PROVIDERS' NEWS

June 2018

A publication for participating providers and their office staffs

Addressing the opioid epidemic

Arkansas Blue Cross and Blue Shield and its family of companies supports and partners with initiatives assisting our members with health management. Two programs addressing the opioid epidemic hosted by the University of Arkansas for Medical Sciences (UAMS) are:

1. Arkansas Improving Multidisciplinary Pain Care Treatment (AR-IMPACT).
2. Medication Assisted Treatment Recovery Initiative for Arkansas Rural Communities (MATRIARC).

These initiatives assist providers in learning about resources and alternatives to managing pain and treating opioid addiction.

AR-IMPACT

AR-IMPACT offers a free weekly education and consultation service for Arkansas healthcare providers to better manage chronic pain patients and those who need their opioid dosage reduced. AR-IMPACT is a live-streaming online video-conferencing service staffed by a multidisciplinary team from UAMS. The team includes a pain physician, an addiction psychiatrist, a psychologist, two pharmacists and a physical therapist. Weekly conferences include a 20-minute presentation on an opioid-related topic and a question-and-answer session. More information is available at arimpact.uams.edu.

MATRIARC

MATRIARC, co-sponsored by the Arkansas Department of Human Services' Division of Behavioral Health Services, focuses on the Medication Assisted Treatment model (MAT) for dealing with the opioid epidemic. This free program offers Arkansas providers education and expertise on evidence based treatment for opioid use disorders.

The MATRIARC program is open Monday Friday, 8:30 a.m. 4:30 p.m. Providers call 501-526-8459 or 1-833-872-7404 to speak with an addiction psychiatrist, as we work collectively to end this harmful epidemic.

TABLE OF CONTENTS

Arkansas Works program changes

Effective in June 2018, DHS is implementing changes to the Arkansas Works (AW) program. Members age 30-49 are required to work, volunteer or do job training for 80 hours per month to keep their Arkansas Works plans.

It is important for Arkansas Works members to report their qualifying activities each month.

How do members report these hours?

- AW members must report work activity on access.arkansas.gov.
- Kiosks will be available in county offices for members who can't access the site via a computer or other device.

What if members don't report their work?

- Members who don't report their hours will be noncompliant for the month.
- If they have three noncompliant months in one calendar year, the member will lose their Arkansas Works plan.
- Members who lose their plans because of non compliance will not be able to obtain Arkansas Works coverage again until the following year.

Does every Arkansas Works member have the work requirement?

No, many members will qualify for an exemption from mandatory reporting of activities. There are several examples of exemptions, but all members 50 years old and older will be exempt. For the first year of the program, members 29 years old and younger also will be exempt. Also, members who have short-term or long-term disabilities will qualify for an exemption.

For more information on the Arkansas Works work requirement, please visit arkbluecross.com/arkansasworks or call 1-800-800-4298.

How does this affect providers?

Simply put, members who fail to meet the new work requirements will have their coverage terminated and will have limited coverage options, until the following January. Unless other coverage is available to these members through an employer, it is likely these members will have to obtain expensive individual policies or go without coverage.

This could impact your ability to serve your patients. It will be very important to utilize the AHIN provider portal to verify benefits and eligibility.

Sometime this summer, AHIN will be updated with additional information that will indicate if an AW member is subject to the work requirement.

Providers can assist their patients create an account and report work activities or exemptions by:

- Directing patients to their local Department of Human Services county office for assistance in creating an account and reporting work activities or exemptions.
- Providers may enroll in a brief training to become a registered reporter. For additional information, please visit the Arkansas Works website at https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Claims Filing

To reiterate, members will not lose their coverage until they have failed to report qualifying activities for any three months in a calendar year. When members have

(Continued on page 3)

Arkansas Works program changes (Continued from page 2)

failed for two months to attest to qualifying activities, the state will send Arkansas Blue Cross a termination for the members' coverage at the end of the month. But, it's important to note that members still have until the fifth day of the following month to report work activities for the previous month, which means the member could be terminated and then have their coverage reinstated, without creating a gap in coverage.

For example, if it's July, and a member already has failed to attest for February and June, if the member doesn't attest by the time the state sends the monthly termination file (let's say the 25th of the month), Arkansas Blue Cross will receive and process the termination to endcoverage as of July 31. Per the rules of the program, the member still has until August 5 to attest for July. So, if the member attests on August 4, Arkansas Blue Cross will receive an enrollment file to reinstate the member's coverage as of August 1.

