# PROVIDERS' NEWS

March 2018

A publication for participating providers and their office staffs


# Have you heard?

## 2018 Spring Provider Workshops

Registration now open for Arkansas Blue Cross and Blue Shield's **2018 Spring Provider Workshops!**

These workshops are a great way to learn about current activities and details of upcoming developments that may impact your practice or organization. For your convenience, our network development representatives will be conducting nine provider workshops throughout the state from April 11 to May 23, 2018.

Workshops are offered at various locations to accommodate as many providers as possible, and all sessions will provide the same information. Please review page two and click the appropriate link to complete the registration for the regional workshop in your area located in the bottom right corner of the page. We hope to see you there!

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**Please note this issue was revised on March 27, 2018.*

# 2018 spring provider workshops

Providers interested in attending one of the workshops listed below can now register online. If you have any additional questions regarding a workshop in your area, contact your Network Development Representative.

## Central Region

**Little Rock**
Chenal Country Club
10 Chenal Club Blvd
Wednesday, April 18
(Choose AM **or** PM session)

**Morning session:**
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

**Afternoon session:**
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

## Northeast Region

**Jonesboro**
St. Bernard's Medical Center
- Auditorium
505 E Washington Ave
Wednesday, May 23
(Choose AM **or** PM session)

**Morning session:**
Registration 8: 30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

**Afternoon session:**
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

## Northwest Region

**Mountain Home**
Baxter Regional Medical Ctr
- Lagerborg Conference Ctr
624 Hospital Dr
Friday, April 13

**Morning session:**
Registration: 8:30 – 9:00 a.m.
Workshop: 9:00 – noon

## Northwest Region

**Springdale**
Jones Center for Families
- Auditorium/Chapel
922 East Emma Ave
Wednesday, April 11

**Morning session:**
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – noon

## South Central Region

**Hot Springs**
National Park Comm College
- Martin Eisele Auditorium
101 College Dr
Thursday, May 3

**Afternoon session:**
Registration 1:00 – 1:15 p.m.
Workshop 1:15 – 3:30 p.m.

## Southeast Region

**Pine Bluff**
Pine Bluff Country Club
1100 W 46th Ave
Tuesday, May 8

**Morning session:**
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

## Southwest Region

**El Dorado**
El Dorado Conference Ctr
311 South West Ave
Tuesday, May 1

**Afternoon session:**
Registration 1:00 – 1:15 p.m.
Workshop 1:15 – 3:30 p.m.

## Southwest Region

**Texarkana**
Texarkana Convention Center
2910 S. Cowhorn Creek Loop
Wednesday, May 2

**Afternoon session:**
Registration 1:00 – 1:15 p.m.
Workshop 1:15 – 3:30 p.m.

## West Central Region

**Fort Smith**
Sparks Regional Medical Ctr
- Shuffield Center
1001 Towson Ave
Thursday, April 12

**Morning session:**
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – noon

**To register on-line, please choose from the following locations:**

El Dorado: https://surveymonkey.com/r/36QBGPV
Fort Smith: https://www.surveymonkey.com/r/THD8BJB
Hot Springs: https://www.surveymonkey.com/r/3TBKHDM
Jonesboro: jdbailey@arkbluecross.com
Little Rock: https://www.surveymonkey.com/r/PCWTJLZ
Mtn. Home: https://www.surveymonkey.com/r/THSY8NS
Pine Bluff: https://www.surveymonkey.com/r/LG297K5
Springdale: https://www.surveymonkey.com/r/TRC8YWC
Texarkana: https://www.surveymonkey.com/r/335JGKL

# Alpha numeric prefixes coming in 2018

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers of the change from all alpha (only) prefixes to the use of alpha numeric prefixes in 2018. This change results from the potential of the current pool of alpha prefixes running out as early as 2018 and will slow the rate of consumption. The move to an alpha numeric prefix solution increases the prefix pool and mitigates the risk of impacting the Plans business and new initiatives. The software update was distributed in Release 17.5 on October 15, 2017, with utilization **effective on April 15, 2018.** These six combinations will be released once the current set is exhausted:

| | | |
|---|---|---|
| A2A | 2AA | 22A |
| AA2 | 2A2 | A22 |

Please contact your network development representative with any questions.

# Performant recovery engagement

In a continuing effort to manage healthcare costs and enhance the quality of services provided to our members, Arkansas Blue Cross and Blue Shield has partnered with Performant Recovery Inc. to perform retrospective claim payment audits. The purpose of these audits is to determine the accuracy of both the information submitted for reimbursement and the amount paid based on the claim.

With broad experience in both the commercial and government-sponsored healthcare markets, Performant provides audit and recovery services for national, regional and commercial payers, including many Arkansas Blue Cross plans, as well as Medicaid MCOs and Medicare Advantage plans.

In October 2008, Performant was named CMS Region A Recovery Audit Contractor (RAC) and has been a RAC auditor since that time. In 2016, Performant was again awarded Region 1 (formerly referred to as Region A) and was also awarded the newly-created Region 5 for which Performant will serve as the sole auditor for DMEPOS, Home Health and Hospice claims nationwide. Under these contracts, Performant identifies and prevents improper payments through the deployment of advanced data mining technology, automated and complex clinical reviews and provider outreach efforts.

Performant uses proprietary claim audit technology built through industry and best practice coding standards, local and national coverage determinations and their experience with Medicare audits. This technology is augmented by a physician-led team of registered nurses, coding specialists and analysts who leverage their company's expertise to ensure audits are appropriately performed. Performant will customize their audit work in accordance with Arkansas Blue Cross contracts and policies.

You may receive a letter from Performant requesting you provide information as part of the audit process. Per the Right to Access and Audit portion of your network agreement, it is important to read and respond in a timely manner to the instructions provided in Performant's audit request with complete information. Not responding to Performant will be considered a "finding" which may result in recoupment of claim reimbursement. We appreciate your cooperation in this necessary program.

# Primary Care Resource: Care Management Portal

If you are a primary care physician with patients aligned to you through Arkansas Blue Cross and Blue Shield and our family of companies, you have access to a tool through the Advanced Health Information Network (AHIN) that can help you manage your patients' care.

The Care Management Portal (CMP) provides clinically relevant data on three levels:

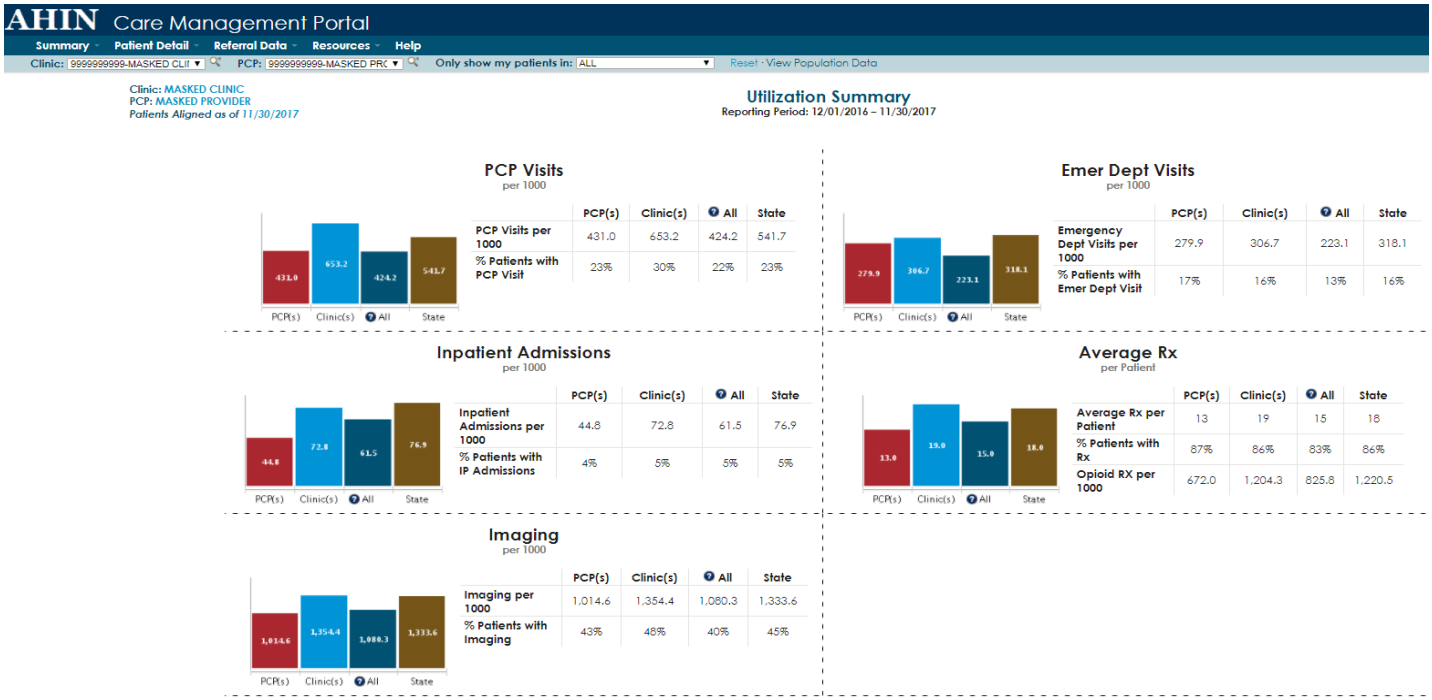
- Summary data at the practice/provider level
- Patient-level detail
- Referral data on facilities and specialists

The CMP data is updated monthly and contains a rolling year's worth of information. Nurse practitioners and physician assistants in certain value-based programs with aligned patients also can access their patients data through the CMP.

