PDP members, you are required to complete annual Medicare compliance training. It also is the provider's responsibility to ensure that all staff serving these Medicare Beneficiaries completes Annual Compliance Training. This includes front office, lab techs, nurses, billing and any other ancillary staff. Compliance training should be completed annually no later than December 31, or within 90 days of hire for any new employees. The OIG has issued guidance with reference to "effective compliance programs" for specific healthcare providers, which can be found at **CMS Compliance Guidance and Program**.

To ensure this requirement is met and to largely reduce the duplicative training required of FDRs by multiple organizations with whom you contract, CMS developed web-based compliance training. FDRs have two (2) options for ensuring its FDRs (including the FDR's employees) have satisfied the general compliance and FWA training requirement as described in the regulations and sub-regulatory guidelines.

1. FDRs/DEs and their employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN). Once an individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be retained by all FDRs/DEs for 10 years. This training is also available as a pdf at **Medicare Parts C and D General Compliance Training (cms.gov)**.
2. FDRs/DEs may download, view or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization's existing compliance training materials/systems. In order to ensure the integrity and completeness of the training, the CMS training content cannot be modified. However, an organization can add to the CMS training to cover topics specific to their organization.

Training materials are available via the following links on CMS's MLN Network: **Fraud Waste and Abuse Training** under Downloads *Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training*. All training documents, including a copy of the training materials and training logs, must be retained by your organization for 10 years, in accordance with CMS record retention guidelines. All documentation is subject to random audit by Arkansas Blue Cross or may be requested as part of a Compliance Program Audit by CMS or CMS designees.

Reminders to complete annual training are administered through our claims clearinghouse, Availity and **Providers' News.**

Should any questions arise, please contact our Regulatory Compliance Office at **regulatorycompliance@arkbluecross.com.**

Information Changes/Updates

Please notify the Provider Network Operations (PNO) division of Arkansas Blue Cross with ANY changes to provider information. Receipt of updated information will assist Arkansas Blue Medicare in providing current information to referring physicians and its members.

Providers must update their physical address, remittance address, network status, specialty, and affiliations with the *Provider Change of Data Form* on **www.arkbluecross.com**. As noted on the form, it needs to be mailed or faxed 501-378-2465 with supporting documents to:

Arkansas Blue Cross and Blue Shield Attn: PNO Division
601 Gaines Street
P.O. Box 2181
Little Rock, AR 72203-2181

If payment to a clinic or group is required, providers should complete an Authorization for Clinic Billing form. Practitioners wishing to use an Employer Identification Number (EIN) for payment must submit verification of EIN (Letter 147C, CP 575 E or tax coupon 8109-C).

Additional Arkansas Blue Cross Provider Network Operations (PNO) contact information:

(501) 210-7050
(501) 378-2465 (fax)
E-mail: **providernetwork@arkbluecross.com**
Contact the **Regional Office** in your area.

Newsletters

Communication is an important factor in delivering quality services to members and educating providers. In an effort to communicate any updates, improvements in policies and procedures, topics of interests, and other pertinent information, the following newsletter is available for providers:

Providers' News

The **Providers' News** is a quarterly publication designed to update providers and their office staff regarding changes or improvements in Arkansas Blue Cross policies and procedures, provider workshops plus other interesting topics. The newsletter is sent to all providers who participate with Arkansas Blue Cross.

The newsletters cover a wide variety of healthcare topics including:

- Current events relative to Arkansas providers
- Helpful hints for understanding health benefit plans and other coverage options
- Pertinent changes in Arkansas Blue Medicare policies and procedures
- Educational meeting schedules and updates
- General topics of interest

It is essential these publications are read by providers and their staff. A provider's network participation status could be affected by failure to keep abreast of all notices published in the **Providers' News**. This is one way of assisting providers in accessing available health plan benefits for Arkansas Blue Cross members.

For ideas, comments or suggestions of topics to be addressed in the **Providers' News**, please call customer service at 800-287-4188 or the local Arkansas Blue Cross **Regional Office**.

Healthcare Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. Medicare Advantage follows HEDIS reporting requirements established by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services. Audited HEDIS reports are used to identify quality improvement opportunities and develop quality related initiatives.

The HEDIS measures Medicare Advantage focuses on include (but are not limited to):

Medicare Advantage HEDIS Measures 2024

- Breast cancer screening
- Colorectal cancer screening
- Osteoporosis management in women who had a fracture
- Diabetes care – Eye exam
- Glycemic Status Assessment for Patients with Diabetes (A1c ≤9%)
- Kidney Health Evaluation for Patients with Diabetes
- Controlling blood pressure
- Statin therapy for patients with cardiovascular disease
- Medication reconciliation post-discharge
- Follow Up After ER Visits for People with Multiple High-Risk Chronic Conditions

In addition, the Medicare Advantage program focuses on several pharmacy-based developed by the Pharmacy Quality Alliance. These measures are used in the CMS Star Rating program and include:

- Medication adherence for hypertension (RAS antagonists)
- Medication adherence for cholesterol (Statins)
- Medication adherence for diabetes medications
- Statin use in persons with diabetes
- Comprehensive Medication Review (CMR)

Medicare Advantage Star Ratings Program (Quality)

CMS evaluates health insurance plans and issues Star Ratings each year; these ratings may change from year to year. The CMS plan rating uses quality measurements widely recognized within the healthcare and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services Arkansas Blue Cross offers. CMS compiles its overall score for quality of services based on measures such as:

- How Arkansas Blue Medicare helps members stay healthyw through preventive screenings, tests and vaccines
- How Arkansas Blue Medicare helps members manage chronic conditions and clinical care
- Member satisfaction with Arkansas Blue Medicare and their provider experience
- How well Arkansas Blue Medicare handles calls from members and how long they remain enrolled in the plan

In addition, because Arkansas Blue Medicare offers prescription drug coverage, CMS also evaluates Arkansas Blue Medicare prescription drug plans for the quality of services covered such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

CMS Star Ratings

CMS developed a set of quality performance ratings for health plans that includes specific clinical, member perception and operational measures. The 2026 Star Ratings (based upon the 2024 measurement year) include 43 measures in six domains of care. Each of the 43 measures has a defined "weight" used in calculating the Star ratings. These measures are adjusted each year and finalized by CMS, as appropriate. At time of the manual publication, the final number of measures in the 2026 Star Rating (based upon the 2024 measurement year) program was 43 measures.

CMS establishes Star thresholds at a measure level, based on CMS specifications, as one through five Stars, where five Stars indicate higher performance. This rating system applies to Arkansas Blue Medicare and Prescription Drug Plans. In addition, the ratings are posted on the CMS consumer website, **www.medicare.gov***, to help beneficiaries choose an MA plan offered in their area.

How are Star Ratings Derived?

A health plan's rating is based on measures in five categories:

Data source	Description	# of Metrics**
HEDIS – Part C	Subset of broad HEDIS data set used to measure health plans' ability to drive compliance with preventive care guidelines and evidence-based medical treatment guidelines related to clinical measures	13
PQA (Part D)	Subset of Pharmacy Quality Alliance medication use measured designed to measure health plans' ability to drive appropriate medication use based upon evidence-based medical treatment guidelines and adherence to medications	5
CAHPS	Survey of randomly selected members focusing on member perception of their ability to access quality medical care	11
HOS	Survey of randomly selected members focusing on members' perception of their own health and recollection of specific provider care delivered	3
CMS	Administrative data collected by CMS related to health plan service capabilities and performance	5
Independent review entity	Timeliness and fairness of decision associated with appeals	2

** The metrics indicate current proposal from CMS for MY2024.

The methodology used by CMS is subject to change and final guidelines are released each fall.

The Star rating methodology was developed to:

- Help consumers choose plans on medicare.gov*
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D
- Penalize consistently poor performing health plans
- Strengthen beneficiary protections

What is the Star Measurement Timeline?