Final note: *all terminations from the state should be prospective. We should not receive a retrospective termination (outside of fraud). We can and will continue to receive retroactive enrollments.*

Value-Based Compensation Initiative timeline adjusted

Dialogue with physicians and stakeholders results in changes to Value-Based Compensation Initiative.

As a result of feedback from continuing meetings with physicians and other stakeholders, Arkansas Blue Cross and Blue Shield has modified the implementation schedule for the Value-Based Compensation Initiative (VBCI).

Value pool contributions now will begin after the end of a 12-month shadow reporting period that will educate providers on information about their performance.

This is a departure from the proposed January 1, 2019 implementation of VBCI, with value pool contributions beginning on that date. The 12-month shadow reporting period will be "triggered" by the date in which shadow reports are released and available to all participating providers.

Currently, it's anticipated that shadow reports will be released in July 2018, which means the value pool contributions would begin 12 months later. During this 12-month shadow reporting period, participants in VBCI will receive access to a full year of information, showing:

- How they are performing relative to their peers – i.e., what is their current value score.
- Where are opportunities for improvement that would allow them to improve their value score.
- What their value pool contribution would have been had VBCI been active for the period.
- What their value pool distribution would have been had VBCI been active for the period.

(Continued on page 4)

Value-based compensation initiative timeline adjusted (Continued from page 3)

Assuming shadow reports are released in July 2018, the "trigger date" will be the first day of the next month, which will be August 1, 2018. The 12-month shadow reporting period will then end on July 31, 2019, and value pool contributions will begin on August 1, 2019. During the shadow reporting period, shadow reports will be released quarterly on AHIN.

The first release of "live" value scores and related value pool distributions would follow 30 days after the end of the calendar-year quarter in which value pool contributions begin. Subsequent release of value scores and value pool distributions will be made on the same schedule (30 days after the close of each calendar-year quarter).

> "We want to assure healthcare providers that we are committed to giving them access to a full year of data to acclimate to this new system before it translates to actual changes in reimbursement," said Steve Spaulding, executive vice president of Enterprise Networks and chief health management officer. "By using a flexible 'trigger' date, followed by a 12-month 'shadow' period, we can ensure that we have an appropriate amount of time for healthcare providers to get comfortable with the system, assess their status and make adjustments, if needed. Deadlines are a necessary tool, but in the end, we believe getting this initiative right is the most important outcome."

Following is the currently planned timeline for implementation of VBCI:

- **Release of shadow reports in AHIN**: July 20, 2018.
- **"Trigger" date** – August 1, 2018. With the currently planned release of shadow reports on July 20, 2018, August 1, 2018 will "trigger" the start of the 12-month shadow reporting period.
- **12-month shadow period** – August 1, 2018 - July 31, 2019. During this period, healthcare providers will receive quarterly shadow reports that identify what their value contribution and value pool distribution would have been based upon their then current value score if the system had been "live" during the period.
- **"Go-live" date** – August 1, 2019. Assuming a "trigger date" of August 1, 2018, value pool contributions would begin August 1, 2019.
- **First "live" value scores and value pool distribution** – October 31, 2019. The first value pool distribution would be based on the previous quarter's value pool contributions and value scores from the most recent 12-month period. Assuming a "go-live" date of August 1, 2019, the first value pool distribution would be made by October 31, 2019.

Meetings and communications with physicians, physician groups and other stakeholders will continue prior to and throughout the shadow reporting period in order to obtain feedback that will contribute to improvements to the program prior to implementation – and beyond.

For more information on Value-Based programs, please visit our website or use the links provided:

- www.arkansasbluecross.com/providers/valueBasedPrograms.aspx
- www.healthadvantage-hmo.com/providers/resource-center/value-based-programs

Alphanumeric prefixes effective June 1, 2018

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers of the change from all alpha (letters only) prefixes to the use of alphanumeric (letters and numbers) prefixes in 2018. This change results from the potential of the current pool of alpha prefixes running out as early as 2018. The move to an alphanumeric prefix solution increases the prefix pool. The first set of alphanumeric prefixes are in effect as of **June 1, 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 Managed Care Organizations (MCOs) and Medicare Advantage plans.