"The Care Management Portal is designed to assist primary care providers across the state in succeeding in value-based programs through the sharing of information," said David Greenwood, vice president of Enterprise Business Intelligence & Health Information Network. "We continue to enhance the portal to provide meaningful data to assist primary care physicians in effectively caring for our members."

The CMP can be used to help you manage your patients in a variety of ways. You can view a number of metrics concerning your aligned patients, such as:

- Care gaps
- Cost of care
- Emergency department visits
- Prescription utilization

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## Primary Care Resource: Care Management Portal (Continued from page 4)

The utilization summary screen includes PCP and emergency department visits, inpatient admissions, and pharmacy use for every aligned patient with comparisons to peers within a clinic or to the statewide averages.

A list of your aligned patients will be provided and you will have the ability to select a patient for additional information. On the patient detail screen, a "Find Patient" option allows you to search for an aligned patient using his/her first name, last name, date of birth or contract number.

The only patients displayed in the CMP are those aligned to you. That means the member did one of the following:

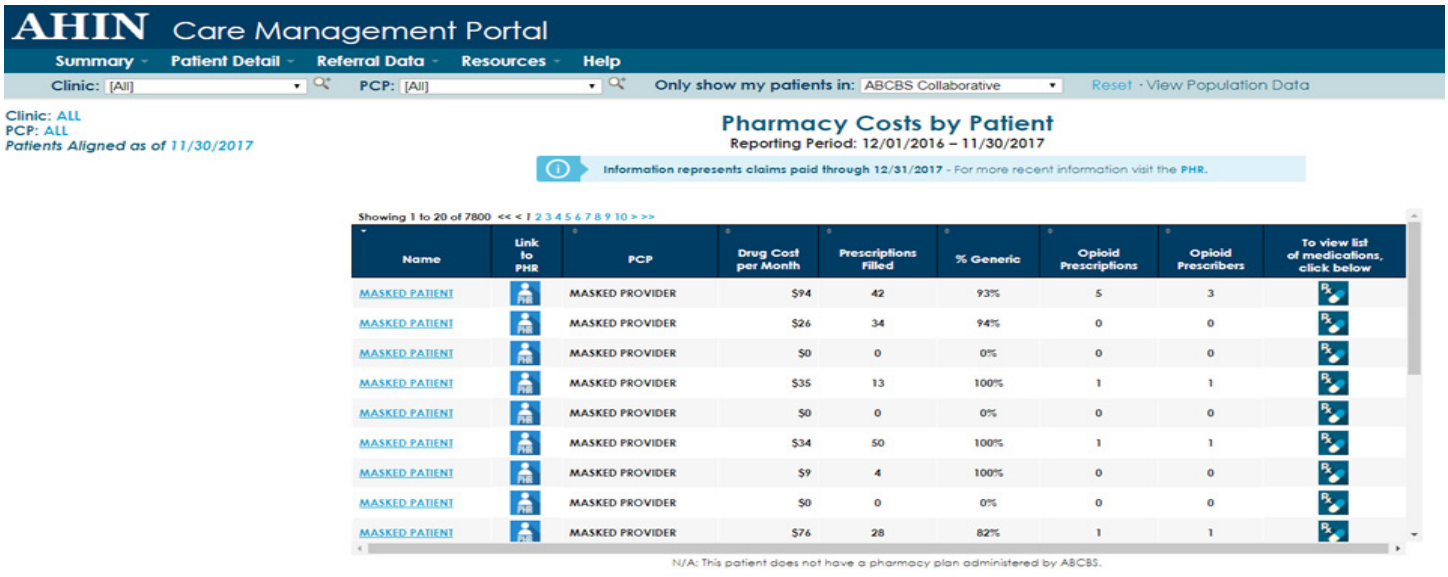
- Selected you through customer service
- Selected you through My Blueprint, our customer self-service web portal
- Had more office visits with you than any other PCP in the previous two years

A separate Medi-Pak® Advantage portal is available to assist your practice in managing this patient population, too. Currently, Federal Employee Program patients are not included in the portal.

Quality metrics chosen are based on HEDIS national standards and collaboration between Arkansas Blue Cross and our provider partners.

The costs shown on the CMP include all costs incurred by your patients, regardless of which provider performed the service or where the service was performed. These costs are displayed in order to assist you in managing the total picture of your patients' care.

Information within the CMP enables practices to provide better patient care. For example, the portal provides patient-specific information to combat the prescription opioid epidemic. The "Pharmacy Costs by Patient" screen identifies the number of opioid prescriptions filled by the patient. It also will identify the number of unique providers who prescribed opioids to the patient, which enables you to better understand the patient's patterns in obtaining opioid prescriptions.




Watch for notices on AHIN to select the best training class for you and your staff. The AHIN training calendar can be found under Provider News on the AHIN home page. If you have questions, contact AHIN customer support at 501-378-2336 or toll free at 855-822-AHIN.

# The Value-Based Compensation Initiative (VBCI): Rewarding value over volume

Arkansas Blue Cross and Blue Shield is working on the development of a new payment model intended to reduce the growth rate in premiums while improving the quality, affordability and sustainability of healthcare by partially transitioning from fee-for-service to value-based compensation.

While much of this article is a re-print of a December 2017 article, it is important to remind hospitals and physicians (including chiropractors, podiatrists and oncologists), that the VBCI will become part of the normal reimbursement methodology for the commercial networks sponsored by Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation (collectively known as "Arkansas Blue Cross"). With that in mind, this is considered an official notice and amendment to all Arkansas Blue Cross provider agreements, that the VBCI program shall be included in each agreements' definition of "Allowance" "Allowances" or "Fee Schedules," as well as becoming part of the Compensation Subject to Health Plan Terms and Payer Policies section in each agreement.

As some topics regarding VBCI may be considered sensitive, Arkansas Blue Cross will be communicating with providers through AHIN when necessary for additional security. However, as much as possible, details of the VBCI will be outlined in the Provider Manual on Arkansas Blue Cross' website and communicated through *Providers' News*.

**REPRINT FROM DECEMBER 2017**

**VBCI OVERVIEW**

As purchasers, healthcare is unaffordable for many, and medical inflation is unsustainable for all of us. There are many reasons that healthcare costs so much and that it increases so much every year. Some of those reasons include:

- Member/patient compliance
- Pharmacy inflation
- Malpractice risks
- Redundancy, waste and lack of coordination
- Provision of low-value care
- Volume-based payments

There is no single solution that will comprehensively address the growing cost of healthcare, and this new payment model is not an attempt to address all of these issues. Rather, this initiative is an effort to address fee-for-service. Fee-for-service incents volume of services rather than value of services. Under the current system, the more covered services that are performed, the more that is paid, regardless of whether those services result in better outcomes. We believe that it's time to change from simply paying for volume, and begin paying for value, and that's the focus of this initiative.

**How does VBCI work?**

Arkansas Blue Cross and Blue Shield's **Value-Based Compensation Initiative (VBCI)** is a new healthcare provider payment model that partially transitions from fee-for-service to value-based compensation.

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Under this payment model, providers who provide high-value care and reduce low-value care have the opportunity to receive more compensation than they would have under fee-for-service only.

Beginning in 2019, we will begin stepping down fee-for-service compensation over a 4 – 5 year period until base fee-for-service compensation approximates Medicare. The funds from this step down of fee-for-service monies will be placed into three separate value pools - hospital, specialist, and primary care. These value pools make up the value-based compensation component.

In 2019, on a quarterly basis, 100% of the value pool funds will be distributed to providers based upon their relative outcomes on a set of value-based performance metrics using the most recent and available 12-month performance period, which will roll forward every quarter.

The performance metrics will be based primarily upon provider scoring using a claims-based scoring methodology developed by a company named RowdMap (www.RowdMap.com). The RowdMap methodology identifies low-value care using widely accepted sources such as Choosing Wisely (www.ChoosingWisely.org), the Dartmouth Atlas (www.DartmouthAtlas.org), and other evidence-based clinical guidelines and research studies.

