PROVIDERS' NEWS

June 2017

A publication for participating providers and their office staffs

New HMO Plus Network

Health Advantage is creating a new provider network that will focus on clinically integrated health systems that can provide optimal coordinated healthcare. This new provider network will be called **HMO Plus**.

The initial creation of this network will begin in central Arkansas and will be centered around the health systems of Arkansas Children's Hospital, Baptist Health and the University of Arkansas for Medical Sciences.

Please note that this network **is different than Health Advantage**. Just because a provider participates in the Health Advantage HMO network does not mean that the provider is in the HMO Plus network. It will be important to ensure referral patterns stay within the HMO Plus network. HMO Plus will be a smaller closed model HMO network that will eventually spread state-wide and will be used primarily by self-insured employer groups.

The benefit program using the HMO Plus network is called **FocusCare**. If a member indicates that his/her Plan is FocusCare, the member must utilize an HMO Plus contracted provider for non-emergency situations. **There are no out of network benefits**.

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Drug resistance analysis for all genotypes in chronic Hepatitis C patients for initial treatment

Drug resistance assay testing (CPT 87902) is performed to assess the drug susceptibility by nucleic acid sequencing of the patient's hepatitis C virus (HCV) to the appropriate inhibitors. According to AASLD guidelines, initial drug resistance testing (NS5A, NS5 B, NS3A, NS4A for all GT) for these resistance associated variants or substitutions is recommended initially only in select situations (such as with the use of elbasvir/grazoprevir). This testing will not be covered in the context of treatment naïve individuals or treatment-experienced individuals limited to prior treatment with ribavirin/interferon or in treatment failures due to adherence/intolerance issues. Current anti-viral HCV medications on the Arkansas Blue Cross and Blue Shield formulary do not require initial drug resistance testing. Please see policy 2014006 Sofosbuvir (Sovaldi). A complete copy of the medical coverage policy can be accessed by selecting Coverage Policy at www.arkbluecross.com/members.

Fee schedule update for DME

Effective October 1, 2017, Arkansas Blue Cross and Blue Shield will begin our pricing update to Durable Medical Equipment on the Physician Fee Schedule. This update is intended to more accurately align our pricing with Medicare.

Fee schedule update for lab

Effective October 1, 2017, the Arkansas Blue Cross and Blue Shield Physician Fee Schedule will be updated to reflect changes in lab procedures.

Lab codes that have relative value units in each component will continue to have pricing for each component. Lab codes with no relative value units for professional and technical components will no longer be priced. Only the total component of the code will have pricing.

Residential treatment center billing reminder

Arkansas Blue Cross and Blue Shield and its family of companies are seeing an increase in bill type code errors related to residential treatment services (RTC). Please review the policy in the provider manual printed below as a reminder.

Inpatient claims are billed with bill type 86X and room revenue codes 1001 and 1002. Allowances are based on global, all-inclusive per diems that are approved by Facility Reimbursement and Pricing. The per-diem allowances are loaded in the per-diem field on ProvWeb. There is no additional allowance for physician services.

Outpatient claims are allowed from these facilities when billed with bill type 13X. They must contain revenue codes 0905, 0906, 0912, 0913 and 0915 which require CPT/HCPCS codes in conjunction with the revenue code(s).

HCPCS codes S0201 (partial hospitalization services, less than 24 hours, per diem) and S9480 (intensive outpatient psychiatric services, per diem) are allowed on a global basis and all other services billed with these codes will be rolled up for pricing. S0201 can only be billed with revenue codes 0912 and/or 0913. S9480 can only be billed with revenue codes 0905 and/or 0906.

RTC benefits are dependent upon any payable member benefits.

Low Level Laser Therapy (LLLT) coverage policy

Under Arkansas Blue Cross and Blue Shield's* medical coverage policy #1997126, low-level laser therapy is covered only for prevention of oral mucositis in patients undergoing cancer treatment associated with increased risk of oral mucositis (including chemotherapy and/or radiotherapy, and/or hematopoietic stem cell transplantation). Low-level laser therapy for the treatment of any other indication is not covered.

*This coverage policy also applies to Arkansas Blue Cross' family of companies.

No specific CPT code defines low-level laser therapy (LLLT) however there is a HCPCS code specific to low-level laser therapy. HCPCS S8948 is available for billing of low-level laser therapy. Per ABCBS Medical Coverage Policy 1997126, HCPCS S8948 or CPT 97026 may be used to bill this service. CPT code 97026 (application of a modality; infrared), may be used because the laser emits light in the infrared spectrum.

A complete copy of the medical coverage policy is accessible by selecting Coverage Policy at www.arkbluecross.com/members.