In October 2008, Performant was named Centers for Medicare & Medicaid Services (CMS) Region A Recovery Audit Contractor (RAC) and has been an RAC auditor since that time. In 2016, Performant was again awarded Region 1 (formerly referred to as Region A) and also was awarded the newly created Region 5, for which Performant will serve as the sole auditor for durable medical equipment, prosthetics, orthotics and supplies (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 that 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 the instructions provided in Performant's audit request and respond in a timely manner (with complete information). Not responding to Performant could result in a "finding," which may result in recoupment of claim reimbursement. We appreciate your cooperation in this necessary program

Federally required annual compliance training notice

Arkansas Blue Cross Blue Shield is required by the federal government to ensure that certain individuals and entities with whom we do business (including healthcare-related professionals and organizations) complete **general compliance training** and **fraud, waste and abuse training** on an annual basis.

Who must complete training?
General compliance training and fraud, waste and abuse training (where applicable), should be completed annually by **all persons** who have contact (indirect or direct) with beneficiaries of the federal Centers for Medicare & Medicaid Services (CMS) and members covered by the Affordable Care Act. This includes staff in all billing, reception, lab and clinical areas.

General compliance training is required for all persons who meet the criteria above, but certain individuals and entities who participate in the Medicare program are deemed to have met the **fraud, waste and abuse training** component by virtue of satisfying Medicare's annual certification requirements. This includes entities and/or individuals who are:

- Participating healthcare providers in the federal Medicare program (Parts A and/or B).
- Accredited, Medicare-approved suppliers of durable medical equipment, prosthetics, orthotics and supplies.

When should training be completed?
The general compliance training and/or fraud, waste and abuse training must occur within 90 days of initial hiring and annually thereafter. The annual training may be completed at any time during a traditional calendar year. Training must be documented, and all documentation is subject to random audit by Arkansas Blue Cross or the federal government.

Methods for completing training
There are three options for satisfying these annual compliance training requirements:

1. **Web-delivered training** – Complete the web-based general compliance and/or fraud, waste and abuse training modules for Medicare (Parts C and D) located on the CMS Medicare Learning Network® (MLN), which are available through the Learning Management and Product Ordering System: https://learner.mlnlms.com/Default.aspx.
   Each individual must create an account. If you are not a current user, select **New user** to create an account.
   - In the Association section, if you do not see an organization with which you are associated or do not want to enter the information, select **None**.
   - When you get to the **Organization** section, choose **Select**, then **Search** and then click the C**MS-MLN Learners Domain Organization** radio button and select **Save**.
   - Select **Create** once all required fields are complete.

   Once you have logged in, proceed with the following steps:
   a) From the home page, in **Browse Catalog**, type in **Medicare Parts C and D General Compliance Training**. If needed, look for **Combating Medicare Part C and D Fraud, Waste, and Abuse (January 2018) (Contact hours: 30 min)**.
   b) Select the title of the training you need to complete and then select **Enroll**.

(Continued on page 7)

c) The enroll screen will default to **Credit** (if continuing education units are needed) or **Normal** course mode; Choose the desired mode and select **Enroll**.

d) Select **Open Item** to begin course or return to the training catalog to select another course by repeating the steps a) through e).

e) To return to the courses after enrolling, choose **Current Training**, select the title of the course you are completing, then select **Open Item** to begin the course.

Once the training is complete **with a score of 70 percent or higher** (with contact hours); the system will generate a certificate of completion at the end of each web-based training event. For CMS Medicare Learning Network® specific instructions and course help: https://www.cms.gov/Outreach-and-_Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LMPOS-FAQs-Booklet-ICN909182.pdf

2. **Download a PDF version to share** – Incorporate the content of the web-delivered standardized training modules from the CMS website into existing compliance training materials/systems. A PDF version is provided on the website. The PDF document is not intended to take the place of the web-based training, and no certificate is provided with the PDF download, which is available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

3. **Integrate content into other training materials** – Incorporate the content of the training modules from the CMS website into written/printed documents for providers (e.g. provider guides, participation manuals, business associate agreements, etc.). Although training content cannot be modified, CMS will allow modification to the appearance of the content (font, color, background, format, etc.). Additionally, organizations may enhance or "wrap around" the CMS training content by adding topics specific to the organization or employees' job functions. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

(**PLEASE NOTE:** *Should your organization provide the federally required trainings, a copy of all training documents – including a copy of the training materials and training logs – must be retained by your organization for 10 years, in accordance with the governing agencies' record-retention guidelines.)*

What do we do with our training records?
Whichever method you choose to complete from the options above, **no documentation should be returned** to Arkansas Blue Cross. So, as noted above, simply retain copies (paper and/or electronic) of all documentation of federally required annual trainings for at least 10 years.