Choosing Wisely is an initiative of the American Board of Internal Medicine that now includes more than 70 societies comprising more than a million physicians that are supporting efforts to promote more effective use of healthcare resources. Dartmouth Atlas analyzes Medicare claims data for hospital and outpatient care to provide information about the distribution and use of health care resources in hospital referral regions and hospital service areas nationwide.

RowdMap developed algorithms using the sources from Choosing Wisely that define low-value care as care that is delivered in place of an alternative treatment, where the alternative yields at least similar, if not better, outcomes at a lower cost. Low-value services are not necessarily inappropriate for each and every patient, but when a provider is performing substantially more of these services compared to his or her peers it signifies diminished value for the patient population.

For 2020 and beyond, total available compensation will be tied to a reasonable trend factor. Our goal is not to reduce total compensation - rather, our goal is to find a way to create a reasonable trend in the growth of healthcare cost that results in sustained affordability for purchasers.

We believe that volume-based compensation does not incentivize high-value care. This is what this initiative is about – reducing the incentives associated with volume-based compensation and beginning to reward providers for value through the addition of a value-based financial component.

In 2017,

- We communicated to as many stakeholders as possible the high-level introduction to the initiative,
- We responded to as many questions from stakeholders as possible and making that information available to stakeholders via FAQ's, and

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The Value-Based Compensation Initiative (VBCI): Rewarding value over volume (Continued from page 7)

- We continued to work through details of the initiative and begin preparing to communicate those details to stakeholders.

During 2018,

- We will continue communicating with stakeholders,
- On AHIN, we have already provided information on the specific metrics and measures by provider specialty type by which providers will be compared to their peers (cohorts), and
- No later than mid-2018 we plan to release shadow reporting that lets providers know how they're scoring based upon historical claims and provide information to help them improve their scores.

Ultimately, in 2019, we'll begin step downs to fee-for-service, and we'll begin distribution of value pool funds quarterly based upon providers' historical performance scores.

Arkansas Blue Cross and Blue Shield's other value-based programs (patient-centered medical homes (PCMH), Comprehensive Primary Care Plus (CPC+) episodes of care (EOC) and Collaborative Health Initiatives (CHI)) will continue as we implement the VBCI. We will continue to evaluate the effectiveness of each of these programs as we continue moving forward.

There will be some providers that are excluded from the VBCI. A current non-facility inclusion/exclusion listing can be found on AHIN, along with a video introduction to the VBCI and a current FAQ document.

Feel free to send additional questions to vbci@arkbluecross.com.

# Credentialing standards updates for all networks sponsored by Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation

Effective January 1, 2018, the following sections of the networks' credentialing standards for all eligible disciplines and applicants for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage PFFS network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage LPPO network, Health Advantage Medi-Pak® Advantage HMO network, USAble Corporation Arkansas' FirstSource® PPO network, USAble Corporation True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been revised as indicated below:

**I. Revised Standards:**
The following standards have been revised and re-stated.

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Credentialing standards updtaes for all networks (Continued from page 8)

**License:**
All wording under this heading is revised and replaced with the following new wording, under the new heading of "License":

"All participating practitioners must hold and maintain continuously a current, active and unrestricted license (or licenses, if more than one is required under applicable law or regulation) to practice in the state(s) where the practitioner conducts any medical practice or delivers any health care services, as determined by the applicable disciplinary board or licensing or oversight agency. In addition, license restrictions in other states or countries (i.e., states other than the state where a practitioner currently conducts any medical practice or delivers any health care services) will be considered in applying these license standards, i.e., even if a practitioner no longer practices or intends to practice in a given jurisdiction, if the practitioner's license in any jurisdiction is restricted (including but not limited to any limitation, restriction, suspension, surrender (whether voluntary or involuntary), withdrawal or revocation of any license due to any disciplinary action or investigation, or while under investigation, or to avoid investigation or a final administrative finding) then in such circumstances the affected practitioner shall be deemed ineligible for network participation pursuant to this "License" standard. While the networks have adopted a policy of deferring to the applicable disciplinary board or licensing or oversight agency on the question of whether a particular action by such board or agency constitutes a "restriction" on the license of a practitioner, in the absence of a clear, official statement or direction from any such board or agency that specifies whether a particular action constitutes a "restriction" on a license, the networks have adopted and will apply the following rules for what constitutes a "restriction" on a license:

In the absence of clear, official direction or specification by the applicable disciplinary board or agency as to whether a particular action constitutes a "restriction" on a license, a license shall be deemed "restricted" by any action of a disciplinary board or agency that imposes any requirements on the practitioner not generally and equally applied to all licensees, including but not limited to continuing medical education requirements, fines, penalties or assessments of any costs of proceedings against the practitioner, proctoring, chaperone or monitoring requirements of any kind in which the practice activities of the practitioner are subject to any form of oversight or review, any requirements or stipulations as to the location(s) where the practitioner may practice, any limitation on a practitioner's scope or manner of practice (including but not limited to any restrictions as to performance of any specific service, procedure or treatment), any limitations on the numbers or categories of patients the practitioner may serve, or any ongoing audit or reporting requirements as to the practitioner's practice activities, competency, qualifications or care of patients. In assessing whether a "restriction" on the license exists – in the absence of clear, official direction or specification by the applicable disciplinary board or agency – restrictions, conditions or limitations arising from any "Agreed Order," "Consent Order" or any other form of agreement or voluntary arrangement or negotiation with any disciplinary board or agency shall be considered the same as restrictions,

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conditions or limitations imposed without agreement or consent of the practitioner. The preceding notwithstanding, unless otherwise indicated by the applicable disciplinary board or agency, the networks do not intend to treat the following circumstances as constituting a "restriction" on a license: (a) Requirements (short of revocation or suspension of license) imposed on a practitioner solely due to missing deadlines for mandatory minimum continuing medical education requirements, provided the practitioner promptly addresses such deficiencies and is not subject to any other disciplinary action; or

(b) Requirements (short of revocation or suspension of license) imposed on a practitioner solely due to omissions to meet purely administrative standards for licensure, such as payment of annual or periodic license fees or completion of related actions or forms, provided the practitioner promptly addresses such deficiencies and is not subject to any other disciplinary action; or

(c) Requirements (short of revocation or suspension of license) imposed for minor infractions of applicable disciplinary or agency rules, procedures or standards that do not involve any lapse in professional competency, quality or the standard of care provided to any patient, nor any imposition of any proctoring, monitoring or chaperone requirements, nor restriction or limitation of any kind on scope or manner of practice; or

(d) Voluntary enrollment in any impaired practitioner program of a disciplinary board or agency, i.e., self-reporting prior to being subjected to any disciplinary board or agency orders or investigation, provided the applicable board or agency permits such practitioner to continue to practice under its oversight or monitoring, and provided such practitioner complies fully at all times with all requirements of such impaired practitioner program, including but not limited to successfully completing any required rehabilitation, education and testing. (With respect to involuntary participation in any impaired practitioner program, in the absence of contrary, clear and official indication by the applicable disciplinary board or agency, such practitioners shall be deemed to have a "restricted" license for two years from the date of their enrollment in such program, and shall be ineligible to participate in any network until after two years of successful participation, including but not limited to successfully completing any required rehabilitation and testing during such two year period. "Involuntary" participation is construed to be any participation not resulting from self-referral by a practitioner prior to any form of disciplinary board or agency action or investigation, including but not limited to any situation in which a practitioner enters into an "Agreed Order" or "Consent Order" or any other form of agreement or consensual arrangement to enroll in a program, but does so only after having been subjected to action or investigation by the disciplinary board or agency)."

**Applications, Release and Attestation:**
The wording of this standard is revised to read:
"All practitioners must complete a standard application and sign and date a release and attestation on forms as required by [Arkansas Blue Cross and Blue Shield, USAble Corporation or HMO Partners, as applicable] and the Arkansas State Medical Board (for Arkansas MDs and DOs)."

# Revision to the notice of Network Terms and Conditions – malpractice claims and abusive or deceptive claims practices

Effective January 1, 2018, the Network Terms and Conditions of participation applicable to all individual network participants and applicants for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage PFFS network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage LPPO network, Health Advantage Medi-Pak® Advantage HMO network, USAble Corporation Arkansas' FirstSource® PPO network, USAble Corporation True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been revised as indicated below:

Section IX, Malpractice Claims, is revised and replaced in its entirety with the following wording:

**IX. Malpractice Claims**

The Networks' credentialing standards have always taken malpractice claims into account in evaluating providers for initial and ongoing credentialing for participation in the Networks. Providers have been and will continue to be subject to exclusion based on their malpractice history. In looking at malpractice history, the Networks reserve the right to exclude a provider based on the number of cases filed against a provider, the types of cases filed, the amount of any settlement made on behalf of the provider, as well as any combination of the preceding factors or any other factors that appear relevant to evaluating the provider's degree of culpability or responsibility for alleged harm to a patient. The Networks shall be entitled to exclude a provider based on their assessment of the provider's malpractice background, regardless of whether some or all claims have been dismissed, withdrawn, settled or resolved at trial, i.e., the Networks reserve the right to make an independent judgment regarding whether the provider's conduct, as questioned in the malpractice allegations, was negligent or otherwise culpable so as to disqualify the provider from network participation. While most malpractice activity is of such a nature that it must be evaluated on a case-by-case basis, the Networks have determined that it is necessary to set some minimal standards of disqualification, regardless of any other factors or circumstances. These minimal standards include the following:

(a) Any provider who has been named in five or more malpractice lawsuits that resulted in settlements or an adverse judgment against the provider in the most recent ten-year period prior to the date of application or credentialing/recredentialing review is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.