Coverage policy manual updates

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

Policy ID#	Policy Name
2017004	Asfotase alfa (Strensiq®)
2017015	Avelumab (Bavencio™)
2006030	Balloon Sinuplasty
2017006	Bevacizumab (Avastin™) for Oncologic Indications
1997054	Bone Mineral Density Study
2017008	Brentuximab (Adcetris™)
2017007	Cetuximab (Erbitux™)
2017009	Denosumab (XGEVA™ and Prolia™)
2017013	Elotuzumab (Empliciti™)
2015004	Genetic Test: Breast Cancer Risk Assessment (PALB2, CHEK2, ATM)
2015008	Genetic Test: Miscellaneous Genetic and Molecular Diagnostic Tests
2013035	Genetic Test: Whole Exome and Whole Genome Sequencing
2001024	HDC & Allogeneic Stem &/or Progenitor Cell Support-Hodgkin's Disease
2001022	HDC & Allogeneic Stem &/or Progenitor Cell Support-Non-Hodgkin's Lymphoma
2014008	Infertility Services
2003015	Intensity Modulated Radiation Therapy (IMRT)
2010046	Intravitreal Implant, Dexamethasone (Ozurdex)
1999001	Nerve Conduction Studies (NCS), Electromyography (EMG) and Surface EMG (SEMG)
2017011	Nusinersen (Spinraza) for the Treatment of Spinal Muscular Atrophy
2017014	Olaratumab (LARTRUVO™)
2008004	Optical Coherence Tomography Anterior Eye Segment Imaging
2003021	Optical Diagnostic Devices for Evaluating Skin Lesions Suspected of Malignancy
1998008	Orthoptic Training for the Treatment of Vision and Learning Disabilities
1998008	Orthoptic Training for the Treatment of Vision and Learning Disabilities
1997248	Pain Management, Facet Joint Block
1997249	Pain Management, Facet Nerve Denervation, other than Radiofrequency
2015003	Patient-actuated End Range Motion Stretching Devices
2016011	PCSK9 INHIBITORS (Evolocumab) (Alirocumab)
2013013	Peripheral Subcutaneous Field Stimulation
1997066	Periurethral Bulking Agents for the Treatment of Urinary and Fecal Incontinence
2014014	Pertuzumab
2000001	PET or PET/CT for Colorectal Cancer

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Coverage policy manual updates (Continued from page 4)

Policy ID#	Policy Name
2011069	PET or PET/CT for Anal Carcinoma
1997166	PET or PET/CT for Brain Imaging, Non-malignant Disease
2001036	PET or PET/CT for Breast Cancer
2002015	PET or PET/CT for Carcinoma of Unknown Primary (CUP)
2005007	PET or PET/CT for Cervical Cancer
2011074	PET or PET/CT for Gastric Cancer
2000023	PET or PET/CT for Head and Neck Malignant Disease
2013002	PET or PET/CT for Hodgkin's Lymphoma
2012035	Preventive Services For Non-Grandfathered (PPACA) Plans: Contraceptive Use And Counseling
2011044	Preventive Services For Non-Grandfathered (PPACA) Plans: Depression Screening In Adolescents
2011043	Preventive Services For Non-Grandfathered (PPACA) Plans: Depression Screening, Adults
2011015	Preventive Services For Non-Grandfathered (PPACA) Plans: High Blood Pressure Screening In Adults
2011040	Preventive Services For Non-Grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV) Counseling & Screening
2011030	Preventive Services For Non-Grandfathered (PPACA) Plans: Obesity In Children; Screening And Counseling
2011025	Preventive Services For Non-Grandfathered (PPACA) Plans: Obesity Screening In Adults
2011066	Preventive Services For Non-Grandfathered (PPACA) Plans: Overview
2011010	Preventive Services For Non-Grandfathered (PPACA) Plans: Serum Lipids Screening
2012031	Preventive Services For Non-Grandfathered (PPACA) Plans: Well-Woman Visits For Adult Women

AHIN claim update reminders

AHIN launched new and improved claims screens on April 10, 2017. The new screens are easy to use and provide updated functionality in the way claims are created, viewed, submitted and/or corrected on AHIN. The following reminders relate to claim updates. Keep in mind, help is available for most pages displayed in AHIN. To view AHIN help, click the question mark icon displayed at the top left corner of each page.

Claims Entry (Direct Data Entry)
AHIN's copy claim feature has been updated to copy the entire claim including diagnoses, service lines, and total charge. Be sure to remove all data not related to the current claim before submitting the claim to AHIN. Currently, this ability is only available for providers with direct data entry and have entered previous claims for their facility.

Changes forthcoming will allow you to copy electronic claims in addition to direct data entry claims. Look for more information to be released concerning the copy claim function later this year.

Submit File
Files can no longer be submitted from the claim summary page. Users must click the folder icon to return to the file before it can be submitted to AHIN. As a reminder, files can hold multiple claims as long as they are the same claim type. For example, files can hold multiple institutional claims or multiple professional claims. Files cannot hold both institutional and professional claims.

Claims Summary
The Claims Summary page displays in three main sections:

- Claim Header
- Claim Navigation
- Claim Detail

The claim header contains newly created icons allowing navigation to additional claims within your search. You can return to the claim search screen or to the file screen. The claim header also displays patient information and initial claim information, such as date of service, created date, payer, etc.

The claim navigation column displays the status, claim type, claim links and other related transactions or documents, based on the status of the claim. For example, you can view the following documents, where available, without having to perform a separate search:

- Claim Status
- Electronic Remittance Advices
- Paper Remittance Advices
- Refund Request Letters
- Medical Records Requests
- Overpayments

The claim detail section updates based upon the selections you make in the claim navigation column. You can also view full details from claim summary by selecting the title of each of following sections:

- Subscriber
- Patient
- Claim Information
- Diagnosis
- Service Lines
- Billing Provider
- Payer
- Rendering Provider
- Other Payer Information

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Some fields no longer display on the claim summary page. For example, the referring provider information is now located under Providers. Select Providers from the claim navigation column or click any provider header from claim summary page to view full provider details.

Claim Errors
When claims encounter edits that cannot be resolved, AHIN will change the status of the claim to E for error. The error(s) will display in red font at the top of the claim detail section. You can correct the error and resubmit the claim or you can clink to view the full details of where the error occurred. You can also correct and resubmit the claim from the full details section.

When payers are unable to process paper claims, AHIN changes the status from E (error) to L (letter). The claim is returned to the provider with a letter of explanation. Currently, these letters are not shown on AHIN.