The Centers for Medicare and Medicaid Services (CMS) created the Part C and D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period. Arkansas Blue Cross Blue Shield is accountable for the care provided by physicians, hospitals and other providers to their enrollees. The measures included in the Star Measurement Timeline demonstrate clinical, perception, operations and the published CMS rating for the review period. The data is a tool for quality improvement of internal and external processes.

2024 Star Rating Calendar

Measure Categories	2022	2023	2024	2025	2026
HOS	Survey		Follow-up Survey		
HEDIS			Services Incurred	Records Retrieved	
Patient Safety			Claims Incurred		
IRE			Appeals		
CMS			Complaints, Membership, Retention, Price Accuracy	Enterprise TTY Services	
CMS Data Publication				★	
CMS Plan Year					
CAHPS				Member Surveys	

Benefits

In most instances, the value of improving performance is well worth the investment for the health plan, the members and the provider community.

Member benefits	Provider benefits	Arkansas Blue Cross benefits
A. Ensure members receive quality care that leads to positive health outcome B. Greater health plans focus on access to care C. Improved relations with doctors D. Increased levels of customer service E. Early detection of disease and healthcare that matches individual needs F. Improved plan benefits	A. Improve care quality and health outcomes B. Improved patient relations C. Improved health plan relations D. Increased awareness of patient safety issues E. Greater focus on preventive medicine and early disease detection F. Strong benefits to support chronic condition management G. Partner with Medicare Advantage providers to encourage patients to get preventive screenings and procedures, and provide support in achieving certain disease	A. Improve care quality and health outcomes B. Improved provider relations C. Improved member relations D. Process improvement E. Key component in financing healthcare benefits for MA plan enrollees

Goals for High-Quality Healthcare

Arkansas Blue Cross is strongly committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. Through the Medicare Advantage Star Rating Goals, Arkansas Blue Medicare works with providers and members to ensure members received appropriate and timely care;

that chronic conditions are well-managed; that members are pleased with the level of service from their health plan and care providers; and that health plans follow CMS operational and marketing requirements.

Arkansas Blue Medicare uses mailings and personal and automated phone calls to remind members about needed care and to help maintain optimal health.

Arkansas Blue Medicare partners with our MA providers by identifying their Arkansas Blue Medicare patients who need specific medical services so providers can contact those patients and schedule necessary.

Provider Tips for Improving Star Ratings and Quality Care

- Review the individually created education sheets for each applicable measure, including the measure information and eligibility, performance goals and recommendations and tips
- Continue to encourage patients to obtain preventive screenings annually or when recommended
- Create office practices to identify noncompliant patients at the time of their appointment
- Submit complete and correct encounters/claims with appropriate codes
- Understand the metrics included in the CMS rating system, as some of them are part of Arkansas Blue Medicare provider quality incentive programs to which you may be eligible to participate
- Review the gap in care files listing members with open gaps
- Ensure documentation includes assessment of advanced illness, frailty, cognitive and functional status
- Identify opportunities for you or your office to have an impact

To access these tips and more tools to help improve Star Ratings and Quality Care, please feel free to visit our provider resource website: **HEDIS Measures**

2024 CMS Quality Star Measures

Although CMS uses up to 43 quality measures to determine a health plan's overall rating, Arkansas Blue Medicare has identified the below measures that providers can help effectively impact during the measurement year 2024. Please note that these may be updated as more information becomes available from NCQA, PQA and CMS.

HEDIS Part C (Clinical Measures)

Weight	Measure	Description
HEDIS Administrative Measures – Data Collected or Processed (Claims) by Plan		
1	Breast cancer screening	Percent of women 52-74 years of age as of December 31, 2024 who had a mammogram from October 1, 2022 through December 31, 2024
1	Osteoporosis management in women who had a fracture	The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture Exclusion: Members who had a bone mineral density test 730 days (24 months) prior to the fracture or members who had a claim for osteoporosis drug therapy during the 365 days (12 months) prior to the fracture

Weight	Measure	Description
1	Statin therapy for patients with cardiovascular disease	Percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year
HEDIS Hybrid Measures – Data Collected/Processed (Claims) by Plan or Retrieved by Medical Record Review		
3x	Glycemic Status Assessment of Patients with Diabetes	**Denominator:** Members 18-75 years of age and who are identified as having diabetes in three ways: 1. Members dispensed insulin or hypoglycemic on an ambulatory basis during the measurement year or year prior 2. Members with at least two outpatient visits, observational visits, ED visits, or nonacute inpatient encounters on different dates of service. Visit types can be different and only one may be telehealth, telephone or online assessment 3. Members with at least one acute inpatient encounter with a diagnosis of diabetes **Numerator:** A. Blood sugar controlled: Members where the last A1c rate during the measurement year is ≤9.0%
1x	Eye Exam for Patients with Diabetes	Members 18 through 75 years of age with diabetes (type 1 or type 2) who had one of the following eye screenings for diabetic retinal disease: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) performed in 2024, A negative retinal or dilated eye exam (negative for retinopathy) in 2023, or Bilateral eye enucleation anytime during the members history through December 31, 2024
3x	Controlling blood pressure	Percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
1x	Medication reconciliation post-discharge	Percentage of discharges from January 1–December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)

Weight	Measure	Description
1x	Colorectal cancer screening	Percent of plan members aged 50-75 who had an appropriate screening for colorectal cancer, either a: 1. fecal occult blood test during the measurement year, or a 2. flexible sigmoidoscopy during the measurement year or four years prior, or a 3. colonoscopy during the measurement year or the nine years prior 4. FIT-DNA during the measurement year or two years prior or a 5. CT colonography during the measurement year or four years prior

Pharmacy Quality Alliance Part D (Pharmacy Measures)

Weight	Measure	Description
PDE		
1x	Statin use in persons with diabetes	Percentage of Medicare Part D beneficiaries 40-75 years old who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period
3x	Part D medication adherence for diabetes medications	Percentage of Part D beneficiaries aged 18 years and older with a prescription for diabetes medication (non-insulin) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication. This is applicable to non-insulin products only
3x	Part D medication adherence for hypertension (RAS antagonists)	Percentage of Part D beneficiaries aged 18 years and older with a prescription for a blood pressure medication who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication
3x	Part D medication adherence for cholesterol (Statins)	Percentage of Part D beneficiaries aged 18 years or older with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication
1x	Medication therapy management	Percent of Medication Therapy Management (MTM) program enrollees who received a Comprehensive Medication Review (CMR) during the reporting period

Consumer Assessment of Health Providers and System (CAHPS)

Weight	Measure	Provider, Health Plan or Member Focused	Description
CAHPS Survey			
2x	Getting needed care	Provider focused	This case-mix adjusted composite measure is used to assess how easy it was for a member to get needed care and see specialists. 1. In the last six months, how often did you get an appointment to see a specialist as soon as you needed? 2. In the last six months, how often was it easy to get the care, tests or treatment you needed?
2x	Getting appointments and care quickly	Provider focused	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. 1. In the last six months, when you needed care right away, how often did you get care as soon as you needed? 2. In the last six months, how often did you get an appointment for a check-up or routine care as soon as you needed? 3. In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
2x	Overall rating of healthcare quality	Provider focused	Case mix adjusted rate of percent of sampled members scoring a nine or a 10 on a 0-10 scale to: Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate your healthcare in the last six months?

Weight	Measure	Provider, Health Plan or Member Focused	Description
2x	Care coordination	Provider focused	This case-mix adjusted composite measure is used to assess care coordination. 1. Whether doctor had medical records and other information about the enrollee's care 2. Whether there was follow-up with the patient to provide test results 3. Whether the follow-up from test results were provided as soon as the patient needed them 4. Whether the doctor spoke to the enrollee about prescription medications 5. Whether the enrollee received help managing care 6. Whether the personal doctor is informed and up to date about specialist care
1	Annual flu vaccine	Member focused	Percent of sampled Medicare enrollees who answered yes to receiving a flu shot since July 1st
Health Outcomes Survey (HOS)			
1	Monitoring physical activity	Provider focused	Percent of sampled Medicare members 65 year and older who had a doctor's appointment in the past 12 months and received advice to start, increase or maintain their level of physical activity
1	Improving bladder control	Provider focused	Percent of sampled Medicare members 65 and older who reported any urinary leakage in the past six months and who discussed treatment options for their urinary incontinence with a provider
1	Reducing the risk of falling	Provider focused	Percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.