How do I show that I have completed the required training?
Arkansas Blue Cross has developed an online attestation, administered through the Advanced Health Information Network (AHIN). The AHIN user administrator (AUA)

(Continued on page 8)

Federally required annual compliance training notice (Continued from page 7)

for each entity will use this reporting system to attest that all required training has been completed.

The attestation should be recorded **only after all affected staff members** have completed the applicable required trainings. Until the attestation is completed, an attestation alert will appear (beginning in June), and AHIN user administrators will be able to verify (through the end of the year) that their staff have completed required trainings. Once an organization has completed the attestation, the alert will stop.

For more information, general compliance training and Medicare Parts C and D fraud, waste and abuse training requirements can be found at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/CompliceProgramPolicyandGuidance.html.

Please direct additional questions to regulatorycompliance@arkbluecross.com.

2017 plan year HHS ACA Risk Adjustment Data Validation (RADV)/Initial Validation Audit

The Centers for Medicare & Medicaid Services (CMS), requires all organizations participating in the Marketplace/Exchange to comply with the Affordable Care Act's Department of Health and Human Services (HHS) Commerical Risk Adjustment Data Validation (RADV) Initial Validation Audit (IVA) program by submitting complete and accurate ICD-10 diagnostic data to CMS for beneficiaries enrolled in an individual and/or small-group health plan.

To comply with program requirements, our partner CIOX Health/ArroHealth will be conducting the retrieval of randomly selected patient charts on our behalf. If you are contacted to assist in the chart-retrieval process, we appreciate your cooperation and prompt attention to fulfill these requests in a timely manner.

This process will begin in June and will relate to services provided during the 2017 calendar year. If you have any questions regarding any portion of this process, you may contact your regional Arkansas Blue Cross network development representative.

Thank you for your ongoing partnership to improve the health of your patients and our members in compliance with CMS-HHS guidelines/regulations.

Nine medical specialty medications to need prior approval beginning July 2018

As Arkansas Blue Cross and Blue Shield continues to prioritize responsible management of the dramatic costs and complexity associated with the administration of certain specialty medications, effective July 1, 2018, prior approval for health plan coverage will be required by Arkansas Blue Cross and its affiliate, Health Advantage, for the following specialty medications used in treating rare, complex conditions that may go through the medical benefit:

- Haegarda® (C1 Esterase, Inhib, Human) – Hereditary Angiodema
- Ruconest® (C1 Esterase, Inhib, Recombinant) – Hereditary Angiodema
- Berinert® (C1 Esterase, Inhib, Human) – Hereditary Angiodema
- Cinryze® (C1 Esterase, Inhib, Human) – Hereditary Angiodema
- Kalbitor® (Ecallantide) – Hereditary Angiodema
- Firazyr® (Icatabant) – Hereditary Angiodema
- Fasenra® (Benralizumab) – Eosinophilic Asthma
- Cinqair® (Reslizumab) – Eosinophilic Asthma
- Lutathera® (Lutetium Lu 177) – Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

Please note: some BlueAdvantage Administrators of Arkansas self-funded group health plans will also implement this prior approval process for the above-stated nine drugs. For all BlueAdvantage members, please call BlueAdvantage customer service at **501-378-3600** to determine whether the patient's specific health plan has adopted this prior approval process for the drugs identified.

By establishing a prior-approval process, members and providers will know whether the member qualifies for coverage of these drugs under clinical/medical criteria of their applicable health plan, based on the information furnished by the provider to us.

Please note: prior approval does not guarantee coverage or payment of benefits for these drugs, even when prior approval is given. Prior approval addresses only the specific coverage policy or clinical/medical criteria applicable to each drug, based on information providers furnish in the prior approval process. Prior approval does not address other terms, conditions or exclusions that may apply under the patient's health plan or policy, such as (by way of example only), whether premiums have been paid or contributed, or whether the patient is still an active employee on the date of service. Accordingly, if any other such health plan or policy conditions are not satisfied, coverage and payment for these drugs may still be denied, despite receipt of a prior approval of the clinical/medical criteria for coverage. In addition, if the facts furnished to us in the prior approval process are inaccurate, or circumstances change between the time of a prior approval and actual administration of the drug or receipt of the claim for benefits, coverage and payment could still be denied.