Claim Rejections
Claim rejections differ from regular claims in error as they have passed all AHIN and payer specific edits, have been transmitted from the clearinghouse to the payer, and have entered into the payer's adjudication system.
Three status codes associated with claim rejections are Status Z, U and Q. These codes are reserved for payers participating in the claim rejection process.

Those payers include:
- Arkansas Blue Cross and Blue Shield
- Health Advantage
- BlueAdvantage Administrators of Arkansas
- BlueCard
- Medi-Pak

Status Z
Claims with a status of Z are rejected by the payer and returned to the provider with an explanation letter. These letters are available on AHIN – select Letter in the claim navigation column. You can also click More Info to view additional details about the rejection.

Status U
Claims with a status of U are the original claims that have been electronically rejected by the payer and returned to the provider. When this occurs, a letter is not generated; however, a new claim is automatically created. The new claim can be corrected and resubmitted. Click More Info to link to the newly created claim.

Status Q
Claims with a status of Q are newly created claims. For status Q claims, you can make the necessary corrections based on the error message and click submit. You can also click More Info to link to the original claim (status U).

McKesson Clear Claim Connection
AHIN has updated the menu option when accessing McKesson Clear Claim Connection. You will still select Links > Edit Coverage > McKesson Clear Claim; however, you will no longer see the line of business as a menu option. The Line of Business Name now displays as a dropdown option on the Claim Entry page.

Enter the following information once the Claim Entry page displays:

1. Select the **Line of Business**
2. Select the patient's **Gender** and enter their

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AHIN claim update reminders (Continued from page 7)

Date of Birth

3. In the first line of the grid, go to the **Procedure** field and enter a procedure code
4. Enter up to four **Modifier** codes (optional)
5. Enter the **Date of Service**
   (If no date is entered, the field defaults to the current date)
6. Enter the number of procedures performed in the **Qty** field
7. Repeat the previous steps for each line as needed
   (If more lines are needed click **Add More Procedures)**
8. When finished, click **Review Claim Audit Results**

The Claim Results page displays.

CPT category II and Z codes aid data collection, reduce administrative work for offices

What are CPT Category II and Z codes?
CPT Category II codes are tracking codes, while Z codes are BMI diagnosis codes. Certain CPT II codes and Z codes facilitate data collection for HEDIS®** measures. Used together, they can give you credit for quality care without the need for medical record review and can help you close gaps for HEDIS measures.

Here's a closer look:

- CPT category II codes describe components that are usually included in the evaluation and management process, such as A1c or blood pressure test results. They are billed in the procedure code field like CPT category I codes are.
- Z codes are diagnosis codes. To illustrate how they might be used to facilitate data collection, submitting a claim with the appropriate ICD-10 diagnosis code to indicate a patient's body mass index will alleviate the need to review the member's medical record for BMI documentation.

Why should my practice use CPT category II and Z codes?
The use of CPT category II and Z codes on claims eases an office's administrative burden. It does this by decreasing, while not completely eliminating, the need for medical record reviews to determine if certain standards are met.

CPT category II codes are adopted and reviewed by the Performance Measure Advisory Group, or PMAG. PMAG is made up of experts in performance measurement

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from organizations such as the American Medical Association, the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services and others.

CPT II Codes: Closing HEDIS Gaps

The following chart is a list and description of CPT II codes that will close HEDIS measures. Please also keep these tips in mind when billing CPT II codes:

- Manage and document all acute and chronic patient conditions appropriately
- Ensure that services provided and diagnoses are documented in the medical record
- Submit accurate and timely claims for every office visit
- Report all services completed on a claim

Medication Reconciliation Post-Discharge Measure	
1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Comprehensive Diabetes Care Measure	
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
3045F	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0%
3046F	Most recent hemoglobin A1c (HbA1c) level greater than 9.0%
3060F	Positive microalbuminuria test result documented and reviewed
3061F	Negative microalbuminuria test result documented and reviewed
3062F	Positive macroalbuminuria test result documented and reviewed
3066F	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)
4010F	Angiotensin converting enzyme (ACE) inhibitor, or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken

ZCodes: BMI Results

ICD 10 BMI results should be included in your office visit claims, typically with the patient's annual wellness visit or physical. Make sure you document the height, weight and BMI in the patients' medical records and that your medical billing coders include the ICD 10 BMI code.

- BMI percentiles for under 21: Z68.51 – Z68.54
- BMI values for 21 and over are: Z68.1 – Z68.45

**HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance.

Coding corner: Best practices for documenting peripheral vascular disease and deep vein thrombosis

Delivering high-quality treatment and care to members is a high priority for Arkansas Blue Cross and Blue Shield. Proper clinical documentation is crucial, as it ensures complete, consistent and accurate information about a patient encounter. For all medical conditions, including vascular disease it is necessary to follow the ICD-10-CM guidelines before assigning the appropriate code.

About vascular disease
Vascular disease is an abnormal condition of the blood cells and includes conditions affecting the circulatory system. The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart.

Deep vein thrombosis
Deep vein thrombosis, or DVT, is a condition that occurs when a blood clot forms in one or more of the deep veins in your body — most often in the legs. DVT can develop if you have risk factors, keep legs fully flexed or haven't moved for long periods of time, such as when traveling or bedridden.