For More Information:

- To learn about the Stars Quality rating system, visit **https://www.cms.gov/files/document/2023-medicare-star-ratings-fact-sheet.pdf**
- To learn more about the HOS, visit **https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/HOS**
- To learn more about the CAHPS survey, visit **https://www.cms.gov/research-statistics-data-and-systems/research/cahps**
- To learn more about the HEDIS, visit **https://www.ncqa.org/hedis/**

Claims Submission Guidelines

Below are provider tips to closing gaps in care via claim submission.

Measure	Codes

Breast cancer screening (BCS)	Mammogram between October 2022 and December 2024
	CPT®: 77061-77063, 77065-77067
	HCPCS: G0202, G0204, G020 Exclusions: Members with a bilateral mastectomy. Any of the following meet criteria for bilateral mastectomy:
	• ICD-10-CM: Z90.11 – Z90.13
	• Bilateral mastectomy
	  • ICD-10-PCS OHTV0ZZ
	• Unilateral mastectomy
	  • CPT®: 19180, 19200, 19220, 19240, 19303-19307
	  • ICD-10 PCS: 0HTU0ZZ, 0HTT0ZZ
	*50 and 09950 modifier codes indicate the procedure was bilateral and performed during the same operative session.

Measure	Codes
Colorectal cancer screening (COL)	FOBT fecal occult blood test between (FOBT) 1/1/2024 and 12/31/2024: • CPT®: 82270, 82274 • HCPCS: G0328 Flexible sigmoidoscopy between 1/1/2020 and 12/31/2024: • CPT®: 45330-45335, 45337-45342, 45345-45347, 45349, 45350 • HCPCS: G0104 Colonoscopy between 1/1/2015 and 12/31/2024: • CPT®: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 • HCPCS: G0105, G0121 CT colonography between 1/1/2020 and 12/31/2024 • CPT®: 74261, 74262, 74263 FIT-DNA between 1/1/2024 and 12/31 2024: • CPT®: 81528 • HCPCS: G0464 AND/OR Chart documentation of previously performed colorectal cancer screening tests. Exclusions: Members with a history of either of the following: Colorectal cancer • HCPCS: G0213-G0215, G0231 • ICD-10-CM: C18.0 – C18.9, C19, C20, C21.2, C21.8 C78.5, Z85.038, Z85.048 Total colectomy • CPT®: 44150-44153, 44155-44158, 44210-44212 • ICD-10-PCS: ODTE0ZZ, ODTE4ZZ, ODETE7ZZ, ODTE8ZZ

Measure	Codes
Comprehensive diabetes care (CDC) – Eye exam	CPT®: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 • CPT® II codes: 2022F, 2023F, 2024F, 2025F, 2026F, 2033F, 3072F • HCPCS codes: S0620, S0621, S3000 Bilateral eye enucleation CPT® Code(s): 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 Bilateral modifier value set (when applicable): CPT® Code(s): 50, 09950 Unilateral eye enucleation with a modifier ICD-10-PCS: 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B00ZX, 08B00ZZ, 08B03ZX, 08B0ZZ, 08B0XZX, 08B0XZ
Comprehensive diabetes care (CDC) – HbA1c controlled <9	CPT® II: 3044F, 3046F, 3051F, 3052F
Controlling blood pressure	ICD-10-CM codes to identify hypertension: • ICD-10-CM: I10 CPT codes to identify blood pressure reading • CPT codes 3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Osteoporosis management in women who had a fracture (OMW)	Codes to identify bone mineral density test: • CPT®: 76977, 77078-77082 • HCPCS: G0130 AND/OR pharmacy claims for osteoporosis drug therapy: HCPCS: J0897, J1740, J3110, J3487, J3488, J3489 , Q2051

SECTION 12: Care Management

Overview of Medicare Advantage Care Management

The Medicare Advantage Care Management program promotes cost-effective and medically appropriate care and services. Components include clinical review of selected services, case management, transitional care coordination and chronic condition management programs.

Care management programs are available to the following Medicare Advantage products:

- BlueMedicare HMO – Subject to utilization and case/chronic condition management programs
- BlueMedicare PPO – Subject to utilization and case/chronic management programs
- BlueMedicare FFS – Subject to case/chronic condition management programs

Please note while PFFS and out of network PPO are not subject to utilization/prior authorization, you or your provider may submit a pre service request to determine whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. Care management provides the following services:

Care Management Services

Utilization Management – Applies Only to Arkansas Blue Medicare HMO/PPO

- Clinical review of select services and maintenance of medical review criteria
- Ensure medical healthcare services that are medically necessary, appropriate and provided in the most cost-effective setting
- Facilitate communication and collaboration among members, providers and the organization to support cooperation and appropriate utilization of healthcare benefits
- Provide information to practitioners regarding utilization management updates and activities
- Render timely determinations and issue timely notifications
  - Medical
    - Standard determinations within 14 calendar days
    - Expedited determinations within 72 hours
  - Part B Pharmacy
    - Standard determinations within 72 hours
    - Expedited determinations within 24 hours
- Assist with hospital discharge planning and transition care needs
- Peer-to-Peer
- Continuity of Care

Transitional Care Coordination/Chronic Condition Management

- Coordination of healthcare services with chronic condition management programs
- Coordination of care among medical care providers and between medical and behavioral healthcare providers
- Member healthcare education
- Discharge planning
- Transition care coordination
- Health risk assessments
- Assuring compliance with accrediting and regulatory governing bodies Medicare Advantage Quality improvement initiatives

Contacting Care Management

Providers can contact clinical management during normal business hours at the number below, unless directed to use another number in this chapter. Normal business hours are 8:00 a.m. to 5:00 p.m. CST Monday through Friday.

Utilization Management
Toll-free telephone: 800-287-4188

Case Management
Transition Care Coordination and Complex Case Management: Toll-free telephone: 800-817-7784

Monitoring Utilization

Arkansas Blue Medicare uses various mechanisms to assure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization, such as overutilization, underutilization and inefficient or inappropriate uses of resources. This helps ensure that Arkansas Blue Medicare members receive the medical services required for health promotion, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of healthcare effectiveness data and information set data
- Results of member satisfaction surveys
- Rate of inpatient admissions
- Rate of emergency services
- Review of alternative levels of care such as observation
- High dollar claim triggers
- Chronic condition identification
- Transitions care whether it be to a facility or within the community
- Review of prior authorization rates for required services
- Monitor plan directed care referrals for out-of-network utilization
- Observation care

Affirmation Statement

Arkansas Blue Medicare bases their utilization decisions about care and service solely on their appropriateness in relation to each member's specific medical condition. Arkansas Blue Medicare's review staff has no compensatory arrangements that encourage denial of coverage or service. Clinicians employed by Arkansas Blue Medicare do not receive bonuses or incentives based on their review decisions. Arkansas Blue Medicare bases all clinical review decisions on medical necessity by applying approved clinical criteria and ensures thorough and consistent utilization management decision-making within the limits of the member's plan coverage.

Appropriate Professionals

Arkansas Blue Medicare continues to demonstrate its commitment to a thorough and consistent utilization decision process by working collaboratively with its participating physicians. A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by Medicare Advantage care management nurses. It may be necessary for the plan medical director to contact physicians for additional information about their patients to assist in making a determination.