For more information on how to submit a request for prior approval of one of these

(Continued on page 10)

Nine medical specialty medications to need prior approval beginning July 2018 (Continued from page 9)

drugs, please call the appropriate Customer Service phone number on the back of the member ID card. ASE/PSE and Medicare (Medi-Pak® Advantage) 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 may 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**.

Habilitative care – modifiers 96 and 97

In January 2014, the Patient Protection and Affordable Care Act (PPACA) began requiring all health insurance issuers offering small-group health insurance coverage (up to 50 full-time employees) and individual health insurance coverage to include essential health benefits in products offered on and off the federally facilitated Health Insurance Marketplace.

Federal law now requires that individual and small-group products include the following 10 categories of essential health benefits:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care
- Mental health and substance use disorder services.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

Without a way to identify habilitative services and devices, Modifier SZ was created to help identify habilitative services.

Modifier SZ was deleted as of December 31, 2017. Modifier SZ was replaced with modifier 96, habilitative services:

- For dates of services on or after July 1, 2014 thru December 31, 2017, Modifier SZ should be used for Habilitative Care.
- For dates of services on or after January 1, 2018, Modifier 96 should be used for Habilitative services.
- For dates of services on or after January 1, 2018, Modifier 97 should be used for Rehabilitative services.

What are habilitative services?
Arkansas' definition of habilitative services: Services provided in order for a person to attain and maintain a skill or function that never was learned or acquired, due to a disabling condition.

Coverage of habilitative services:
Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder and developmental coordination disorder.

CPT code modifiers impacting pricing

- Modifier 52: Reduced Services - 67 percent of allowable charges based on documentation.
- Modifier 53: Discontinued Procedure - 32 percent of allowable charges.
- Modifier 62: Co-Surgery - 62.5 percent of allowable charge.
- Modifier 63: Infant Procedure - 120 percent of allowable charge.
- Modifier 73: Discontinued Procedure - 50 percent of allowable charge (limited to facility billings).
- Modifier 78: OR Return - 70 percent of allowable charge.
- Modifier 80: Assistant Surgeon - 20 percent of allowable charge.
- Modifier 81: - 10 percent of allowable charge.
- Modifier 82: - 20 percent of allowable charge.
- Modifier AS: 20 percent of allowable charge (limited to specialties 50 and 89; in combination with specialty discount of 75 percent, results in payment of 15 percent of allowable).

Arkansas Blue Cross and its family of companies **do not recognize modifiers 54, 55 or 56**. Providers should bill E&M codes for these services rather than billing the surgery code with these modifiers.

CPT code changes

Effective June 1, 2018, Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries no longer reimburse for CPT code 83993 (fecal calprotectin testing). Please refer to Coverage Policy No. 2018003 [Copanlisib (Aliqopa)] for details. A complete copy of the medical coverage policy is accessible by selecting **Coverage Policy** at http://www.arkansasbluecross.com/members/.

Also effective June 1, 2018, CPT code 87633 will be considered a noncovered service, per Coverage Policy No. 2016004 [Lab Test: Identification of Microorganisms Using Nucleic Acid Probes]. The code descriptor for CPT code 87633 [infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus)], includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets.

CPT codes 87631 (3-5 targets) and 87632 (6-11 targets) also are addressed in Coverage Policy No. 2016004 and will remain covered tests.

Referring provider requirement on all claims with laboratory services

As of April 1, 2018, all laboratory service claims for Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators members must identify the referring provider. Any submitted outpatient claim (from physicians, nurse practitioners, independent labs, etc.) that includes a laboratory service must contain the referring provider name and National Provider Identifier (NPI).

The referring provider identified on the claim must 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.

Arkansas Blue Cross is required to submit risk-adjustment data to state and federal agencies. Many claims for lab work pertaining to risk-adjustable conditions are submitted without the referring provider being identified. Listing the referring provider on the laboratory claim allows us to contact that provider for additional information that may be necessary for our data submission for government-affiliated business.

Recredentialing packets on AHIN and provider data letters

Arkansas Blue Cross and Blue Shield and its affiliates, Health Advantage and USAble Corporation,strive to streamline processes for providers who participate in their separate provider networks. AHIN offers the gateway and will begin including access to recredentialing packets July 2018. Once you log into AHIN and a Re-credentialing application is displayed for one of your providers, you will have to complete the required forms before you can access any other options in AHIN. If you are required to submit proof of insurance, you will be able to upload your document through AHIN (this must be a PDF). For providers with no access to AHIN, the packets will be faxed to providers 90 days prior to the provider's due date for recredentialing. If the fax fails to transmit, the packet will be mailed to providers.