DVT can develop if you have certain medical conditions that affect how your blood clots. It can be a serious condition because blood clots in your veins can break loose, travel through your blood stream and potentially lodge in your lungs, causing a pulmonary embolism. Use the following guidelines when documenting DVT:

- Code assignment is based solely on the provider's specific description of the condition in the medical record.
- The condition in the medical record should be identified as acute or current, or chronic:
  - o I82.401 — **Acute** embolism and thrombosis of unspecified deep veins of right lower extremity
  - o I82.501 — **Chronic** embolism and thrombosis of unspecified deep veins of right lower extremity
- A specific anatomic site where the thrombus is located should be identified (for example, right, left, bilateral, femoral vein, iliac vein, popliteal vein, tibial vein or other specified):
  - o I82.491 — Acute embolism and thrombosis of other specified deep vein of r**ight lower extremity**
  - o I82.702 — Chronic embolism and thrombosis of other specified deep vein of **left upper extremity**
- When DVT is completely resolved and the provider documentation indicates past history of DVT, assign a personal history code:
  - o Z86.718 — Personal history of other venous thrombosis and embolism
  - o Medical coders shouldn't assign a code for DVT if the patient doesn't have the condition.

Pulmonary embolism
An embolus is a blood clot that can occur in the veins of a body part, most commonly the legs. Emboli can dislodge and travel to other organs in the body. A pulmonary embolism is a clot that lodges in the lungs, blocking the pulmonary arteries and reducing blood flow

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to the lungs and heart. Document pulmonary embolisms as:

- I26.929 — Saddle embolus of pulmonary artery without acute cor pulmonale. Other pulmonary embolism without acute cor pulmonale
  - o This code includes acute pulmonary embolism and pulmonary embolism NOS.

Peripheral vascular disease

"Peripheral vascular disease" and "peripheral artery disease" are two terms used interchangeably. Provider progress notes may reference a physical exam of the lower extremity pulses or the ankle-brachial index (ABI). Supporting documentation may also consist of claudication, pain, cramping or wounds that are not healing. Treatment may include anti-platelet medications, a walking exercise plan or surgical interventions. PVD is coded as:

- I73.9 — Peripheral vascular disease, unspecified

Tobacco use, diabetes, obesity, cardiovascular disease, hypertension, hyper lipidemia and physical inactivity are a few examples of risk factors and should also be clearly documented when present. When PVD is a manifestation of diabetes, it is important that the documentation ties the conditions together. Assigning the correct combination code is equally important. Review the route below to find the proper diagnosis code using the ICD-10-CM:

- Locate the term "disease."
- Locate the sub-term "vascular."
- Under the sub-term, locate "peripheral."
  - o In "diabetes mellitus," see E08 to E13 with .51.

When coding conditions of the circulatory system, it's important to review all documentation and follow the ICD-10-CM guidelines before assigning the appropriate code.

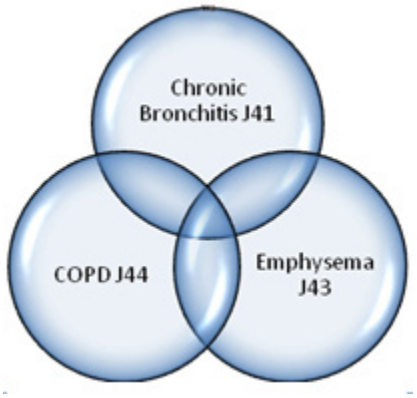
None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.

Coding corner: Medical record documentation for COPD and associated respiratory conditions

With the increased specificity required by ICD-10-CM, accurate and detailed medical record documentation is more important than ever. Chronic obstructive pulmonary disease and associated respiratory conditions need to be properly documented in the medical record to support the correct ICD-10-CM diagnosis code.

What is COPD?

Chronic obstructive pulmonary disease is a common and progressive disease that causes airflow from the lungs to be obstructed. Common symptoms include a productive cough, wheezing, shortness of breath and chest tightness. The two main forms of COPD are emphysema and chronic bronchitis. However, many patients with COPD have both emphysema **and** chronic bronchitis.



What causes COPD?

Smoking tobacco and exposure to tobacco smoke are the leading causes of COPD. According to the Centers for Disease Control and Prevention, smoking also accounts for as many as eight out of 10 COPD-related deaths. However, as many as one out of four people in the U.S. who have COPD never smoked cigarettes. Other causes include long-term exposure to lung irritants such as air pollution, chemical fumes and dust.

Tips to remember

- When coding for COPD, bronchitis (acute, chronic), asthmatic bronchitis (acute, chronic), emphysema and other associated respiratory conditions, indicate through coding whether or not the condition is acute, chronic or in acute exacerbation.
- Since COPD-related conditions can be coded in a variety of ways, the final code selection must take into account all the specific details of a patient's condition, as documented by the healthcare provider.
- ICD-10-CM code J44.9 (chronic obstructive pulmonary disease, unspecified) should only be used if the type of COPD being treated is not specified in the medical record.
- Always document and code to the highest specificity. For example, if the provider documents "acute bronchitis" or "chronic bronchitis" (both unspecified), then report ICD-10-CM codes J20.9 and J42, respectively. However, if the provider does not indicate whether the bronchitis is acute or chronic, then the appropriate ICD-10-CM code would be J40 (Bronchitis not specified as acute or chronic).
- When COPD with an acute exacerbation is documented without acute bronchitis, then report ICD-10-CM code J44.1 (chronic obstructive pulmonary disease with acute exacerbation).
- Code J44.0 (chronic obstructive pulmonary disease with acute lower respiratory infection) when the medical record supports acute bronchitis and COPD. Use an additional code to identify the infection.