Peer-to-Peer

The peer-to-peer process is intended to facilitate a discussion between a provider and a plan medical director. The peer-to-process should be used to explain or clarify something that a clinical record cannot convey. It should not be used as a means to provide additional clinical information. A peer-to-peer review may be initiated by the requesting provider any time prior to a pre-service written determination being rendered. A peer-to-peer discussion may be requested any time for a concurrent review determination if the member has not discharged from the facility.

Providers who wish to discuss an authorization with a plan medical director may do so by contacting Care Management at 800-287-4188 between 8 a.m. CST and 5:00 p.m. CST, Monday through Friday.

SECTION 14: Clinical Review Requirements

Overview of Clinical Review

Medicare Advantage clinical review process is established to do the following:

- Ensure uniformity in the provision of medical care
- Ensure the medical appropriateness and cost effectiveness of certain services
- Improve the overall quality of care Arkansas Blue Medicare members receive
- Lower the cost of coverage for Medicare Advantage members
- Render timely determinations and issue timely notifications specific to **CMS regulation**
  - Medical
    - Standard determinations within 14 calendar days
    - Expedited determinations within 72 hours
  - Part B Pharmacy
    - Standard determinations within 72 hours
    - Expedited determinations within 24 hours

Arkansas Blue Medicare determines which services are subject to clinical review by analyzing the plan's utilization data and comparing it with the following:

- Internal goals
- External benchmarks, such as HEDIS®
- Medical policies and other evidenced based criteria

Other factors are also taken into consideration, such as:

- Procedures high in cost or volume
- Trends toward increasing use of a procedure or service
- Evidence of or reason to suspect actual or potential misuse
- Variations in practice patterns

In deciding which services require clinical review, Arkansas Blue Medicare also looks carefully at:

- The negative impact the proposed review program might have on providers
- The acceptability of any existing criteria, such as InterQual criteria, Medicare guidelines or information from the medical literature
- Administrative impacts to the health plan and providers
- Market analysis or benchmarking, to determine whether the procedure is within the range of reasonable or accepted practice
- Net cost savings, considering any possible administrative cost offset

Criteria and Guidelines for Decisions

The criteria adopted by the plan are updated annually and include CMS Medicare Guidelines and the following:

Criteria	Application
CMS guidelines • NCDs • LCDs • Medicare articles • Other CMS coverage manual or guidance	• Inpatient admissions • Continued stay • Discharge readiness
InterQual	1. LOC: Acute Criteria 2. LOC: Post Acute Inpatient Criteria 3. LOC: Post Acute Outpatient Criteria 4. Ambulatory Care Criteria, including Medicare content 1. DME 2. Part B Drugs, Non-Oncology 3. Procedures
eviCore® utilizes InterQual review criteria available at **https://www.evicore.com/provider**	• Radiology • Radiation therapy • Durable medical equipment • Oncology
Lucet Health internet medical policy available at **https://lucethealth.com**	• Outpatient services • Residential services • Inpatient services • In addition to behavioral health case management

Obtaining Criteria

The review criteria related to a specific decision are available to physicians upon request by calling Medicare Advantage Care Management at 800-287-4188.

Clinical Review Determination

In addition to reviewing clinical information, Arkansas Blue Medicare evaluates the following:

- The member's eligibility coverage and benefits
- The medical need for the service
- The appropriateness of the service and setting
- Continuity of Care

If additional clinical information is required to approve the service, a Medicare Advantage Care Management representative will call and/or fax the provider to ensure that all needed information is received in a timely manner.

Clinical Review Required

Arkansas Blue Medicare must review and approve select services before they are provided. The primary

reason for clinical review is to determine whether the service is medically necessary, whether it is performed in the appropriate setting and whether it is a benefit covered by the member's plan. Clinical information is necessary for all services that require clinical review to determine medical necessity.

A complete list of the clinical criteria and required information that apply to each requested service can be found below:

- Acute hospital admissions (Notification required next business day)
- 30-day bundling for readmissions (Notification required next business day)
- Skilled nursing facility admissions (Notification required prior to admission and prior to exhausted days for concurrent review)
- Long-term acute care hospital admissions (Notification required prior to admission and prior to exhausted days for concurrent review)
- Inpatient rehabilitation (Notification required prior to admission and prior to exhausted days for concurrent review)

The Medicare Advantage Prior Authorization Guide and Prior Authorization Forms can be found on the Arkansas Blue Cross Website: **https://www.arkansasbluecross.com/providers/resource-center/provider-forms**

Submit the Required Clinical Information with the Initial Review Request
Providers are encouraged to submit the required clinical information with the initial request for clinical review sent via fax.

Clinical information for acute and post-acute hospital admissions and expedited pre-service authorizations can be submitted by faxing it to clinical management at 816-313-3013. Standard authorizations can be submitted by faxing to 816-313-3014. Part B Pharmacy authorization can be submitted by faxing Pharmacy team to 816-313-3015.

Arkansas Blue Medicare is required by regulatory agencies and by Medicare to notify members as to what clinical information is needed to process a request for clinical review. When providers submit the clinical information with the initial request, it decreases the number of letters Arkansas Blue Medicare is required to send to members.

Guidelines for Observations and Inpatient Hospital Admissions

Contracted facilities must notify Arkansas Blue Medicare of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that Arkansas Blue Medicare members receive care in the most appropriate setting, that Arkansas Blue Medicare is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Arkansas Blue Medicare of admissions by telephone or fax as follows:

- Telephone: 800-287-4188
- Fax: 816-313-3013

Medicare Advantage nurses conduct admission reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Medicare Advantage nurses also speak to attending physicians when necessary to obtain information.

Clinical information includes relevant information about the member in regard to the following:

- Health history
- Physical assessment
- Test and laboratory results
- Consultations
- Emergency room treatment and response
- Admitting orders

Once authorization is attained, the facility will be provided with an authorization number that is valid for the entire length of stay for the acute care admission.

Emergency Admissions
When an admission occurs through the emergency room, Arkansas Blue Medicare will ask that the facility contact the primary care physician prior to admission to discuss the member's medical condition and to coordinate care prior to admitting.

Elective Admissions
Prior authorization is required, primary care and specialist physicians are required to notify Arkansas Blue Medicare at least 14 days before arranging elective inpatient, whenever possible.

Arkansas Blue Medicare reviews the request to determine whether the setting is appropriate and, if required, meets criteria. Arkansas Blue Medicare notifies the member, primary care physician, attending physician and facility of the determination.

Obstetrical Admissions
Arkansas Blue Medicare requires facilities provide both admission and discharge information on deliveries via fax or phone to the Care Management Department. For all deliveries, the facility should notify Arkansas Blue Medicare one day after discharge. The following information must be provided:

- Admission date, delivery date and discharge date
- Type of delivery
- Whether the baby was born alive
- Whether both mother and baby were discharged alive

Observation Care
Observation care is a well-defined set of specific, clinically appropriate services that are described as follows:

- The services include ongoing short-term treatment, assessment and reassessment.
- The services are furnished while a decision is being made regarding whether a member requires further treatment as a hospital inpatient or can be discharged from the observation bed.

Observation stays of up to 48 hours for Arkansas Blue Medicare members may be eligible for reimbursement when providers need more time to evaluate and assess a member's needs in order to determine the appropriate level of care. Examples (not all-inclusive) of diagnoses that may be treated in an observation setting include:

- Chest pain
- Syncope
- Cellulitis
- Pneumonia

- Bronchitis
- Pain or back pain
- Abdominal pain
- Pyelonephritis
- Dehydration (gastroenteritis)
- Overdose or alcohol intoxication
- Close head injury without loss of consciousness

Options Available Beyond the Observation Period
For members who require care beyond the observation period, the following options are available:

- Contact care management clinical staff to discuss alternate treatment options such as home care or home infusion therapy
- Request an inpatient admission

Note: If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should re-evaluate the member's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.

Medical Necessity Considerations: Inpatient vs. Observation Stays
When Arkansas Blue Medicare members are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses.