In addition, AHIN will begin including provider profiles that will enable providers to change their information. Federal and state agencies are placing high demands of the reliability of provider directory information and are mandating frequent review and approval from the provider community. Adding AHIN accessibility to provider data profiles will allow providers to review data and submit changes efficiently.

HEDIS® measure: colorectal cancer screening

Some Arkansas Blue Cross and Blue Shield-administered health plans such as Medi-Pak® Advantage, Health Insurance Exchange Marketplace and the Federal Employee Plan are required to report annually (as part of our HEDIS data) the percentage of our members who undergo or who have undergone colorectal cancer screenings. The following is a summary of this particular HEDIS measure.

Measure description:
The Colorectal Cancer Screening measure examines the percentage of adults ages 50 to 75 who undergo an appropriate screening for colorectal cancer. It excludes patients who have a history of colorectal cancer or a total colectomy as well as those who are in hospice care.

Important reminders:

- Begin colorectal screening at age 50 and monitor screening in accordance with screening guidelines. For high-risk patients, begin screenings sooner.
- Check with patients to ensure they complete testing.
- Once a patient is screened for colorectal cancer, submit a claim and document the name of the test, the date it was performed and the ultimate results in the patient's medical record.

How to "close the gap":
The following preventive screenings meet HEDIS specifications for an appropriate screening for colorectal cancer:

Procedure	HEDIS Specification	Notes
Screening colonoscopy	Every 10 years	When an abnormality is discovered during a colonoscopy screening, it becomes a diagnostic colonoscopy and the member may incur cost-sharing.
Screening flexible sigmoidoscopy	Every 5 years	
Screening CT colonography	Every 5 years	While it meets HEDIS screening requirements, Medicare doesn't reimburse for it as of April 1, 2017.
FIT DNA (i.e. Cologuard®)	Every 3 years	Visit https://www.cologuardtest.com/hcp/ordering-cologuard/how-to-order-the-test to order Cologuard by fax or online.
Fecal occult blood test (FIT, iFIT, guaiac)	Every year	Performing fecal occult testing on a sample collected from a rectal exam does not meet screening criteria by the American Cancer Society or HEDIS.

Medication adherence star measures

Some Arkansas Blue Cross and Blue Shield-administered health plans such as Medi-Pak® Advantage and the Health Insurance Exchange Marketplace are required to report annually as part of our HEDIS data the percentage of our members who are adherent to their medication. The following is a summary of this particular HEDIS measure and a few tips for addressing nonadherence with your patients.

"Drugs don't work in patients who don't take them." — C. **Everett Koop, M.D., former Surgeon General**

Medication adherence is critical to patient quality outcomes. The Centers for Medicare & Medicaid Services stressed the importance of medication adherence by including three triple-weighted clinical pharmacy measures in the Star rating program for Medicare Advantage health plans. CMS also requires reporting these measures in the Health Insurance Marketplace plans.

The three medication adherence measures cover medications for diabetes, hypertension [angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs)] and cholesterol (statins). Member compliance for these three measures is based on the percentage of plan members who fill their diabetic, hypertension or cholesterol prescriptions often enough to cover 80 percent or more of the period during which they are supposed to be taking the medication.

Why are patients nonadherent and what can you do?
Here are common reasons why patients do not take their medication as prescribed and ways to help you encourage compliance:

Reason for nonadherence	Compliance strategy:
The patient forgets to refill the prescription on time.	Consider writing 90-day supplies of maintenance medications. A study published in The American Journal of Managed Care showed that patients on 90-day supplies were more adherent than patients on 30-day supplies.
A patient thinks the medication costs too much.	If cost is a concern, especially with a brand-name medication, consider switching the patient to a lower-cost generic medication, if possible. If there is another brand-name medication in the same class, one brand may be preferred over the other by the patient's health plan and have a lower co-pay. It is not recommended for physicians to prescribe a double dose to financially disadvantaged patients and telling them to cut the medication in half. This could result in mismatched printed and verbal directions, which could lead to patient or caregiver confusion.