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ICD-10-CM code	Description of respiratory condition
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J44.-	Other obstructive pulmonary disease J 44.0 – COPD with acute lower respiratory infection J44.1 – COPD with (acute) exacerbation J44.9 – COPD, unspecified
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.9	Emphysema, unspecified
J45.-	Asthma (additional 5th and/or 6th characters required) J45.2 – Mild Intermittent asthma J45.3 – Mild persistent asthma J45.4 – Moderate persistent asthma J45.5 – Severe persistent asthma J45.9 – Other and unspecified asthma
R09.02	Hypoxemia
Z93.0	Tracheostomy status
Z99.81	Dependence on supplemental oxygen (code the underlying condition first)
Z43.0	Encounter for attention to tracheostomy

It is important to review the ICD-10-CM Coding Guidelines (Chapter 10: Diseases of Respiratory System J00-J99), as well as any instructional notes under the various COPD subcategories and codes in the tabular list of the ICD-10-CM manual to select the correct code. In addition to the codes listed above, you may need to use additional codes to identify current or previous tobacco usage and dependence or other environmental exposure.

Note: ICD-10-CM coding for all conditions should follow coding conventions, chapter specific guidelines and general coding guidelines.

If you have questions or need more information, contact your provider consultant.

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with applicable state and federal laws and regulations.

Bluecard: RA balancing instructions and guidelines related to coordination of benefits (COB)

There has been an increase in inquiries due to the calculation on the remittance when two or more policies are involved on a claim. Below are examples of some of the more common calculations used in the coordination of benefits. However, due to the differences in COB policies and rules for other Blue Cross and Blue Shield carriers, an example cannot be provided for all instances. Therefore, when in doubt, bill the member the amount indicated in Member Liability on the remittance advice. If there is an error in payment, the member's Home Plan will initiate any necessary adjustments.

The following examples should assist providers in determining patient liability on claims.

Example 1: Charges Discount Paid Payment

Total Charges = $ 545.50
Less Blue Cross Discount = ($ 121.08)
Less payment on RA = ($ 97.21)
Less Other Insurance Paid = ($ 126.04)
Equals patient liability = $ 201.17

Provider bills patient $ 201.17

NOTE: The patient responsibility amount on the RA is $327.21, which includes the other insurance paid amount of $126.04. $327.21 - $126.04 = $201.17 current patient responsibility.

Patient responsibility on RA = $ 327.21
Less Other Insurance = ($ 126.04)
New Patient Responsibility = $ 201.17

Example 2: Charges Allowed Discount Coinsurance Payment

Total Charges = $ 1,190.85
Less Blue Cross Discount = ($ 538.48)
Less payment on RA = ($ 489.29)
Difference is coinsurance = $ 163.08

Patient responsibility is $163.08 which is the coinsurance amount. Providers will need to bill the patient for the coinsurance amount.

Example 3: Charges Discount Paid Payment

Total Charges = $ 242.00
Less Blue Cross Discount = ($ 104.68)
Payment on RA = ($ 0.00)
Less Other Insurance = ($ 106.16)
Patient responsibility = $ 31.16

No payment was made on this claim to subtract. Provider bills patient $31.16.

NOTE: The patient responsibility amount of RA is displayed as $137.32 which includes the other insurance paid amount of $106.16. $137.32 - $106.16 = $31.16 current patient responsibility.

Patient responsibility on RA = $ 137.32
Less other Insurance = ($ 106.16)
New Patient Responsibility = $ 31.16

Example 4: Charges Discount Paid Payment

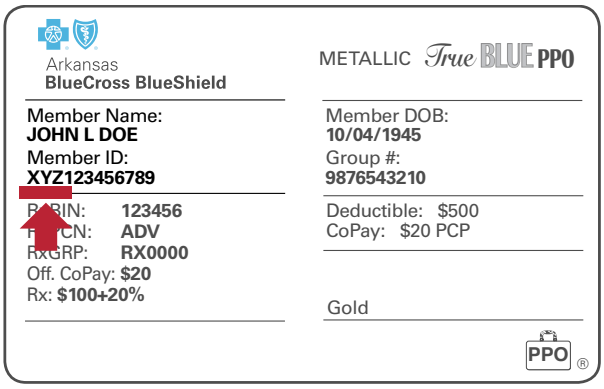
Total Charges = $ 5,444.86
Less Blue Cross Discount = ($ 3,782.86)
Less Other Insurance Paid = ($ 1,662.00)
Patient responsibility = $ 00.00

There is no payment from the patient on this claim. The balance is zero with nothing remaining to bill the patient. The patient responsibility amount matched what the other insurance paid $1662.00.

Alpha Numeric Prefixes coming in 2018

Background

The three-position alpha prefix of a Member's Identification Number (ID) is a foundational component of the BlueCard Program and Inter-Plan Teleprocessing Services (ITS). Although originally used primarily for claims routing, the functions/processes dependent on the alpha prefix have expanded along with the program.



Issue

With the potential for the current pool of alpha prefixes to run out as early as 2018, it is important to expand the pool and/or slow the rate of consumption.

Resolution

The Blue Cross and Blue Shield Association is changing the field from an alpha (only) prefix to an alpha numeric prefix. 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 will be distributed in Release 17.5 which implements October 15, 2017, with utilization **effective on April 15, 2018**.

Action Needed

Arkansas Blue Cross and Blue Shield is currently assessing the impact of this system change. If any providers have hard-coded system edits that may be impacted by this change, **please contact your network development representative** as soon as possible.