Here are some guidelines that clarify how Arkansas Blue Medicare determines medical necessity:

- Arkansas Blue Medicare uses InterQual criteria to make determinations of medical necessity for all Medicare Advantage members.
- Arkansas Blue Medicare does not require physician certification of inpatient status to ensure that a member's inpatient admission is reasonable and necessary. For Original Medicare patients, however, this certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under **42 CFR Part 424 subpart B** and **42 CFR 412.3**.
- When the application of InterQual criteria results in an Arkansas Blue Medicare member's inpatient admission being changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- The Medicare Advantage clinical review process takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures and the "two midnight" rule.

Review of Readmissions that Occur Within 30 Days of Discharge
Arkansas Blue Medicare reviews inpatient readmissions that occur within 30 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member has the same or a similar diagnosis. Arkansas Blue Medicare reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of, or inadequate, discharge planning
- A planned readmission
- Surgical complications

In some instances, Arkansas Blue Medicare combines the two admissions into one for purposes of the DRG

reimbursement. Arkansas Blue Medicare guidelines for bundling a readmission with the initial admission are available: **https://www.arkansasbluecross.com/providers/resource-center/provider-forms**

Guidelines for Submitting Skilled Nursing, Long-Term Acute Care and Inpatient Rehabilitation Facilities

Facilities must notify Arkansas Blue Medicare of all post-acute admissions and provide clinical information prior to the admission for initial requests and prior to the expiration of approved days for continued stay review requests. Timely notification helps ensure that Arkansas Blue Medicare members receive care in the most appropriate setting, that Arkansas Blue Medicare are involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Arkansas Blue Medicare of admissions by telephone or fax as follows:

- Telephone: 800-287-4188
- Fax: 816-313-3013

Arkansas Blue Medicare requires that requests for transitional or discharge planning services be handled during the business hours noted above.

Medicare Advantage nurses conduct admission and discharge planning via telephone or fax by obtaining information from the hospital's utilization review staff. Medicare Advantage nurses also speak to attending physicians when necessary to obtain information.

Clinical information includes relevant information about the member regarding the following:

- Health history
- Prior level of functioning
- Clinical assessment
- Therapy evaluations
- Admitting orders
- Discharge plans

Outpatient and Professional Services Requiring Authorization

Outpatient and professional service prior authorization requirements apply to providers who participate in Arkansas Blue Cross and Blue Shield Blue Medicare Advantage plans.

These requirements affect services provided to members of the following Medicare Advantage plans:

- BlueMedicare HMO
- BlueMedicare PPO

Where prior authorization is required, primary care and specialist physicians are required to notify Arkansas Blue Medicare prior to rendering services. Arkansas Blue Medicare reviews the request to determine if requested services meet the medical necessity criteria. Arkansas Blue Medicare notifies the member, referring physician and rendering physician of clinical determinations.

Prior authorization applies to but is not limited to:

- Durable medical equipment

- Diagnostic testing
- Genetic testing
- Surgical procedures
- Medical procedures
- Professionally administered Part B drugs

Requests for prior authorizations required services are classified in two ways specific to CMS regulation and are to be requested as follows:

- EXPEDITED prior authorization is to be requested when care is deemed to be of priority need and authorization response given within 72 hours.
- STANDARD prior authorization is to be requested when routine care is being provided or scheduled. Authorization response will be within 14 days for standard requests.

*Disclaimers:
The Prior Authorization does not apply to out of network services for PPO members.

Prior authorization is not required for emergencies seen in emergency room and urgent care visits.

Contracted providers should utilize appropriate in-network providers, labs and imaging centers whenever possible as required and in accordance with the participating provider contract. If provider fails to inform member of referral or admission to out-of-network entities or providers, such action shall constitute a material breach of the agreement which may lead to termination of contract(s).

Decision Criteria and Guidelines

Arkansas Blue Medicare criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan or a combination of both. Individual circumstances of a member are taken into consideration when applying the criteria, as are characteristics of the local delivery system such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the network to support the member after discharge
- Member's coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care, where needed
- Ability of network hospital(s) to provide all recommended services within the established length of stay

The review criteria are available to physicians upon request by calling Medicare Advantage Care Management at 800-287-4188.

Discharge Planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member
- Family members
- Primary care physician
- Specialist
- Hospital discharge planning staff
- Ancillary providers, as necessary

Arkansas Blue Medicare monitors all hospitalized members to assess their readiness for discharge and assist with post-hospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. Medicare Advantage nurses work in conjunction with members' primary care physicians to authorize and coordinate post-hospital needs, such as home

healthcare, durable medical equipment and skilled nursing placement. For these members, providers should follow the processes described in the "Guidelines for Transitional Care" section of this chapter.

Note: Only acute care, skilled nursing, long-term acute care and inpatient rehabilitation facilities require pre-authorization.

Standard Timeframes for Medicare Advantage Decisions

The care management staff conducts timely reviews of all requests according to the type of service requested. Decisions are made according to the following standard timeframes:

Type of Request	Decision	Initial Notification	Written Notification	Type of Service
Pre-service urgent/ concurrent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification	Acute and post-acute admissions
Pre-service non-urgent	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request	Surgery

Requests for Information

Pre-service requests: An extension of up to 14 calendar days is allowed if the member asks for the extension or if Arkansas Blue Medicare needs more information to make a decision about the request. The member can request an extension by phone or in writing, using the information on the previous page to contact Arkansas Blue Medicare.

Steps to Take Before Rendering Services that are Not or May Not be Covered

It is recognized that the member may consent to receive services that are not or may not be covered by Arkansas Blue Medicare and that therefore may be payable by the member. Providers are encouraged to verify member benefits prior to service.

To verify member benefits, please contact Provider Customer Service by calling the appropriate number below:

- Provider Customer Service – Medical: 1-800-287-4188
- BlueMedicare Pharmacy: 1-844-280-5833

Expedited Decision

Either the physician or the Arkansas Blue Medicare member may request an expedited decision if they believe that waiting for a standard decision could or would do one of the following:

- Seriously harm the life or health of the member
- Seriously compromise the ability of the member to regain maximum function
- Subject the member to severe pain that cannot be adequately managed with the care or treatment that is being requested

Arkansas Blue Medicare relies on the physician to determine conditions that warrant expedited decisions.

- If the physician requests an expedited decision, the decision is made according to pre-service time frames.
- If the member requests an expedited decision, Arkansas Blue Medicare calls the physician to determine whether the member's medical condition requires a fast decision.
  - If the physician agrees, Arkansas Blue Medicare makes a decision to approve or deny the request according to pre-service expedited time frames (see table found above chapter under the

subheading "Standard Time Frames for Arkansas Blue Medicare members").

- If the physician disagrees, Arkansas Blue Medicare makes a decision according to standard time frames (see table above) and notifies the member of a decision not to make an expedited decision.
- Arkansas Blue Medicare will not make an expedited decision about payment for care the member has already received.

How the Physician May Request an Expedited Decision

Physicians may request an expedited decision per CMS expedited definitions, provider certifies that applying the standard review time frame may seriously jeopardize the member's life, health, or ability to recover, or result in serious impairment or permanent disability. Requests sent as expedited that do not meet the above criteria will be changed to a standard request.

- Imaging, therapeutic radiation or durable medical equipment (DME) contact eviCore by calling 800-646-0418 or by logging into the provider portal available at **https://www.evicore.com/provider**
- Behavioral health by contacting Lucet Health at 888-611-6285 or through their website **lucethealth.com**
- Medical services by calling Arkansas Blue Medicare Care Management at 800-287-4188, or by faxing prior authorization form to 816-313-3013. Expedited telephonic medical requests can only be processed during normal business hours 8 a.m. to 5 p.m. by contacting 800-287-4188

Medical Necessity Considerations: General

As Medicare Advantage organizations, Arkansas Blue Medicare is required by CMS to provide coverage to enrollees for all Part A and Part B Original Medicare covered services. However, CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes as Original Medicare does for providers.