(Continued on page 15)

Reason for nonadherence	Compliance strategy:
A patient is not convinced that the medication is important, or the patient thinks taking the medication would be harmful.	While any drug carries possible risk, stress the potential negative consequences for the patient if he or she does not take the medication. The benefits of the medication should outweigh the risk. Remind the patient to let you know immediately if he or she experiences side effects. The patient should not stop or change the regimen on his or her own because there are ways to manage side effects. Some examples: • Lowering a dose. • Taking medications with food or water. • Taking medications at bedtime instead of during the day. • Changing from an immediate-release to an extended-release version. • Changing to a different medication within the same class.
It's difficult for a patient to remember to take the medication when he or she should.	Offer the following suggestions: • Using weekly or monthly pillboxes. • Setting cell-phone reminder alarms. • Making use of medication adherence smartphone apps. • Placing medications in a highly visible area (but in properly closed containers and safely out of reach of children or pets).
A patient is unable to get to the pharmacy because of unreliable transportation.	Inform the patient that many pharmacies offer delivery services. Mail-order pharmacy is an option as well.

As a physician, you can have a huge impact on medication adherence. Your insight can help identify reasons as to why patients struggle with medication adherence, and your expertise can help guide them to healthier outcomes.

HEDIS®-related claim edit requirements for 2018

As healthcare continues to move toward value-based care, with an ever-increasing emphasis on quality metrics, health plans are being asked more often to report on metrics regarding the quality of care provided.

Arkansas Blue Cross and Blue Shield is required by our regulators to report HEDIS® quality data for many of the plans we offer, including Arkansas Works, Medi-Pak® Advantage and the Federal Employee Program.

We have two primary options in collecting the necessary HEDIS data:

- Through data submitted on your claims information
- Through data captured in your medical record that is retrieved, reviewed and abstracted.

In an effort to minimize the medical record review burden on all sides and more efficiently capture the required data elements, Arkansas Blue Cross will be implementing the following edits through the claims system effective June 28, 2018:

- BMI Codes will be required when an annual wellness exam is submitted and the place of service is office (11).
- Hemoglobin A1c results needed for A1c testing. The HbA1c test results will be required when HbA1c testing is submitted and the place of service is office (11) or home (12).
- Retinopathy screening in primary care physician's (PCP's) office - CPT code 92250 must be accompanied by 2022F (which indicates that the photographs were interpreted by a specialist) when the provider specialty on the claim is not 41 (optometry) or 18 (ophthalmology). **Please note:** the edits are on the provider specialty type and not the service location.

Initial notification and information concerning the appropriate CPT and diagnosis codes associated with these edits were provided in the March 2018 issue of *Providers' News* (pages 22, 31-33).

HEDIS® measure: plan all-cause readmissions

Some Arkansas Blue Cross and Blue Shield administered health plans such as Medi-Pak® Advantage, our federally facilitated Health Insurance Marketplace plans and the Federal Employee Program are required to report annually (as part of our HEDIS data) the percentage of our members who are readmitted to a hospital after they are discharged. The following is a summary of this particular HEDIS measure and a few tips for preventing unnecessary hospital readmissions.

The HEDIS® Plan All-Cause Readmissions measure assesses the number of acute inpatient admissions that were followed by an unplanned acute readmission for any diagnosis within 30 days. Planned readmissions (e.g., maintenance chemotherapy, a planned procedure, rehabilitation) are not included as a readmission.

(Continued on page 17)

The commercial measure applies to patients ages 18 – 64. The star measure applies to Medicare patients ages 18 and older.

Help patients prevent unnecessary hospital readmissions

Coordinating care from the hospital to home and ensuring a follow-up visit with the primary care physician can help your patients avoid a readmission.