(b) Any provider who has moved practice locations three or more times in the most recent ten-year period prior to the date of application or credentialing/recredentialing

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review, and who also had three or more malpractice lawsuits that resulted in settlements or an adverse judgment against the provider during the same ten-year period, is disqualified and shall be excluded from the Networks on that basis alone, irrespective of any other factors.

(c) Any provider who moves to Arkansas from another state or jurisdiction and whose malpractice history reflects more than three malpractice lawsuits that resulted in settlements or an adverse judgment against the provider in the most recent ten-year period prior to the date of application or credentialing/recredentialing review is disqualified for a minimum period of three years on that basis alone, irrespective of any other factors.

(d) Any provider who has had three or more malpractice lawsuits that resulted in settlements or an adverse judgment against the provider, and who also has received any form of discipline, probation, warning, reprimand, censure, admonition, educational requirement, fine, penalty or other adverse action ("Sanction") from any state medical board or similar state or federal disciplinary authority or agency is disqualified for a minimum period of three years on that basis alone, irrespective of any other factors, including the fact that the medical board or other disciplinary authority or agency may have withdrawn, modified, stayed or suspended its original Sanction at the time of Provider's initial credentialing or recredentialing review. The foregoing notwithstanding, if it is clear that a Sanction, as referenced in this section, is not related to any patient health or safety issue or any quality or competency issue or concern with a practitioner's practice, and is instead simply and exclusively a matter of an administrative oversight or formality of paperwork completion unrelated to the quality of medical services or appropriateness of the practitioner's professional or personal conduct, then in such circumstances, the Sanction shall not be considered when applying this subpart (d), so long as:
(i) no questions or concerns related to patient health or safety, quality, competency or misconduct of the practitioner were involved or implicated in any way in the proceedings; and
(ii) the practitioner promptly pays any applicable fine or penalty, timely completes all compliance mandates, and fully resolves the matter with the applicable disciplinary board or agency; and
(iii) provided that the administrative oversight or problem with paperwork completion was a single incident and has not been repeated.

NOTE: The minimum three-year disqualification period referenced in subsections (c) and (d) above, shall begin upon the date of the credentialing or recredentialing decision that first follows the publication date of this Notice, except that if the affected provider appeals the credentialing or recredentialing decision, the minimum three-year disqualification period shall begin upon the date of the final adverse Appeals Committee decision on such appeal. The minimum three-year disqualification period may be extended based on the number of malpractice claims, the nature of such claims, the amount of any settlement(s), or the number or nature of any Sanctions.

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Section XI (c), Abusive or Deceptive Claims Practices, is revised and replaced in its entirety with the following wording:

**XI. Claims Filing and Coding Policies**
**(c) Abusive or Deceptive Claims Practices**
Network-participating providers must be aware and agree that payers who receive claims from such providers are relying on the completeness and accuracy of the data submitted on the claim form, whether the form is submitted electronically or otherwise. Each data entry is critical to the correct processing of the claim. Participating providers who use the American Medical Association's CPT Manual, ICD-9/ICD-10 procedure codes, HCPCS codes, or the successor or updated versions of any of these established coding conventions to file claims with payers are deemed to make an affirmative representation of fact to the payer that the services or procedures performed are, in fact, the services or procedures described in the code the provider selected and used from the CPT Manual or ICD-9/ICD-10 or HCPCS publications, as reflected on the claim submitted. Submission of a claim that uses an incorrect CPT, ICD-9/ICD-10 or HCPCS code shall be deemed to be an abusive and deceptive practice (and may even constitute fraud) unless clearly accidental and limited to a single source of error (e.g., multiple claims submitted at the same time due to one human or computer error). Any participating provider who, after receiving written notice of incorrect or inaccurate coding or other incorrect or inaccurate claims submission practices, submits any claim under an incorrect code, or uses a code that does not, in fact, describe the service performed, or who submits other inaccurate or misleading information in connection with a claim, shall be subject to exclusion from the network on that basis.

Furthermore, even if submission of incorrect claims was accidental and limited to a single source of error, if the error is repeated after being brought to the attention of participating provider, such provider shall be subject to network exclusion on that basis alone, regardless of whether the inaccuracy was done knowingly, and regardless of the reasons for the repeat error because the network-sponsoring companies must be able to rely on participating providers to diligently correct any claims submission errors and problems to avoid repetition, particularly where such problems have been brought to participating provider's attention. (NOTE: If it is found that a provider had actual knowledge of submitting a false or inaccurate claim, such provider may be subject to network exclusion without first receiving a written notice of the deliberately inaccurate or false submission, i.e., if actual knowledge of false submission is shown, a second chance after notice/warning need not be given).

# Non-specific diagnosis codes

ATTENTION: Non-specific diagnosis codes should not be submitted as the primary diagnosis according to the ICD 10 instructions. The use of these non-specific diagnosis codes may delay claims processing by requiring us to issue a medical records request to accurately adjudicate the claim. To expedite claims processing, please use the most specific diagnosis possible as the primary diagnosis. Remember to include all applicable diagnosis codes; when additional diagnosis codes are included, use of the most specific diagnosis possible is encouraged and may also reduce the need for medical records.

# Cloned Medical Record Documentation Policy

All Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation ("ABCBS") network provider participation agreements require that all providers create and maintain a standard, contemporaneous medical record for each Member receiving services. The medical records shall be created and maintained in compliance with, and shall contain the information required by, state and federal laws and regulations, including requirements of the Medicaid and Medicare programs, and shall be retained for such time periods required by law or regulation, but in any event not less than seven years after the date of service.

All documentation in the medical record must be specific to the individual patient and specific to the individual encounter.

The word 'cloning' refers to documentation that is worded exactly like previous medical record entries. Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). The United States Department of Health and Human Services, Office of Inspector General strongly discourages cloning of medical records and continues to monitor it closely. Cloning of documentation which fails to take into account patient specific variations will be considered a misrepresentation of the medical necessity requirement for coverage of services. In other words, it will be considered a breach of the required terms of each ABCBS provider agreement. Any claim connected to medical record cloning described herein may be denied, and further, providers will not be allowed to bill or seek to collect from the Member any charges described in the cloned medical records.

# Hospital visit and critical care on same day

When a hospital inpatient (or emergency department, or office/outpatient) evaluation and management service (E/M) is furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care, both the critical Care Services (CPT codes 99291 and 99292) and the previous E/M service may be paid on the same date of service.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a code from CPT code range 99231–99233.

Both Initial Hospital Care (CPT codes 99221–99223) and Subsequent Hospital Care codes are "per diem" services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Physicians and qualified non-physician practitioners (NPPs) are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims. The retained documentation shall support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services.

# Referring provider requirement on all claims with laboratory services

Effective April 1, 2018, Arkansas Blue Cross and Blue Shield, Health Advantage and Blue Administrators (ABCBS) are changing their claims billing policy on laboratory service claims to require the referring provider on all professional service claims. Any outpatient claim (physician, nurse practitioners, independent lab, etc.) submitted with a laboratory service must contain the referring provider name and NPI. This referring provider will need to be a provider registered/enrolled in the provider database of Arkansas Blue Cross or its family of companies. Listing a referring provider who is not registered with Arkansas Blue Cross will result in claim rejection or denial.

Over the last few years Arkansas Blue Cross has been required to submit risk adjustment data to state and federal agencies. We have discovered there are many members having lab work done for risk adjustable conditions, but we have no other associated providers' claims in our system. When a referring provider is listed on the laboratory claim, we are able to contact that provider to get additional information necessary for our data submission for our state and federal government affiliated business. We ask that provider offices begin adding the referring providers on these claims immediately, if possible. This request will become a requirement on lab services claims beginning April 1, 2018.

# Testing for Serum Vitamin D levels

Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries have established a Medical Coverage Policy #2018006 for testing for serum vitamin D levels. Effective June 01, 2018, the coverage criteria included in this policy will be applied to claims for testing for serum vitamin D levels billed with the following CPT codes:

- 82306 Vitamin D; 25 hydroxy, includes fraction(s), if performed
- 82652 Vitamin D; 1, 25 dihydroxy, includes fraction(s); if performed

**TESTING FOR SERUM VITAMIN D LEVELS FOR ANY INDICATION NOT LISTED IN THE COVERAGE POLICY, INCLUDING SCREENING OF ASYMPTOMATIC INDIVIDUALS AND TESTING OF AVERAGE RISK INDIVIDUALS IS NOT COVERED.**

In November 2014, the U. S. Preventive Services Task Force issued a Grade "I" recommendation for screening for vitamin D deficiency in asymptomatic adults. A Grade "I" recommendation indicates the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. Health insurance plans are not required to provide coverage for Grade "I" recommendations.