Frequently Asked Questions

1. **Will the alpha numeric prefix still be three positions?**
   Yes, the change to alpha numeric allows us to keep the current three position prefix most are accustomed to.
2. **Will all positions of the prefix be allowed to be numeric?**
   No, a prefix cannot be all numeric. The system edits will be modified to allow for numeric positions.
3. **With the move to numeric, is there an impact to the Federal Employees Program (FEP)?**
   FEP ID numbers start with an R, which has been taken into consideration and will be accounted for in the requirements and design process.
4. **Are there any restrictions on the numeric character?**
   Yes, zero and one will not be used. The numeric characters will be two through nine.
5. **How many prefixes does a numeric position add to the overall prefix pool?**
   This would add about 30,000 prefix combinations.
6. **What order will the alpha numeric prefix be released?**
   There are six combinations that will be released once the current set is exhausted:

Additional Alpha Numeric Prefix Combinations					
A2A	2AA	22A	AA2	2A2	A22

Balloon Sinuplasty Pilot Policy to take effect in June

Effective June 01, 2017 through May 30, 2019, Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries will have a pilot policy for balloon sinuplasty. The pilot policy is in effect only for providers directly contracted with Arkansas Blue Cross and its family of companies. Balloon sinuplasty procedures performed as stand-alone procedures outside of the scope of this pilot policy are not covered and addressed in separate policy #2006030.

Please refer to coverage policy #2017010 for details as there are a number of specific requirements for reimbursement. Claims processing for this pilot policy will be effective June 12, 2017 and retroactive to June 01, 2017. Claims for these services should be submitted after June 11, 2017.

The complete coverage policy #2017010 can be accessed on the Arkansas Blue Cross website under the "Coverage Policy" page under the "Doctors and Hospitals" tab (http://www.arkansasbluecross.com/members/other_links/coverage_policy.aspx).

Arkansas Blue Cross Health Insurance Literacy Campaign

Arkansas Blue Cross and Blue Shield has launched a new online health literacy campaign that you can use as a resource for your patients.

A new website, arkbluecross.com/howitworks, helps people understand the basics of health insurance and how to navigate the healthcare system. On the site, you will find upbeat videos, a glossary of terms, helpful articles, FAQs and more. Sample topics include insurance terms, where to go for healthcare and how to save money on prescription medications.

Arkansas Blue Cross is also using its social media channels, publications, ArkansasBlue stores and community events to share information about the healthcare system and how it works. Find information on our Facebook page @ArkansasBlueCross or our other social media outlets:

Twitter: @ArkBlueCross
Instagram: @arkansasbluecross
YouTube: arkbluecross
LinkedIn: www.linkedin.com/company/arkansas-blue-cross-blue-shield

New ID cards coming for Arkansas Blue Cross group members

Arkansas Blue Cross and Blue Shield group members began receiving new ID cards, with new member ID numbers, in April as part of an improvement to our internal systems. The new ID cards will be issued as each group is renewed, which means you may have patients receiving new member ID cards over the course of a 14-month span. As a reminder, you should continue to check AHIN to verify a member's eligibility and coverage.

Why is this happening?
By moving all lines of business to a newer claims system, we will improve productivity and processes, provide consistent security measures and lower administrative and maintenance costs. Claims will process by date of service, using the ID for that respective coverage period.

What should you do?
Please ask your patients with Arkansas Blue Cross member IDs if they have recently received a new member ID card. If they have, please update your information to ensure your patient's claims are handled efficiently. It's important that the claim is filed with the correct ID number, including the alpha prefix. If they haven't, let them know that if they are with a group health plan, they may be receiving a new ID card, with a new number, soon.

New Payment Cycle
Due to the change in claims systems, a new payment cycle for these Arkansas Blue Cross and Blue Shield members began in April. The EFT number format is 'BC BC' and check numbers begin with 'BC'. The claim payment cycles are scheduled to run once a week with the exception for holidays and month-end processing.

AHCPII episode of care updates

The Arkansas Healthcare Payment Improvement Initiative (AHCPII) has been fully operational for four years for many physicians and hospitals participating in Arkansas Blue Cross and Blue Shield's Preferred Payment Plan (PPP), Health Advantage's HMO network, USAble Corporation's Arkansas' FirstSource® PPO and True Blue PPO networks. We have seen improvements in quality as well as cost effectiveness. To further these advancements, Arkansas Blue Cross has created three new episodes of care.

Episode of Care	Definition/Scope	Principal Accountable Provider
Pneumonia in the ER	Emergency room diagnosis of Pneumonia plus all related claims through 30 days after discharge from facility	Hospital
Hysterectomy	Procedure plus all related claims from 60 days prior to procedure to 60 days after discharge from facility	Surgeon
Lumbar Spinal Fusion	Procedure plus all related claims from 30 days prior to procedure to 90 days after	Surgeon

Principal accountable providers (PAPs) in these episodes have **preparatory reporting available in 2017** on the AHIN "APII Portal" under "Episodes." During this time, you will have access to reports designed to help you understand your current practice patterns and the financial and quality outcomes they generate. The data for those reports will be pulled from existing claims data and from a limited set of data that providers will enter into a provider portal for some of the episodes. These reports are available on AHIN and should be reviewed as soon as possible by the PAPs. The payment methodology for three new episodes will be implemented on January 1, 2018. Both PAPs and non-PAPs will continue to file claims and receive reimbursement as usual. No changes in reimbursement will occur during the 2017 preparatory period.

The value-based programs link at www.arkansasbluecross.com (under Doctors & Hospitals) contains detailed information for each active episode; including individual episode details and algorithms, gain and risk share requirements, appeal process and the report glossary. The direct link is www.arkansasbluecross.com/providers/valueBasedPrograms.aspx

Important Reminders

1. The colonoscopy episode of care was on hold for the 2016 performance period, and resumed January 2017.
2. The congestive heart failure (CHF) episode of care was suspended for the 2017 performance period. This was not a complete suspension of the congestive heart failure episode program; we will evaluate the volume and impact on an annual basis to determine program necessity.

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AHCPII episode of care updates (Continued from page 18)

3. Effective January 1, 2017, the Arkansas Blue Cross AHCPII payment system has financial and quality targets for the individual metallic business sold through the Arkansas Marketplace (also known as Qualified Health Plans (QHP)). These services are reimbursed at a different percentage of the fee schedule than usual commercial business, thus the need for separate financial targets.