While Arkansas Blue Medicare does apply medical necessity criteria to determine coverage; the criteria do not have to be applied in the same manner as is required under Original Medicare. Specifically:

- Benefits: Arkansas Blue Medicare plans must provide or pay for medically necessary covered items and services under Part A (for those entitled) and Part B.
- Access: Arkansas Blue Medicare enrollees must have access to all medically necessary Part A and Part B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under Original Medicare.
- Billing and payment: Arkansas Blue Medicare plans need not follow Original Medicare claims processing procedures. Arkansas Blue Medicare plans may create their own billing and payment procedures if providers, whether contracted or not, are paid accurately, in a timely manner and with an audit trail.

When determining medical necessity, both Arkansas Blue Medicare and Original Medicare coverage and payment are contingent upon a determination that the following conditions are met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member or is a covered preventive service.

Members Held Harmless

In accordance with their affiliation agreement, providers may not seek payment from members for elective services that have not been approved by Arkansas Blue Medicare unless the member is

informed in advance regarding his or her payment responsibility. Some of the circumstances in which members are held harmless for denied covered services include:

- Urgent/emergent admission denials
- Partial denial of a hospital stay
- Requests for elective services provided by contracted providers that require clinical review but were not forwarded to Medicare Advantage Care Management prior to the service being rendered
- Denials issued for post-service requests for services provided by contracted providers when the information submitted is not substantiated in the medical record

Members at Risk

In certain instances, members are held at financial risk for denied services. These instances occur when:

- The member's contract was not in effect on the date of service.
- The member refuses to leave an inpatient setting after the attending physician has discharged the member.
- A denial has been issued for pre-certified services.
- Services are rendered that are not a covered benefit under the member's certificate.
- Services are rendered at a non-contracted facility.

Medical Records Requests

Medical records may be requested to render a medical management decision or to investigate potential quality concerns. The member's contract allows Arkansas Blue Medicare to review all medical records. Arkansas Blue Medicare must receive all records within 7-10 days of the request. Urgent requests may be made in accordance with expedited CMS requests. Providers cannot charge a copying fee for medical records requested by Arkansas Blue Medicare.

Emergency Room and Urgent Care Services

Emergent Care Defined

Arkansas Blue Medicare provides eligible members with coverage for emergency and urgent care services necessary to screen and stabilize their condition without precertification.

Emergency Care Definitions:

- **Medical emergency:** The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a member's health or pregnancy (in the case of a pregnant woman), serious impairment to bodily functions or serious dysfunction of any bodily organ or part
- **Accidental injury:** A traumatic injury that, if not immediately diagnosed and treated, could be expected to result in permanent damage to the member's health

Medicare Advantage members should not be referred to emergency rooms or urgent care centers for services that can be performed in the primary care physician's office during regular business hours or that do not meet emergency or urgent care definitions.

Coordination of Emergent and Urgent Care Services

Members are encouraged to contact their primary care physician to assist in arranging urgent care services required after hours. Emergency and urgent care providers should send a written summary of the services

provided and the treatment plan to the primary care physician within 30 days of the date of service.

Excessive Use of Emergency Services
All Arkansas Blue Medicare members receive information on the appropriate use of emergency room services, as well as guidelines to follow when a situation does not require emergency care.

Case managers address the unique needs of the high-volume ER user. The member is assessed and interventions are employed including interaction with the Medicare Advantage Pharmacy Services department as well as the member and primary care physician. Members are educated regarding appropriate ER usage and follow up with the primary care physician is arranged as appropriate. In addition, members identified for case management services are sent a document with tips for appropriate ER usage.

The case manager provides written communication to the physician regarding opportunities to assist the member and coordinate an appropriate plan of care.

Part B Medications (Outpatient/Office Administered Drugs)

Submit the Required Clinical Information with the Initial Review Request
Providers are encouraged to submit the required clinical information with the initial request for clinical review sent via fax. These forms should be faxed to the Arkansas Blue Medicare Part B Drug Management at 816-313-3015.

Clinical information includes relevant information about the member in regard to the following: A copy of the form used to submit clinical information for the Part B drug and can be found on our website at **https://www.arkansasbluecross.com/providers/resource-center/prior-approval-for-requested-services**

Diagnosis Information

- Drug name, J code, dose and quantity requested
- Pertinent test and laboratory results
- Documentation of failed therapies

Part B Medical Drug Reviews

- Utilize InterQual Specialty Medication Criteria for Part B drugs administered in outpatient or office for non-oncology purposes

Note: For oncology drug requests or drugs administered with chemotherapy, please call EviCore at 800-646-0418.

CMS Regulated Timeline for Decisions on Part B Medications

- Standard determinations within 72 hours
- Expedited determinations within 24 hours
- Expedited determinations are considered where a member is in direct health harm if the drug is not administered urgently.

Administrative Denials

Administrative denials are determinations made by Arkansas Blue Medicare in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness.

Administrative denials can be issued by Arkansas Blue Medicare with or without review by a plan medical director. Examples of situations likely to result in administrative denials include but are not limited to:

- Authorization submissions for non-covered benefits
- Requests for out-of-network exceptions requests when care is available in-network

The administrative determination appeal process affords providers and practitioners one level of appeal for Medicare Advantage Care Management determinations related to administrative denials.

Medicare Advantage Health Education and Management Program

Arkansas Blue Medicare has developed a chronic condition management program to help members manage chronic diseases through a partnership among physicians, members and the plan.

Arkansas Blue Medicare's healthcare management strategies include education about staying healthy and living with an illness. The objective of these strategies is to improve clinical outcomes, reduce costs and improve member and physician satisfaction.

Goals for Chronic Condition Management
Arkansas Blue Medicare identifies members with chronic conditions who may benefit from chronic condition management interventions designed to:

- Promote early diagnosis and appropriate treatment according to recognized clinical practice guidelines
- Provide tools to simplify member self-management efforts
- Improve member adherence to a treatment plan
- Provide continuity of care through specialty case management when indicated
- Integrate health promotion and wellness initiatives across the continuum of care
- Educate members about the purpose and importance of advance directives

Arkansas Blue Medicares role in chronic condition management includes:

- Analyzing plan data and targeting conditions appropriate for program development
- Researching, developing and distributing clinical practice guidelines
- Developing and implementing comprehensive chronic condition management programs
- Using predictive modeling to determine individual member interventions
- Mailing educational materials to members about self-management, preventive health issues, relevant medical tests, lifestyle issues and medication compliance
- Offering registered nurse chronic condition managers who make outreach calls to identified members
- Providing educational resources to physicians
- Studying outcomes to determine the impact of chronic condition management programs

Member Participation

Members identified as eligible for specific Medicare Advantage chronic condition management programs are automatically enrolled (member identification criteria are consistent with Arkansas Blue Medicare's clinical practice guidelines). Members can decline participation in a program at any time.

Source of Information	Description
Medicare Advantage Health Education and Management Program: 866-427-8681 Monday through Friday 8:00 a.m. to 4:30 p.m. CST (except holidays)	A toll-free number staffed by experienced registered nurses. Arkansas Blue Medicare encourages members and physicians to ask questions and request additional information.

Medicare Advantage Health Risk Assessments

A health assessment completed by the member is encouraged as part of an annual wellness visit for Medicare Advantage members, according to the Patient Protection and Affordable Care Act and CMS.

Quality Management

All Arkansas Blue Medicare organizations are required to have a quality improvement (QI) program as described in the federal regulations at 42 CFR §422.152, "Quality improvement program." The requirements for the PDP Quality Assurance program are based in regulation as per 42 Code of the Federal Regulations § 423.153(c).