# Six medical specialty medications to need prior approval beginning April 2018

Due to dramatic costs and complexity associated with the administration of certain specialty medications, **effective April 1, 2018**, prior Arkansas Blue Cross and Blue Shield and its family of companies for payment of the following specialty medications used in treating rare, complex conditions that may go through the medical benefit:

1. Nusinersen (Spinraza) – Spinal muscular atrophy
2. Cerliponase alfa (Brineura) – Late infantile neuronal ceroid lipofuscinosis type 2 (CLN2 or Batten disease)
3. Eculizumab (Soliris) – Paroxysmal nocturnal hemoglobinuria (PNH), atypical (complement mediated) hemolytic uremic syndrome (aHUS), and refractory generalized AchR positive myasthenia gravis
4. Alemtuzumab (Lemtrada) – refractory relapsing remitting multiple sclerosis
5. Asfotase alfa (Strensiq) – Perinatal/ infantile or juvenile-onset hypophosphatasia
6. Metreleptin (Myalept) – Congenital or acquired complete generalized lipodystrophy (GL) with leptin deficiency

Specialty medications already needing prior approval include:

7. Omalizumab (Xolair) – Moderate to severe persistent asthma and chronic idiopathic urticaria
8. Mepolizumab (Nucala) – Severe persistent asthma with an eosinophilic phenotype in patients 12 years of age or older

By establishing a prior approval process, members and providers will know whether the member qualifies for these drugs. A concurrent review will be conducted six months after approval to determine whether a patient is benefitting from the prescribed medication.

For more information on how to submit a request for prior approval of one of these drugs, please call the appropriate Customer Service phone number on the back of the member ID card. ASE/PSE and Medicare are not included in this prior approval program.

Customer Service will direct callers to the prior approval form specific to the member's group. Blue Advantage members can find the form at the following link: http://www.blueadvantagearkansas.com/providers/forms.aspx. For all other members, the appropriate prior approval form can be found at the following link: http://www.arkansasbluecross.com/providers/AuthServices.aspx.

These forms and any additional documentation will be faxed to 501-210-7051 for Blue Advantage members. For all other members, the appropriate fax number is 501-378-6647.

# Contract amendment – substance use disorder patient records and consents

**Effective immediately**, all network participation agreements of all healthcare providers who participate in any networks of Usable Mutual Insurance Company, d/b/a Arkansas Blue Cross and Blue Shield, HMO Partners, Inc., d/b/a Health Advantage, and USAble Corporation (the "Networks") are amended to add the following provision:

**Substance Use Disorder Patient Records and Required Patient Consents**

Provider agrees to comply with all applicable provisions of the Confidentiality of Substance Use Disorder Patient Records Rule ("Final Rule"), and subsequent modifications or additions thereto, as promulgated by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, in two Federal Register notices: 82 Federal Register 6052, January 18, 2017 and 83 Federal Register 239, January 3, 2018, and as referenced in 42 C.F.R. Part 2. Without limiting the scope of the compliance commitment stated in the previous sentence, Provider further agrees to the following specific requirements intended to fully address all relevant obligations of the Final Rule:

1. Provider agrees to immediately revise all patient consent forms to comply with the requirements of the Final Rule, including but not limited to adding provisions that specifically reference the Final Rule and substance use disorder ("SUD") records and provide for patient consent to use and disclose SUD records for purposes of submitting and processing claims for reimbursement of Provider for provision of SUD services to the patient.
2. With respect to any patient for whom Provider intends to or actually submits any claim to any Payer, as defined in Provider's network participation agreement with the Networks, Provider agrees to immediately revise all patient consent forms to include language that specifically names the applicable Payer(s) and their third party claims administrator (where applicable), including any contractor or subcontractor of each, as authorized to receive, use and re-disclose any and all SUD records of the patient for the purposes of (i) payment by the Networks and/or their contractors and subcontractors, including but not limited to receiving, processing, investigating, evaluating and paying a claim for health plan or insurance benefits (a process that may include checking eligibility, enrollment and premium payment status, as well as collection activities); and (ii) healthcare operations of the Networks and their contractors and subcontractors, including but not limited to conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, case management, care coordination, provider credentialing, evaluating and rating provider performance, underwriting, premium rating, renewal or replacement of insurance, ceding, securing or placing a contract for reinsurance of risk relating to claims for healthcare (including stop-loss insurance and excess loss coverage), medical review, utilization review, legal

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services, auditing functions, fraud and abuse detection and compliance programs, business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Networks and/or their contractors or subcontractors, coverage policies, business management and general administrative activities of the Networks and/or their contractors or subcontractors, legal and regulatory compliance activities, customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, internal grievance resolution, sale, transfer, merger or consolidation of the Networks and/or their contractors or subcontractors with another entity, and creating de-identified health information or a limited data set.

3. With respect to any patient for whom Provider intends to or actually submits any claim to Arkansas Blue Cross and Blue Shield, Provider agrees to immediately revise all patient consent forms to include language that specifically names Arkansas Blue Cross and Blue Shield, including any contractor or subcontractor of Arkansas Blue Cross and Blue Shield, as authorized to receive, use and re-disclose any and all SUD records of the patient for the purposes of (i) payment by Arkansas Blue Cross and Blue Shield and/or its contractors and subcontractors, including but not limited to receiving, processing, investigating, evaluating and paying a claim for health plan or insurance benefits (a process that may include checking eligibility, enrollment and premium payment status, as well as collection activities); and (ii) healthcare operations of Arkansas Blue Cross and Blue Shield and/or its contractors and subcontractors, including but not limited to conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, case management, care coordination, provider credentialing, evaluating and rating provider performance, underwriting, premium rating, renewal or replacement of insurance, ceding, securing or placing a contract for reinsurance of risk relating to claims for healthcare (including stop-loss insurance and excess loss coverage), medical review, utilization review, legal services, auditing functions, fraud and abuse detection and compliance programs, business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating Arkansas Blue Cross and Blue Shield and/or it contractors or subcontractors, coverage policies, business management and general administrative activities of Arkansas Blue Cross and Blue Shield and/or its contractors or subcontractors, legal and regulatory compliance activities, customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, internal grievance resolution, sale, transfer, merger or consolidation of Arkansas Blue Cross and Blue Shield and/or its contractors or subcontractors with another entity, and creating de-identified health information or a limited data set.
4. With respect to any patient for whom Provider intends to or actually submits any claim to Health Advantage, Provider agrees to immediately revise all patient consent forms to include language that specifically

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names Health Advantage, including any contractor or subcontractor of Health Advantage, as authorized to receive, use and re-disclose any and all SUD records of the patient for the purposes of (i) payment by Health Advantage and/or its contractors and subcontractors, including but not limited to receiving, processing, investigating, evaluating and paying a claim for health plan or insurance benefits (a process that may include checking eligibility, enrollment and premium payment status, as well as collection activities); and (ii) healthcare operations of Health Advantage and/or its contractors and subcontractors, including but not limited to conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, case management, care coordination, provider credentialing, evaluating and rating provider performance, underwriting, premium rating, renewal or replacement of insurance, ceding, securing or placing a contract for reinsurance of risk relating to claims for healthcare (including stop-loss insurance and excess loss coverage), medical review, utilization review, legal services, auditing functions, fraud and abuse detection and compliance programs, business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating Health Advantage and/or it contractors or subcontractors, coverage policies, business management and general administrative activities of Health Advantage and/or its contractors or subcontractors, legal and regulatory compliance activities, customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, internal grievance resolution, sale, transfer, merger or consolidation of Health Advantage and/or its contractors or subcontractors with another entity, and creating de-identified health information or a limited data set.