Providers must have five or more eligible cases of an episode to be considered principal accountable providers (PAPs). Individual metallic members (QHP members) will not count toward a provider's count for regular commercial members (non-QHP members). The following chart demonstrates that five or more eligible cases must be present for both memberships for a provider to qualify as a PAP in both. It is possible, based on patient mix, for a provider to be a PAP for one group, but not for another.

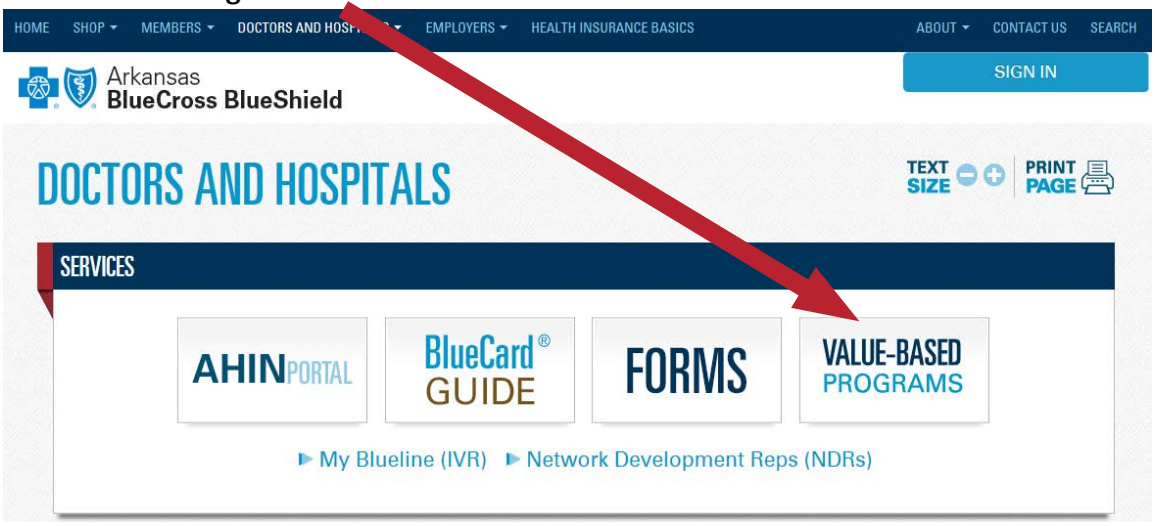
Eligible Episodes of Care		PAP Eligibility for Gain/Risk Sharing
QHP Members	Non-QHP Members	
4 or less	4 or less	Not eligible for either
4 or less	5 or more	Non-QHP Members ONLY
5 or more	4 or less	QHP Members ONLY
5 or more	5 or more	Eligible for both

New location for value-based programs information

The value-based programs now have a direct link separate from the provider manual. The links are:

- Arkansas Blue Cross and Blue Shield: www.arkansasbluecross.com/providers/
- Health Advantage: www.healthadvantage-hmo.com/providers/
- BlueAdvantage Administrators of Arkansas: www.blueadvantagearkansas.com/providers/

Select "Value-Based Programs" under "Services."



Annual compliance training requirement due by December 31

As a contractor with Centers for Medicare & Medicaid Services (CMS) and a qualified health plan (QHP) through the U.S. Department of Health and Human Services (HHS) and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act), Arkansas Blue Cross and Blue Shield is required to develop and maintain an effective compliance program and ensure annual compliance training is satisfied by our first-tier, downstream and related entities (FDRs) and delegated entities (DEs).

According to the Federal Register Notice CMS-4124-FC and 45 C.F.R. Subpart D §156.340, Providers are considered first tier and/or delegated entities because there is a direct contract for Medicare/ACA Services between Arkansas Blue Cross and each provider. All providers we contract with and the provider's staff that has contact (indirect or direct) with Medicare beneficiaries and Affordable Care Act (ACA) patients **MUST** complete the required annual CMS compliance training by 12/31/2017 for this plan year.

MLN General Compliance Training Link/ Download Information

As a contractor with Centers for Medicare & Medicaid Services (CMS) and as a Qualified Health Plan (QHP) through the Affordable Care Act, Arkansas Blue Cross annual compliance training is required.

For organizations who do not conduct their own general compliance training, this requirement can be met by completing the training on the Medicare Learning Network (MLN). Should your organization choose to incorporate the General Compliance Training into your internal training, the materials can be downloaded at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf. These training materials cannot be modified and must be retained along with a training log, which includes the name and date the individual completed the training.

To obtain a certificate (which includes contact hours), each user must complete the CMS MLN training on the link below and a certificate of completion is generated upon a passing score of 70 percent or higher.

The updated and free Medicare Parts C and D General Compliance Training web-based training (WBT) course is available through the Learning Management System, by logging into or creating an account through the MLN https://learner.mlnlms.com/Default.aspx. Each provider will need to create their own account if you are not already an MLN user. To create a new user account on the MLN, select *new user* and follow the prompts. When you get to the Organization Section; select '*Search*' and then select '*CMS-MLN Learners Domain Organization*', select '*Save.*' Once your account is created, you will be on the home page of

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the MLN. To the right of the page, above '*Browse Categories*' in the search box; type '*Compliance Training*' and search. Medicare Parts C and D General Compliance Training (January 2017) (Contact hours: 20 min.) will populate, select the course, then select 'Enroll'. Although it is specified as Medicare Part C and D, this is general compliance for all our lines of business, including other Plan Sponsors.