<table>
<tr><td>For hospitals</td><td>• Schedule the patient's post discharge follow-up visit.
• If unable to schedule the patient's post discharge follow-up appointment, make sure the patient's discharge instructions provide information needed to schedule their appointment, such as when the appointment should occur.
• Provide discharge medications from the hospital pharmacy.
• Ensure patient's discharge instructions and any outstanding test results are sent to the primary care physician or the follow-up physician(s).</td></tr>
<tr><td>For providers</td><td>• Build flexibility into appointment systems, so patients who were discharged from the hospital may be seen within seven days of their discharge.
• Utilize electronic admission, discharge and transfer data.
• If patients have not scheduled a post-discharge follow-up appointment, reach out to the patient and schedule an appointment.
<table>
<tr><td>Before the follow-up appointment</td><td>• Obtain and review the patient's hospital discharge summary from the hospital
• Obtain any test results that weren't available when the patient was discharged</td></tr>
<tr><td>During the follow-up appointment</td><td>• Discuss with the patient/caregiver:
o His or her diagnosis.
o Why he or she was admitted.
o When he or she should call you (during or after office hours) or go to the emergency room (e.g., "If you experience these symptoms...").
• Conditions and/or events (e.g., medication adherence) that contributed to the patient's hospitalization
• Discuss the plan of care with the patient or caregiver
• Ask the patient if he or she has:
o Completed or scheduled prescribed outpatient work-ups or other services such as physical therapy and home health care visits.
o Obtained durable medical equipment.
• Conduct Medication Reconciliation Post Discharge, which is also a star measure, within 30 days of a hospital discharge.
• Document medication reconciliation in the patient's medical record and submit a claim with CPT® Category II code 1111F (Discharge medications reconciled with the current medication list in the outpatient medical record).</td></tr>
</table></td></tr>
</table>

Aim for the "drop zone": managing your patient's high blood pressure

Some Arkansas Blue Cross and Blue Shield administered health plans such as Medi-Pak® Advantage and the Health Insurance Exchange Marketplace are required to report annually as part of our HEDIS data the percentage of our members whose blood pressure is adequately controlled. The following is a summary of this particular HEDIS measure and a few tips for addressing high blood pressure with your patients.

High blood pressure contributes to more than 1,000 deaths a day. Let's work together to help patients get their blood pressure – and their health – under control. Use these tips when working with patients who have high blood pressure:

Accurate blood pressure readings are key: Patients can have inaccurate blood pressure readings for various reasons.

- **Cuff size**: too small of a cuff will give a false high reading whereas a cuff size too large will provide a false low reading.
- **Good posture**: ensure patients have their feet flat on the floor and don't cross their legs during the reading.
- **Arm position**: make sure the elbow is at the same level as the heart (otherwise the blood pressure can be 17 points higher).
- **Repeat readings**: consider taking multiple readings during the same visit when uncontrolled readings are recorded.
- **Documentation**: Don't round up manual readings:
  - o If multiple blood pressure readings are taken within the same visit, the lowest systolic and diastolic readings can be used to make up the representative blood pressure reading.
  - o Documenting the exact reading in the patient's medical record with each visit is recommended.

Patient Education: Discuss with the patient:

- Eating healthy and lowering sodium intake.
- The benefits of exercise.
- Limiting alcohol intake.
- Losing weight.
- Taking blood pressure medication as prescribed and directed.
- Monitoring blood pressure at home and thresholds that require medical attention.

Treatment Recommendations

- Refer the patient to a cardiologist for further evaluation, if necessary.
- If hypertension is resistant to treatment, assess for sleep apnea.
- If lifestyle changes alone aren't effective, evaluate current medication therapy and consider initiating pharmacologic, anti-hypertensive treatment for patients, including an ACE or ARB.

Although the American Heart Association (AHA) and the American College of Cardiology (ACC) have recently updated their blood pressure guidelines, the 2017 HEDIS Controlling High Blood Pressure criteria for blood pressure control are:

- <140/90 (139/89 or less) for patients ages 18-59.
- <140/90 (139/89 or less) for patients ages 60-85 with diabetes.
- <150/90 (149/89 or less) for patients ages 60-85 without diabetes.

Visit arkansasbluecross.com/providers for additional resources.
Statistic source: Centers for Disease Control and Prevention

New Medicare beneficiary identification number

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 is requiring the federal Centers for Medicare & Medicaid Services (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 give Medicare beneficiaries a safer form of easy-to-use identification that reduces the risk of identity theft.

CMS began mailing new, redesigned Medicare ID cards to beneficiaries in phases by geographic regions beginning on April 1, 2018, and will complete the mailings 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' claims system has been equipped to accept the new MBI number or the historical SSN-based HICN since April 1, 2018. Starting January 1, 2020, the new card will be the only one that is valid.

Resources:

- Consolidated Omnibus Budget Reconciliation Act of 1985 (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.

PLEASE NOTE

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies.

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PROVIDERS' NEWS STAFF

Providers' News is published quarterly for providers and their office staffs by Arkansas Blue Cross and Blue Shield
Editor: Suzette Weast • 501-378-2002 • FAX 501-378-2464 • ProvidersNews@arkbluecross.com

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 2181
Little Rock, AR 72203