5. Provider agrees to immediately revise Provider's patient consent forms to include specific authorization and consent of the patient to allow any Payer, Arkansas Blue Cross and Blue Shield and Health Advantage, and/or their contractors and subcontractors, to respond to any claim submission or communication from Provider regarding such patient, including but not limited to sending of related Explanation of Benefits or Personal Health Statement forms to the patient or their legal representative, Remittance Advice or other claims-related communications to Provider or Provider's billing agent or contractor/subcontractor, including but not limited to responses to claims status and eligibility inquiries, customer service responses, medical records requests, claims adjustments, audit inquiries, quality reviews, and processing of any appeals from initial claims adjudication decisions.
6. With respect to any patient for whom Provider intends to or actually submits any claim to Arkansas Blue Cross and Blue Shield or Health Advantage, Provider agrees to immediately revise all patient consent forms to include language that specifically names the following contractors or subcontractors as also authorized to both receive, use and re-disclose SUD records of the patient, and to respond to both the patient and the Provider with respect thereto, for purposes of case management or care coordination: (i) Alere Health Improvement Company; (ii) Pronounced Health Solutions, Inc.;

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(iii) New Directions Behavioral Health; (iv) MHM Support Services; (v) Mercy Health; (vi) Washington Regional Medical Center; (vii) St. Bernards Hospital; (viii) Baptist Memorial Hospital-Jonesboro (ix) Baptist Health; (x) Baptist Health Physician Partners; (xii) Collom & Carney Clinic; (xiii) Arkansas Health Network; (xiv) St. Vincent Infirmary Medical Center; (xv) University of Arkansas for Medical Sciences; (xvi) White County Medical Center; and (xvii) White River Health System. Provider further agrees that with respect to all of the above-named entities, Provider's patient consent forms shall further specify that each such entity shall be authorized to re-disclose all SUD records and related patient information to the patient's current and former treating healthcare providers.

7. Provider warrants and represents to the Networks that to the extent that Provider constitutes a Part 2 program as covered by the Final Rule or is otherwise subject to the provisions of the Final Rule, including but not limited to the patient consent requirements thereof, that Provider shall not submit any claim to the Networks or to any contractor or subcontractor of the Networks without first having obtained from the applicable patient a consent that (a) meets all requirements of the Final Rule and (b) contains the specifics required in paragraphs 2, 3, 4, 5 and 6 above, as applicable. Specifically, Provider acknowledges and agrees that it shall be reasonable for any Payer or Network, and their respective contractors and subcontractors, to rely upon Provider's good faith compliance with the Final Rule and the terms hereof and to assume that if Provider submits a claim involving SUD records that is subject to the Final Rule, Provider thereby is affirmatively representing to such Payer, Network, contractor and subcontractor that Provider has obtained the required patient consent in a form that fully complies with the Final Rule and with the specifics required in paragraphs 2, 3 , 4, 5 and 6 above. Provider further agrees that if Provider is unable for any reason to obtain a patient consent in the form and with the content required by the Final Rule and paragraphs 2, 3, 4, 5 and 6 above, then in such circumstances Provider shall refrain from submitting any claim to any Payer, Network, contractor or subcontractor until such time as Provider has been able to obtain a fully compliant patient consent.

8. Provider understands and agrees that should Provider fail to comply with the Final Rule and with the specific requirements outlined in paragraphs 2, 3, 4, 5 and 6, above, Arkansas Blue Cross and Blue Shield or Health Advantage may be obligated by law to decline to acknowledge or process any claim for services lacking the required patient consent. Provider further agrees that if Provider fails to comply with the Final Rule or with the requirements outlined in paragraph 2, 3, 4, 5 and 6, above, Arkansas Blue Cross and Blue Shield or Health Advantage shall be entitled in their discretion to reject and decline to process or pay any related claim lacking the proper patient consent; in such event, Provider agrees to refrain from billing or seeking to collect on such claims from any other party, including but not limited to the patient, except for the patient's applicable deductible or coinsurance amount. Provider further agrees, upon request from Arkansas Blue Cross and Blue Shield or Health Advantage to furnish documentation to Arkansas Blue Cross and Blue Shield and Health Advantage evidencing Provider's compliance with the terms of the Final Rule and paragraphs 2, 3, 4, 5 and 6, above.

# Coverage policy manual updates

Since November 2017, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The table highlights these additions and updates. To view entire policies, access the coverage policies located on our website at arkansasbluecross.com.

| Policy ID# | Policy Name |
|---|---|
| 1997153 | Iron Therapy, Parenteral |
| 1997195 | Sleep Apnea and Other Pulmonary Diseases, Ventilation Support and Respiratory Assist Devices |
| 2000008 | HDC & Autologous Stem &/or Progenitor Cell Support-Hodgkin's Disease |
| 2001035 | PET or PET/CT for Prostate Cancer |
| 2001039 | PET or PET/CT for Neuroendocrine Tumors |
| 2006039 | Artificial Vertebral Disc, Cervical Spine |
| 2008027 | Genetic Test: Colon Cancer, KRAS, NRAS and BRAF Mutation Analysis to Determine Tumor Sensitivity to Chemotherapy |
| 2011045 | Preventive Services for Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening |
| 2011053 | Autism Spectrum Disorder, Early Behavioral Intervention |
| 2011069 | PET or PET/CT for Anal Carcinoma |
| 2012003 | Genetic Test: Molecular Markers in Fine Needle Aspirates of the Thyroid |
| 2012039 | Preventive Services for Non-Grandfathered (PPACA Plans: Tuberculosis Screening |
| 2012068 | Genetic Test: Preconception or Prenatal Testing Using the Counsyl Foresight™ Carrier Screen |
| 2014001 | Genetic Test: Analysis of MGMT Promoter Methylation in Malignant Gliomas |
| 2015034 | Telemedicine |
| 2016004 | Lab Test: Identification of Microorganisms Using Nucleic Acid Probes |
| 2016010 | Mepolizumab (Nucala) |
| 2016012 | Daratumumab (Darzalex) |
| 2016016 | Atezolizumab (Tecentriq) |
| 2016023 | Eteplirsen (Exondys-51) |
| 2017001 | Alpha-1 Proteinase Inhibitor Therapy |
| 2017003 | Ziv-aflibercept (Zaltrap) |
| 2017004 | Asfotase alfa (Strensiq®) |
| 2017007 | Cetuximab (Erbitux™) |
| 2017011 | Nusinersen (Spinraza) for the Treatment of Spinal Muscular Atrophy |
| 2017014 | Olaratumab (LARTRUVO™) |
| 2017015 | Avelumab (Bavencio™) |
| 2017021 | Ocrelizumab (Ocrevus) |

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Coverage policy manual updates (Continued from page 21)

| Policy ID# | Policy Name |
|---|---|
| 2017022 | Cerliponase Alfa (Brineura™) |
| 2017023 | Bezlotoxumab (Zinplava™) |
| 2017025 | Etelcalcetide |
| 2017030 | Guselkumab |
| 2017032 | Synthetic Cartilage Implant for Joint Pain |
| 2017034 | Inotuzumab Ozogamicin (Besponsa™) |
| 2017035 | Gemtuzumab Ozogamicin (Mylotarg™) |
| 2017036 | Metreleptin |
| 2017037 | Direct Acting Antiviral Medications for Treatment of Chronic Hepatitis C |
| 2018001 | Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease |
| 2018002 | Chemodenervation, Botulinum Toxins |

# Coverage for diabetic retinal screening

The rate of screening for retinopathy in diabetics is suboptimal in Arkansas. In an effort to promote screening, ABCBS has expanded coverage for retinal photography. CPT 92250 (fundus photography, with interpretation and report) is now covered when the following criteria are met:

1. The member has a diagnosis of diabetes but not diabetic retinopathy;
2. The site of service is an office,
3. The frequency is no more than once per calendar year,
4. The member has not had a visit with an eye specialist within the past six months, and
5. CPT code 92250 must be accompanied by 2022F (which indicates that the photographs were interpreted by an eye specialist).

Coverage for fundus photography by ophthalmologists and optometrists for the diagnosis, monitoring and treatment of eye diseases will remain unchanged.

# AHIN Corner

**The Importance of an AHIN User Administrator (AUA)**

AHIN User Administrator, also known as AUA, is responsible for maintaining access for each user within the facility/clinic. AUAs play a vital role in the support of AHIN Users. One facility/clinic may have several AUAs. In a larger facility/clinic this would be preferred.