When should the training be completed?
The general compliance training must occur within 90 days of initial hiring and annually thereafter, but no later than December 31 of any given contract year.

What do we do with our training records?
No documentation should be returned to Arkansas Blue Cross at this time. However, Arkansas Blue Cross has developed an online attestation, administered through AHIN and will require that the AHIN User Administrator (AUA) attest on behalf of the facility, that that each FDR/DE has completed the appropriate general compliance through their organization or through the Medicare Learning Network® (MLN). Later this year, the AUAs will received the online attestations via AHIN, and should attest that should **ALL** applicable staff at the facility have completed the required annual compliance training through one of the approved methods.

All training documents, including a copy of the training materials and training logs, should you choose to download the materials, must be retained by your organization for 10 years, in accordance with CMS/HHS 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/HHS or CMS/HHS designees.

Quantity limits to prevent opioid misuse

With opioid misuse on the forefront of public health, Arkansas Blue Cross and Blue Shield is committed to ensuring the safety and wellness of our members and our communities. To honor that commitment, stricter opioid quantity limits will be placed on our formulary products to better align with current public health guidelines. These quantity limits have been in place for members with exchange plans, and will be put into effect on all members (excluding Medicare Part D members) on July 1, 2017. The limits will be based on both current CDC guidelines and the Institute for Clinical Systems Improvement Chronic Pain Guidelines, and will include:

- Initial daily quantity limits of 90 morphine milligram equivalents (MME) per opioid product
- Options for increased daily limits up to 200 morphine milligram equivalents with a prior authorization for members that meet criteria

Quantities over 200 MME daily will not be allowed due to the increased risk of overdose. The Institute for Clinical Systems Improvement Chronic Pain Guidelines state that among patients receiving opioids, an average dose of 200 mg or more morphine (or equivalent) was associated with a nearly nine-fold increase in the risk of overdose relative to lower doses.

2017 HEDIS® clinical quality and documentation tips for CMS Star Measures

Arkansas Blue Cross and Blue Shield continuously strives to improve the quality of care for your patients and our members.

The National Committee for Quality Assurance establishes Healthcare Effectiveness Data and Information Set, or HEDIS® measures to assess a broad range of health issues and allow consumers to compare health plans on quality measures. Annual reviews by NCQA examine the same set of standards for all insurance companies. HEDIS has become an integrated system that improves the accountability of the managed health care industry with the ultimate goal of improving the quality of care for members. Arkansas Blue Cross encourages health care providers to assist in this effort by carefully and accurately coding claims for their patients, as well as ensuring documentation is included in the medical records for the services provided.

Arkansas Blue Cross believes it is valuable for participating health care providers and their staffs to be aware of the standards measured by HEDIS® and how they can improve the quality of care for their patients. To this end, Arkansas Blue Cross developed a set of tip cards to help you improve medical record documentation, Centers for Medicare & Medicaid Star ratings and your HEDIS scores.

This set of tip cards is easily accessible from the arkansasbluecross.com provider website at the following location: www.arkansasbluecross.com/providers under the Resource Center section heading by selecting "2017 HEDIS Clinical Quality and Documentation Tips for CMS Star Measures."

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Rural Health Center reporting requirement change

On April 1, 2016, CMS changed the reporting requirements for rural health centers. CMS now requires a HCPCS/CPT code to be included for each service line along with a revenue code for each Medicare claim. Medi-Pak® Advantage made the decision to exclude this requirement for the remainder of the 2016 claims. On January 1, 2017, claims began to deny if the required HCPCS/CPT was not included on the claim. As a courtesy to our providers, Arkansas Blue Cross Medi-Pak® Advantage has decided to waive the requirement until July 31, 2017. All claims previously denied for submission of HCPCS code will be reprocessed to allow payment. Effective August 1, 2017, all rural health center claims not billed with the appropriate HCPCS/CPT code will be denied.

Medicare Advantage providers are requested to review their demographic information

Providers in the Arkansas Blue Cross and Blue Shield's Medi-Pak® Advantage network should review their demographic information we have on file to ensure accuracy.

Keeping your information current:

- Helps us provide our members with accurate information through our online and printed provider directories
- Allows our members to locate and access the care and services from in-network providers
- Helps other providers make referrals and accurately direct their patients' care to in-network practitioners and suppliers
- Ensures payment and other correspondence are received timely, and reduces the potential for delayed or denied payments resulting from inconsistent demographic information
- Meets the regulatory standards set by the Centers for Medicare & Medicaid Services

Please visit the "Find a Doctor or Hospital" tab to verify accuracy of the information published in Arkansas Blue Cross' online provider directory.

When reviewing your listing, please ensure the following is accurate:

- Demographic information
- If your practice is accepting new patients
- Your physical address or addresses
- The specialties of the providers affiliated within your health care organization

If inaccuracies exist, please complete our "Provider Change of Data Form" located at www.arkansasbluecross.com/providers/forms

FEP restricted coverage for supervised polysomnography

Previous Providers' News articles have indicated sleep studies done in a facility require prior authorization for FEP members. Studies in a facility will be approved only if they meet the criteria as published in the coverage policy available at https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms/medical-policies?page=2. These criteria include:

- Age <18
- Not meeting criteria for a home study
- A previous non-diagnostic home sleep study in a patient with a high pretest probability of OSA
- A previous technically inadequate home study
- Failure of resolution of symptoms or recurrence of symptoms during treatment
- To re-evaluate the diagnosis of OSA and need for continued CPAP (e.g. If there is a clinical change)
- Presence of a comorbidity that might alter ventilation or decrease the accuracy of a home sleep study (e.g. heart failure, neuromuscular disease, chronic pulmonary disease, or obesity hypoventilation syndrome).

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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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