The primary goal of the MA organization's QI program is to effect sustained improvement in patient health outcomes. As provided under 42 CFR §422.152(c) and §422.152(d), Arkansas Blue Medicare's QI program must include at least one chronic care improvement program (CCIP) for one chronic condition and a quality improvement project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

Obtaining a Pre-Service Organization Determination

(not related to services or items requiring pre-authorization/certification)

Providers may choose to obtain a written pre-service organization determination from us before providing a service or item.

All Arkansas Blue Medicare plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets Original Medicare medical necessity criteria, it will be covered by Arkansas Blue Medicare, subject to the member cost share and the terms and conditions of the member's particular health plan.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To request a pre-service organization determination, print the form from our website by clicking on the appropriate link **Organization Determination Form** and submitting your request by fax to 816-313-3014.

Arkansas Blue Medicare will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Arkansas Blue Medicare's justification that the delay is in the member's best interest.

In cases where you believe that waiting for a decision under this time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, fax your request indicating "Urgent" or "Expedite" on the first page of the request. We will notify you of our decision within 72 hours; unless a 14-day extension is requested by the member or the plan justifies a 14-day extension is in the best interest of the member.

Be sure to include the following information with your request for an advance coverage determination:

- Provider or supplier contact information including name and address
- Anticipated date of service, if applicable
- Procedure/HCPCS and diagnosis codes
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Documentation and any correspondence that supports your position that the plan should cover the service or item (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)
- Name and signature of the provider or provider's representative

Network Exception

Arkansas Blue Medicare members do not have out-of-network benefits.* In addition, BlueMedicare PPO and PFFS members may have a higher cost share for services or items received from an out-of-network provider. Providers have the option of requesting a network exception for specialized services when there is limited or no access to Arkansas Blue Medicare network providers.

To request a network exception, complete the **Out-of-Network Exception Form** and fax to:

- Standard requests: 816-313-3014
- Expedited requests: 816-313-3013

*Exceptions: emergency care, urgently needed services when the network is not available and out-of-area dialysis services.

Quality Improvement Organization – KEPRO

A Quality Improvement Organization consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan like Arkansas Blue Medicare. The QIO for Arkansas is KEPRO.

Contacting the QIO

Members may request a QIO review from KEPRO if they disagree with the decision of an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency to discharge them.

To appeal, members may contact KEPRO at:

5201 West Kennedy Blvd.
Suite 900
Tampa, FL 33609
ATTN: Records Department
Toll-free phone number: 888-315-0636
TTY* 711

Hours: 9 a.m. to 5 p.m. Monday through Friday 11 a.m. to 5 p.m. Weekends and Holidays
Toll-free fax: 844-878-7921

Member Appeal Rights for Hospital Discharge

Members who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe that coverage of their hospital stay is ending too soon.

Hospitals are required to notify all Arkansas Blue Medicare members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the standard CMS form *An Important Message from Medicare About Your Rights* twice – the first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the member or of his or her representative and provide a copy.

Note: A link to the form An Important Message from Medicare About Your Rights is found at: cms.gov > Covering more Americans > Medicare > Medicare Program – General Information > Beneficiary Notices Initiative > Hospital Discharge Appeal Notices > **Important Message from Medicare - English and Spanish.**

Arkansas Blue Medicare members have the right to appeal to the QIO for immediate review when a hospital and Arkansas Blue Medicare, with physician concurrence, determine that inpatient care is no longer necessary.

Hospital Discharge Appeal Process

If the Arkansas Blue Medicare member is dissatisfied with the discharge plan:

1. A member who chooses to exercise his or her right to an immediate review must submit a request to the QIO, following the instructions on the *An Important Message from Medicare About Your Rights* notice.
2. If Arkansas Blue Medicare is driving the discharge, The QIO notifies the health plan that the member has requested an immediate review.
3. Arkansas Blue Medicare or the facility is responsible for delivering to the member a *Detailed Notice of Discharge* as soon as possible, but no later than noon of the day after the QIO's notification. The standardized notice includes a detailed explanation of the reason that services are either no longer reasonable and necessary or are otherwise no longer covered. The *Detailed Notice of Discharge* must be completed and submitted by the entity that determines that covered services are ending, whether it is Arkansas Blue Medicare or the facility.
4. Arkansas Blue Medicare or the facility must supply any other information that the QIO needs to make its determination as soon as possible but no later than the close of business on the day that Arkansas Blue Medicare notifies the facility of the request for information. This includes copies of both the *An Important Message from Medicare About Your Rights* notice and the *Detailed Notice of Discharge* and written records of any information provided by phone.
5. The QIO makes a determination and notifies Arkansas Blue Medicare, the member, the hospital and the physician of its determination within one calendar day after it receives the requested information.
6. Arkansas Blue Medicare continues to be responsible for paying the costs of the member's stay until noon of the next calendar day following the day that the QIO notifies the member of their coverage decision.
7. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from Arkansas Blue Medicare.

Member Responsibilities Related to Hospital Discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to hospital discharges.

If …	Then …
The QIO agrees with the doctor's discharge decision	The member is responsible for paying the cost of his or her hospital stay beginning at noon of the calendar day following the day that the QIO notifies the member of the coverage decision.
The QIO disagrees with the doctor's discharge decision	The member is not responsible for paying the cost of additional hospital days, except for certain convenience services or items not covered by Arkansas Blue Medicare.

Circumstances in Which the Immediate Review Process Does not Apply

The immediate review process does not apply in these circumstances:

- To care provided in a physician clinic
- To observation care
- To inpatient-to-inpatient transfers
- To admissions for services that Medicare never covers
- When the member has exhausted all his or her Medicare days

QIO Immediate Review of SNF, CORF and HHA Discharges

Special expedited appeal rights for members being discharged from SNF, CORF or HHA services

Arkansas Blue Medicare members receiving skilled nursing facility care, home health agency services or services at a comprehensive outpatient rehabilitation facility, have special appeal rights that allow an expedited review if they disagree with the decision to end covered services.

The Medicare form Notice of Medicare Non-Coverage is delivered to Arkansas Blue Medicare members by the providers of SNF, HHA or CORF services in one of the following situations:

- When medical necessity criteria are no longer met and no additional days are authorized by Arkansas Blue Medicare or the facility/provider
- At least two days prior to a scheduled discharge date

The *NOMNC* contains detailed instructions about how members may request an immediate appeal directly to the QIO if they disagree with the decision to end services.

The *NOMNC* Appeal Process

Medicare regulations require the provider to deliver the standard *NOMNC* to all members when covered services are ending, whether or not the member agrees with the plan to end services. Here's how:

1. The provider delivers the *NOMNC* to members at least two calendar days before coverage ends. If the member is receiving home health agency services and the span of time between services exceeds two days, the provider may deliver the *NOMNC* at the next-to-last time that services are furnished. The form must be delivered whether or not the member agrees with the plan to end services.
2. Special considerations related to delivery of the NOMNC:
   - Arkansas Blue Medicare encourages providers to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.
   - If services are expected to be less than two days in duration, the provider may deliver the *NOMNC* at the start of service. A member who receives the *NOMNC* and agrees with the termination of services before the end of the two days may waive the right to request the continuation of services.
   - If the member is not mentally competent to receive the notice, the provider must deliver it to the member's authorized representative.
3. The provider requests that the member sign and date the *NOMNC*, acknowledging receipt of his or her appeal rights. If the member refuses to sign the form, the facility must record the date and time it was delivered to the member.
4. The provider must fax the signed *NOMNC* for Skilled Nursing Facilities only back to Medicare Advantage Care Management at 816-313-3013, Attention: Medical Records.
5. The provider is expected to retain a signed copy of the *NOMNC* form with the member's medical record. The member is responsible for contacting the QIO by noon of the day before services end if he or she wishes to initiate an expedited review by following the detailed instructions on the form.
6. When the member initiates an expedited review, the *Detailed Explanation of Non-Coverage (DENC)* is delivered to the member by the close of business on the same day that the QIO is notified of the member's request for appeal. The *DENC* provides specific and detailed information as to why the member's SNF, HHA or CORF services are ending.