- AUAs are responsible for maintaining each AHIN user within their clinic(s) or facility(s) and granting user access to various AHIN functions.
- It is the AUAs responsibility to terminate AHIN access for any user no longer employed, or when job functions change and AHIN access is no longer required.
- Access to medical information and the security of this information must be a priority of the

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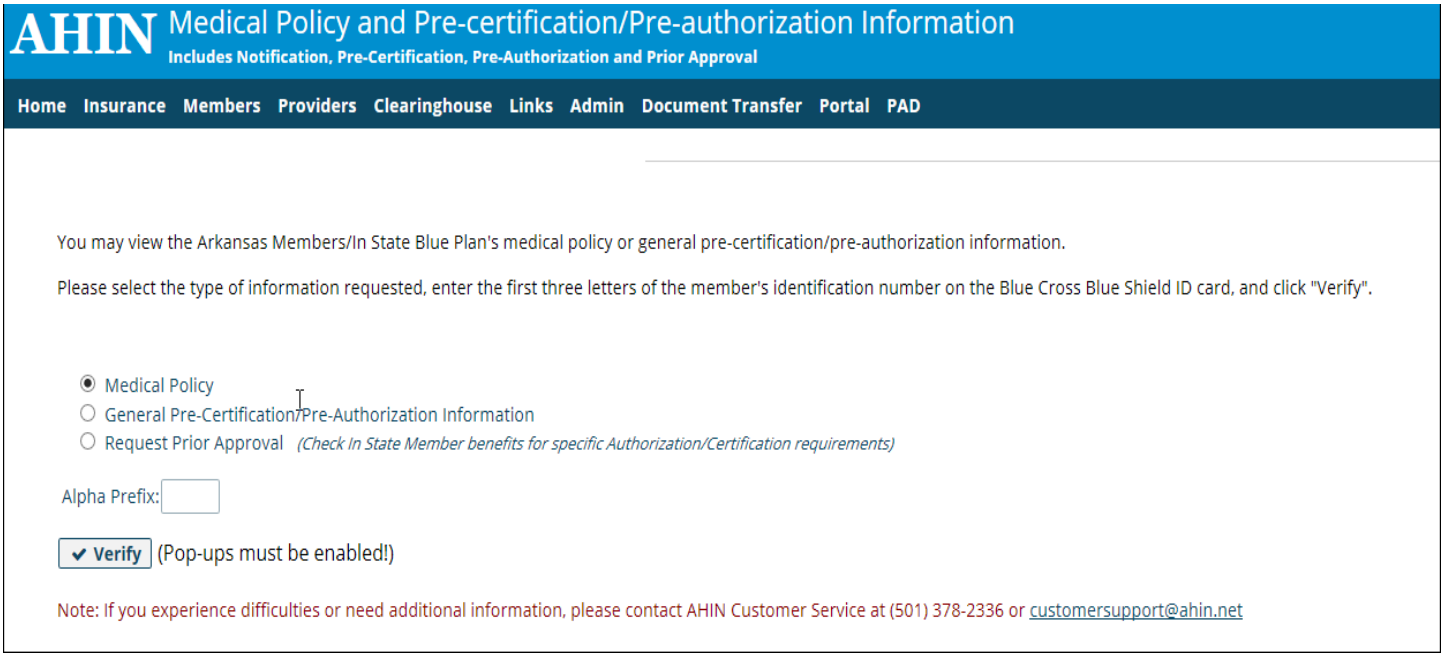
AUA. Protecting Personal Health Information (PHI) and Personally Identifiable Information (PII) is a responsibility of everyone who accesses AHIN.

- AUAs are responsible for password resets for the AHIN users they oversee. AUAs have the ability to reset passwords when user accounts become disabled or locked.
- AUAs should periodically re-visit the needs of his/her AHIN users and adjust the level of access required according to minimum job functions or changes within their organization.

**Reminder:** To comply with security standards, a mandatory recertification of all AHIN users, including AUAs, is required once every 60 days. Failure to log into AHIN every 60 days can result in termination of User access.

**Using AHIN for Prior Approval/Pre-Service Review**

Prior approval/pre-service review is a review process prior to the time a specified service/procedure is delivered to determine if the service meets primary coverage criteria and will be covered by the member's benefit plan. Depending on a member's plan there may be services that require prior approval processes. AHIN allows providers the ability to quickly and easily obtain prior approval electronically, without the need to contact Customer Service. Prior approval is found under the Members tab on AHIN.




Dependent on the line of business, you can obtain prior approvals for Radiology Services, Inpatient Services and Outpatient/Clinic Services.

Obtaining prior approval through AHIN is as simple as entering the member's information, requesting physician, attending physician, admission information, the facility and then clicking submit for review.

We encourage providers to utilize the self-service tools found within AHIN. Please see the AHIN training calendar under "Provider News" on the AHIN Home Page email ahinuniversity@ahin.net to schedule a time to receive training on the prior approval process or any other functionality within AHIN; or contact AHIN Customer Support at 501.378.2336 for assistance.

# Prior approval: AHIN pre-service review

Prior approval should be requested using the AHIN pre-service review. Improvements are underway which include centralizing prior approval guidelines, providing CPT/HCPCS code information, simpler submission entry. Easier checking status, etc. Please note that we are planning to review these new and improved pre-service and prior approval processes at the upcoming provider workshops.
The Pre-service Submission is accessed under the "Members Tab," select "Pre-Service Review." Options then include reviewing coverage policy, guidelines, checking codes, requesting prior approval, checking episodes and other valuable information.

# Prior approval change for individual metallic health plans

**Member's with identification numbers beginning with AEE, AXC, EXX, XCB, XCQ, XCR**

Prior approval is no longer required for therapy services related to outpatient and office rehabilitation therapy. This includes chiropractic physical therapy services.

# New Medicare beneficiary identification number

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 is requiring CMS to remove Social Security Numbers (SSNs) from Medicare cards by April 2019. A new, unique Medicare beneficiary identification (MBI) number will replace the SSN-based Health Insurance Claim Number (HICN) on each new Medicare card. The goal is to decrease identify theft and ease the burden of disruption of service and provide a solution to providers. CMS will start mailing new, redesigned Medicare ID cards to beneficiaries in phases by geographic regions beginning on April 1, 2018, and ending by December 31, 2019. During this transition period all providers, insurance plans and third parties must modify their claims processing systems and electronic medical records to start testing and processing both the new MBI and existing HICN identifiers. Arkansas Blue Cross Blue Shield's claims system will be equipped to accept the new MBI number or the historical Social Security Number based HICN in April 2018. Please note that starting January 1, 2020, the new card will be the only one that is valid.

Resources:

- COBRA trading partners can identify their members by utilizing the CMS crosswalk file located on the CMS website at COBRA File Formats and \Connectivity.
- Provider Information: https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html
- Member Information: https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html
- Regional mailing schedule: Mailing Plan for States

**New Medicare Card Mailing Schedule***

| Wave | States Included | Cards Mailing |
|---|---|---|
| 1 | Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia | April – June 2018 |
| 2 | Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon | April – June 2018 |
| 3 | Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin | After June 2018 |
| 4 | Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont | After June 2018 |
| 5 | Alabama, Florida, Georgia, North Carolina, South Carolina | After June 2018 |
| 6 | Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming | After June 2018 |
| 7 | Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands | After June 2018 |

*CMS Source: https://www.cms.gov/Medicare/New-Medicare-Card/NMC-Mailing-Strategy.pdf

For additional questions or concerns, members may reach out to CMS at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048. Providers can submit comments and post questions to the CMS team mailbox at NewMedicareCardSSNRemoval@cms.hhs.gov.

# Reminders about HIPAA and HITECH

As a Qualified Health Plan participating in the Federal Facilitated Marketplace (FFM) including the Multi State Plan Program (collectively known as the Exchange) this is Arkansas Blue Cross and Blue Shield's reminder to all network participating providers that they must be compliant with their applicable sections of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economics and Clinical Health (HITECH) in order to be in our provider networks.

Please be aware that:

1. Providers must comply with applicable interoperability standards and demonstrate meaningful use of health information technology in accordance with the HITECH Act, and
2. Subcontractors, large providers, providers, vendors and other entities required by HIPAA to maintain a notice of privacy practices, must post such notices prominently at the point where an Exchange enrollee enters the website or web portal of such subcontractors, large providers, providers and/ or vendors.

For more detailed information, please visit: https://www.hhs.gov/hipaa/for-professionals/index.html

# Reminder on billing qualified Medicare beneficiaries

Medicare providers are prohibited by federal law from billing qualified Medicare beneficiaries for Medicare deductibles, copayments, or coinsurance. Providers should accept Medicare and Medicaid payments received for billed services as payment in full. Dual-eligible members classified as qualified Medicare beneficiaries (QMBs) are covered under this rule.

QMBs who are enrolled in Medi-Pak® Advantage to administer their Medicare benefits would have Medi-Pak® Advantage as primary coverage and Medicaid as secondary coverage. Payments are considered accepted in full even if the provider does not accept Medicaid.

Providers are subject to sanctions if billing a QMB patient for amounts not paid by Arkansas Blue Cross and Blue Shield and Medicaid.

Additional information about dual-eligible coverage is available under the Medicare Learning Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

# HEDIS medical record reviews began in February

Each year from February through May, Arkansas Blue Cross and Blue Shield manages Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews to help improve our member quality initiatives.

Inovalon, our vendor, will conduct HEDIS reviews for Medi-Pak Advantage (PFFS), Health Advantage Medi-Pak Advantage (HMO) and Health Insurance Exchange Marketplace members for the 2017 measurement year.

**What are HEDIS Reviews?**
Inovalon looks for details that may not have been captured in claims data such as blood pressure readings, HbA1c lab results, colorectal cancer screenings and body mass index.

Inovalon will contact you to schedule an appointment for a HEDIS review or request that you fax the necessary records. HEDIS also requires proof of service documentation for data collected from a medical record.

**2018 Chart Review Schedule**
Arkansas Blue Cross and Blue Shield also conducts other medical record reviews throughout the year for different purposes as outlined in the schedule below.

We greatly appreciate your assistance with these important reviews.

| Type of Review | Dates | Vendor |
|---|---|---|
| HEDIS | February – May 2018 | • Arkansas Blue Cross<br>• Inovalon |
| Medicare Advantage RADV | February – June 2018 | • In state: Tessellate<br>• Out of state: Inovalon |
| Medicare Advantage Retro | February – December 2018 | • CIOX |
| Stars | September – December 2018 | • Arkansas Blue Cross<br>• Tessellate |

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*

# Know the codes: CPT Category II and Z codes can help drive better outcomes

CPT Category II codes and Z codes are valuable tools that can help support better health outcomes for your Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage, Health Insurance Exchange Marketplace and Federal Employee Plan patients and make your practice more efficient.

These codes give us more accurate information about the health of our members with speed and efficiency. A better understanding of our members' health is key to identifying ways to work with you to improve it. This could lead to an improvement of your practice's performance on Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

In addition, using the right CPT II and Z codes frees up your staff's time. Their use reduces our need to request medical records from your practice to confirm completion of services for HEDIS purposes.

For your convenience, here are CPT II and Z code guides your practice can use that will easily close certain gaps in care for HEDIS measures:

**CPT II codes for HEDIS Support**
CPT Category II codes can be billed in the same procedure code field as CPT Category I codes.

| HEDIS Measure | Description | CPT Category II Code |
|---|---|---|
| Medication Reconciliation Post-Discharge | Discharge medications reconciled with the current medication list in outpatient medical record | 1111F |
| Comprehensive Diabetes Care: Eye Exam | Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed | 2022F |
| | Low risk for retinopathy (no evidence of retinopathy in the prior year) | 3072F |
| Comprehensive Diabetes Care: HbA1c Control | Most recent hemoglobin A1c (HbA1c) level less than 7.0% | 3044F |
| | Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% | 3045F |
| | Most recent hemoglobin A1c (HbA1c) level greater than 9.0% | 3046F |

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| HEDIS Measure | Description | CPT Category II Code |
|---|---|---|
| Comprehensive Diabetes Care:<br><br>Medical Attention for Nephropathy | Documentation of treatment for nephropathy (includes visit to nephrologist, receiving dialysis, treatment for end stage renal disease, chronic renal failure, acute renal failure or renal insufficiency) | 3066F |
| | Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken | 4010F |
| Controlling Blood Pressure | This measure requires a medical record review per the HEDIS specifications but providing the blood pressure range can help support member-facing programs and outcomes.<br><br>The diagnosis of hypertension must be documented in the medical record on or before June 30. Compliance means:<br>• BP < 150/90 (149/89) for 60-85 years old without diabetes.<br>• BP < 140/90 (139/89) for 60-85 years old with diabetes. | 3074F – most recent systolic blood pressure <130 mm Hg<br><br>3075F – most recent systolic blood pressure 130 – 139 mm Hg<br><br>3077F – most recent systolic blood pressure >= 140 mm Hg<br><br>3078F – most recent diastolic blood pressure <80 mm Hg<br><br>3079F – most recent diastolic blood pressure 80 – 89 mm Hg<br><br>3080F – most recent diastolic blood pressure >=90 mm Hg |

(Continued on page 30)

**Z codes for HEDIS Support**

Z codes can be billed in the same field as ICD-10 diagnoses.

| HEDIS Measure | Description | Z Code |
|---|---|---|
| Adult BMI | BMI of 19 or less | Z68.1 |
| Adult BMI | BMI 20.0-20.9 | Z68.20 |
| Adult BMI | BMI 21.0-21.9 | Z68.21 |
| Adult BMI | BMI 22.0-22.9 | Z68.22 |
| Adult BMI | BMI 23.0-23.9 | Z68.23 |
| Adult BMI | BMI 24.0-24.9 | Z68.24 |
| Adult BMI | BMI 25.0-25.9 | Z68.25 |
| Adult BMI | BMI 26.0-26.9 | Z68.26 |
| Adult BMI | BMI 27.0-27.9 | Z68.27 |
| Adult BMI | BMI 28.0-28.9 | Z68.28 |
| Adult BMI | BMI 29.0-29.9 | Z68.29 |
| Adult BMI | BMI 30.0-30.9 | Z68.30 |
| Adult BMI | BMI 31.0-31.9 | Z68.31 |
| Adult BMI | BMI 32.0-32.9 | Z68.32 |
| Adult BMI | BMI 33.0-33.9 | Z68.33 |
| Adult BMI | BMI 34.0-34.9 | Z68.34 |
| Adult BMI | BMI 35.0-35.9 | Z68.35 |
| Adult BMI | BMI 36.0-36.9 | Z68.36 |
| Adult BMI | BMI 37.0-37.9 | Z68.37 |
| Adult BMI | BMI 38.0-38.9 | Z68.38 |
| Adult BMI | BMI 39.0-39.9 | Z68.39 |
| Adult BMI | BMI 40.0-44.9 | Z68.41 |
| Adult BMI | BMI 45.0-49.9 | Z68.42 |
| Adult BMI | BMI 50-59.9 | Z68.43 |
| Adult BMI | BMI 60.0-69.9 | Z68.44 |

# Here's what you should know about urinary incontinence in older adults

Akansas Blue Cross and Blue Shield Medi-Pak® Advantage members are asked annually by a CMS vendor whether or not they have discussed urinary incontinence with their healthcare provider. Because your patients, who are also our members, are asked to report this, we wanted to provide you with the following information to assist your conversation with your patients. Bladder control is a widespread issue among older adults. According to the National Association for Continence, one in five individuals older than 40 suffers from urinary incontinence.

Urinary incontinence isn't just a physical condition. It can also affect a patient's quality of life. It causes many older people to avoid activities, limit social interactions, become depressed and even struggle to get a good night's sleep. There's also the risk of falling in patients who try to make it to the bathroom in time.

**A Challenge for Sufferers**

Even though it's common and can cause problems, patients find the subject difficult to bring up with their doctors. According to the Agency for Healthcare Research and Quality, more than 50 percent of women never get treatment for their stress incontinence.

Not only do patients find it embarrassing, they assume incontinence or leakage is a natural part of the aging process. They may not realize it's a treatable condition.

Starting the discussion about urinary incontinence with patients may be what helps them understand they no longer have to live with it.

**Forms of Urinary Incontinence**

To help you discuss the topic with patients, here's a refresher on the ways urinary incontinence can occur.

- Urge incontinence: The most common diagnosis, this involves an urgent need to urinate resulting in the loss of urine before one arrives to a toilet.
- Stress incontinence: This occurs when an increase in abdominal pressure overcomes the closing pressure of the bladder. Abdominal pressure rises when you cough, sneeze, laugh, climb stairs or lift objects.
- Overflow incontinence: Rarely diagnosed, this happens when one's bladder never completely empties causing leakage when the bladder becomes overly full.
- Functional incontinence: This is a form of urinary incontinence in which a person is usually aware of the need to urinate but for one or more physical or mental reasons, the person is unable to get to the bathroom.
- Mixed incontinence: Sometimes patients experience more than one type of incontinence, and usually it's a combination of stress and urge incontinence, especially for women.

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Here's what you should know about urinary incontinence in older adults (Continued from page 31)

**Treatment Options**

After a diagnosis is made, available courses of treatment include:

- Behavioral therapy: Usually the first line of treatment is behavioral therapy, which will often help improve the incontinence. Treatments can include bladder training, scheduled bathroom trips, pelvic floor muscle exercises and fluid and diet management.
- Medications: These are frequently used in combination with behavioral therapies and include anticholinergic or antispasmodic drugs, topical hormonal therapy for females or antibiotics when incontinence is caused by a urinary tract infection or an inflamed prostate gland.
- Medical devices: Women can be prescribed devices such as urethral inserts, which are placed usually before activities related to urinary incontinence episodes, and pessaries or intra-vaginal devices, which are similar to diaphragms and support the bladder.

With your help, urinary incontinence doesn't have to take over the lives of your patients. Start the discussion and tell them about the variety of treatments that can help them enjoy life without the worry of leakage.

Sources: www.ahrq.gov, www.aafp.org, www.auanet.org, www.nafc.org, www.nih.gov and www.hhs.gov

# Medi-Pak® Advantage Part D prescriber requirements

The Centers for Medicare & Medicaid Services (CMS) requires any physician or other eligible professional (collectively referred to as "providers") who prescribes Medicare Part D covered drugs to either be enrolled 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 should do so to ensure enrollees will continue to receive their Part D covered prescriptions.

Please note: Part D benefit plans are not 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 rule, Arkansas Blue Cross and Blue Shield requires all providers to be enrolled in Original Medicare before they can be considered for participation in any of its Medi-Pak® Advantage networks, including the Private Fee-for-Service (PFFS) or Health Maintenance Organization (HMO).

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# PROVIDERS' NEWS STAFF

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## PLEASE NOTE

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies. The newsletter does not pertain to traditional Medicare. Traditional Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.



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