Note: The *DENC* must be completed and submitted by the entity that determines that covered services are ending, whether it is Arkansas Blue Medicare or the SNF, HHA or CORF provider.

7. Arkansas Blue Medicare may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.
8. A copy of the *DENC* is also sent to the QIO.
9. The expedited review process conducted by the QIO is usually completed within 48 hours. The provider, the member and Arkansas Blue Medicare is notified of the decision by the QIO.
10. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from Arkansas Blue Medicare.

Other Considerations in the *NOMNC* Process

Providers should also be aware of the following when notifying a member that his or her services are ending:

- Contracted facilities should be using the appropriate *NOMNC* forms. Providers should insert their name, address and phone number in the spaces provided at the top of the form.
- Arkansas Blue Medicare may issue a next review date when authorizing SNF services. The next review date does not mean Arkansas Blue Medicare is denying further coverage.
- Providers should submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, Arkansas Blue Medicare will allow for two additional days for the provider to supply.
- The member with the *NOMNC*. The form should only be given to members when SNF criteria are no longer met and no further days are authorized by Arkansas Blue Medicare or two days prior to a scheduled discharge date.
- If there is a change in the member's condition after the *NOMNC* is issued, both Arkansas Blue Medicare and providers should consider the new clinical information. If there is a change in the effective date that coverage ends, the provider should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended *NOMNC* at least two days before services end.

Member Responsibilities when Appealing SNF, CORF or HHA Discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to discharges from SNF, CORF or HHA services.

If …	Then …
The QIO agrees with the doctor's decision to end covered services	The member is financially responsible for services on the date indicated on the *NOMNC*.
The QIO disagrees with the doctor's decision to end covered services	BCN Advantage will continue to cover the services.

Transitional Care Coordination/Complex Case Management Program Overview

The Medicare Advantage transitional care and complex case management programs provides patient-focused, individualized case management for members who meet trigger criteria, including the following:

- Are dealing with an active disease process
- Are at high-risk for health complications
- Demonstrate high use of healthcare resources
- Experience admissions and readmissions to an inpatient care setting
- Have gaps in medical care
- Have medication compliance issues

Members with complex conditions who need coordination of care may be eligible for the case management services described in this section.

Members with chronic conditions who require less coordination of care may be eligible for one of Arkansas Blue Medicare's chronic condition management program.

Information on the chronic condition management program is found in the Chronic Condition Management section of this chapter.

Transitional Care Coordination/Complex Case Management Direct Referral Sources
Typical referral sources may include:

- Arkansas Blue Medicare customer service
- Arkansas Blue Medicare chronic condition management programs
- Inpatient admissions
- Discharges from skilled nursing facilities and rehabilitation centers
- Caregivers and members

Predictive Modeling Indicators
In addition to the typical direct referral sources for case management or transitional care coordination, Arkansas Blue Medicare uses a predictive modeling approach to prospectively identify members who might benefit from case management. Predictive modeling allows for assessment of the entire Medicare Advantage population and identification of the following members:

- Those at risk for progression of illness, development of chronic disease and incurring high costs in the future
- Those admitted and readmitted to inpatient care settings
- Those admitted for inpatient care who might have been treated in an ambulatory care setting
- Those with gaps in medical care
- Those with medication compliance issues

Calling for Transitional Care Coordination/Complex Case Management Services
Providers can contact Medicare Advantage Care Management during normal business hours for any case management services at 800-817-7784.

Transitional Care Coordination/Complex Case Management Team
The case management team is staffed by registered nurse case manager Transitional Care Coordinators and social workers. Case managers receive extensive training in case management and many are certified in case management.

Case managers/transitional care coordinators, in conjunction with the member's treating practitioners, provide education and coordination of services to help the member achieve optimal health outcomes and prevent disease complications.

Conditions Addressed by Transitional Care Coordination/Complex Case Management Services with Clinical Associates
Case management services are available for members with the following conditions:

- Chronic obstructive pulmonary disease
- Complex conditions
- Diabetes
- Heart failure
- High-risk pregnancy
- Ischemic heart disease
- Kidney health management
- Oncology
- Transplants

Provider Notification
Arkansas Blue Medicare will send providers a copy of the case letter when members participate in the case management program.

Transitional care coordinators/complex case managers may also call a provider about a member's condition, such as when there is a significant change in health status, a compliance issue or any potential urgent or emergent situation that requires immediate attention.

The Transitional Care Coordination/Complex Case Management Role

A Medicare Advantage transitional care coordinator/complex case manager facilitates the physician's plan of treatment and the provision of healthcare services as outlined in evidence-based clinical practice guidelines. The transitional care coordinator/complex case manager contacts members by phone to perform an assessment of the member's healthcare status. Goals are identified and interventions are implemented to support the physician's treatment plan. The case manager provides personalized support and education on disease, nutrition, medication and managed care processes and identifies and facilitates access to benefits and resources available to prevent complications and progression of disease.

The transitional care coordinator/complex case manager coordinates care with the treating physician and offers suggestions to practitioners for member management. Timely communication with the treating practitioner is essential in the performance of case management activities. Ongoing communication occurs based on changes in the member's condition or identified needs.

The transitional care coordinator/complex case manager may contact the treating practitioner, and talk with the plan medical director, as necessary, in the following circumstances:

- When there are significant changes in the member's health status
- When intervention on the part of the treating practitioner is thought to be necessary
- When the member uses emergency room services or is admitted for inpatient care
- To review the member's progress at various intervals in the case management process
- To notify the treating practitioner that:
  - A member who was participating in the case management program but who refuses further intervention even though goals are unmet
  - A member has not complied with the recommended plan of care
  - A potential urgent or emergent situation has been identified related to a member (for example, safety issues such as a member self-reporting that he or she took an unusually large dose of medication or the case manager identifying a potential case of abuse or neglect)
- To obtain the health information necessary to ensure the highest quality of care

Note: The transitional care coordinator/complex case manager notifies the treating practitioner the same day on which the potential safety issue is identified.

To contact a transitional care coordinator/complex case manager or to provide comments and feedback regarding case management services, providers should call 800-817-7784 during normal business hours.

Arkansas Blue Medicare members have access to both community and telephonic based case managers.

Nurses and social workers provide individualized, case management in the state of Arkansas and contiguous counties to high-risk members. Transitional care coordinator/complex case manager work remotely and are based out of the home or office but work collaboratively with the community and physician offices, home care agencies, hospitals and other healthcare facilities.

Telephonic based nurses-provide support to lower risk members via telephone and are licensed in the state in which the member resides.

What Physicians Can Expect from Transitional Care Coordination/Complex Case Management

Transitional Care Coordinator/Complex Case Managers Recognize the Provider's Right to:

- Obtain information about Arkansas Blue Medicare's case management programs and staff, including staff qualifications, with which the provider's members are involved
- Be informed about how Arkansas Blue Medicare coordinates case management activities, interventions and treatment plans through reports from the transitional care coordinator/complex case managers throughout the course of case management
- Be supported by the transitional care coordinator/complex case managers in making decisions interactively with members regarding member healthcare needs
- Receive courteous and respectful treatment from the case management staff
- Communicate a complaint to the case manager or the case management unit and receive appropriate follow up on the complaint
- Know how to contact the person responsible for managing and communicating with the provider's patients

Note: Transitional care coordinator/complex case managers may receive requests for services specifically excluded from the member's benefit package. Arkansas Blue Medicare does not make exceptions to member benefits, which are defined by the limits and exclusions outlined by the individual member's certificate and riders. In these situations, Medicare Advantage case managers inform the member about alternative resources for continuing care and how to obtain care, as appropriate, when a service is not covered or when coverage ends.

Coordination of Medical and Behavioral Healthcare Needs
Through the medical management review process, Medicare Advantage's clinical staff screens member behavioral health conditions.

If a potential behavioral health need is identified, the member is referred to Lucet Heatlh.