September 2022

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Published for providers and their office staffs by Arkansas Blue Cross and Blue Shield

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PROVIDERS' NEWS

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Arkansas Blue Cross and Blue Shield

2022 Open Enrollment – Please use Availity

The 2022 Open Enrollment period begins October 1 and will continue through January 15, 2023. The enrollment of many new members and renewal of current members produces extremely high call volumes, which are expected to remain elevated through January 31, 2023.

Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the website for the following:

- **Availity** – Use for information regarding eligibility, benefits, and claims status. Availity displays information on benefits to assist providers when scheduling appointments, checking eligibility, and identifying benefits.
- **AHIN** – If you need to request a prior authorization for medical inpatient and outpatient services, please continue to use AHIN.
- **AIM portal** – If you need to request a prior authorization for imaging and high-tech radiology, please continue to use the AIM portal.

Please be aware that call volume can spike and exceed our ability to answer every call. Availity uses the same information available to our customer service representatives and can save you valuable time. **Effective immediately, we encourage providers to use the appropriate provider portal to request prior authorization. This will help reduce call volume and result in quicker service to members.**

Annual compliance training

The federal annual compliance training through the Centers for Medicare and Medicaid has changed. The Medicare Part C and D compliance training is no longer required, but a training link is available for providers to view on the Availity payer space. Providers are not required to attest. Contact Regulatory Compliance at regulatorycompliance@arkbluecross.com with any questions.

Air ambulance policy

Notice of Material Amendment

Description:

Air ambulance transport services utilizing specially designed and equipped airplanes or helicopters are important in providing rapid medical care and transport of ill or injured patients. These air medical services may be involved in a primary response—transporting a patient from an original scene to the nearest facility capable

of providing the medical care required, or a secondary response—involving an interfacility transport due to the patient's need for continuing care or a higher level of care than is available at the original facility.

Air ambulance providers must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits.

The following coverage policy will go into effect October 1, 2022.

Effective January 1, 2023, prior authorization is required for all non-emergency air ambulance transport services.

As per Arkansas Code § 23-99-1107, no prior authorization for transport services shall be required when the requested transportation is in response to the presence of a medical emergency. Licenses must be compliant with all the local, state and federal laws and regulations.

Policy/Coverage:

For some contracts, this service is a contract specific benefit. Additional restrictions may apply to members with contracts with limitations or exclusions for air medical transport.

A) Emergency air ambulance transport from site of accident, injury or illness may meet primary coverage criteria when the patient is in critical condition and/or has unstable vital signs, respiratory status, or cardiac status, including but not limited to **ONE** of the following conditions:

- Intracranial bleeding requiring emergent intervention;
- Cardiogenic shock;
- Acute myocardial infarction requiring emergent intervention;
- Burns requiring immediate treatment in a Burn Center;
- Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries;
- Life-or limb threatening trauma;
- Transplants;
- High-risk pregnancy (high risk of preterm delivery or high medical risk to the mother or fetus);
- Life-threatening pregnancy condition (e.g., eclampsia, placental abruption, hemorrhage);
- Life or limb threatening hemorrhage or vascular occlusion/dissection;
- Resuscitation from cardiopulmonary arrest;
- Poisoning or overdose with respiratory crisis;
- Respiratory crisis (e.g., status asthmaticus, respiratory arrest, acute airway obstruction, etc.);
- Cardiac arrhythmia (heart block, ventricular tachycardia/fibrillation, SVT) with decompensation (hypotension, angina, CNS changes, etc.);
- Shock/hypotension life-threatening **AND ONE** of the following:
  - The point of pick-up is inaccessible by land vehicle, or ground ambulance transport is precluded due to adverse weather, terrain and/or road conditions (e.g., flooding, ice, or snow) **OR**
  - Transportation by ground ambulance poses a threat to the patient's survival or seriously endangers the patient's health due to the time or distance.

B) **Emergency** air ambulance transport services from a **Health Care Facility/Hospital Emergency Department**

or Inpatient Setting may **meet primary coverage criteria** when **ALL** the following criteria are met:

- The patient is in critical condition, has unstable vital signs, unstable respiratory or cardiac status, including *but not limited* to ONE of the following conditions:
  - Intracranial bleeding requiring emergent intervention;
  - Cardiogenic shock;
  - Acute myocardial infarction requiring emergent intervention;
  - Burns requiring immediate treatment in a Burn Center;
  - Conditions requiring immediate treatment in a Hyperbaric Oxygen Unit;
  - Multiple severe injuries;
  - Life-threatening trauma;
  - Transplants;
- High-risk pregnancy (high risk of preterm delivery or high medical risk to the mother or fetus); **AND**
  - The patient requires acute medical or surgical intervention(s) that the transferring facility cannot provide; **AND**
  - The patient is being transferred to the nearest equivalent or higher level of acuity inpatient facility unless the nearest appropriate hospital is on divert, has no available beds or accepting physician, or the air ambulance cannot land; **AND**
  - Transportation by ground ambulance poses a threat to the patient's survival or seriously endangers the patient's health due to the time, or distance.

Any situations not meeting the criteria for emergency air ambulance transport from site of accident or from Health Care Facility/Hospital Emergency Department or Inpatient Setting are considered non-emergency situations and require prior authorization.

C) Emergency air ambulance meets primary coverage policy criteria for a **deceased individual** when **either**:

- the member was pronounced dead while in route to facility **OR**
- the member was pronounced dead after the ambulance was dispatched but prior to arrival at scene.

Emergency air ambulance services do not meet primary coverage criteria for transfer of a deceased individual to funeral home, morgue, or hospital when pronounced dead at the scene prior to dispatch of the air ambulance.

D) **Non-emergency** air ambulance medical transportation from a Health Care Facility/Hospital Emergency Department or Inpatient Setting to an equivalent or higher level of acuity facility may **meet primary coverage criteria** when **ALL** the following criteria are met:

- The patient requires acute inpatient care; **AND**
- The patient requires services that are unavailable at the originating facility; **AND**
- The receiving hospital is the nearest one with the required capabilities; **AND**
- The patient cannot be safely discharged from inpatient setting; **AND**
- The patient cannot be safely transported using commercial air transport; **AND**
- Ground ambulance transport is precluded due to adverse weather, terrain and/or road conditions (e.g., flooding, ice, or snow).

E) **Non-emergency following stabilization.** Air ambulance medical transportation from a Health Care Facility/ Hospital Emergency Department or Inpatient Setting to an equivalent or higher level of acuity facility may meet primary coverage criteria when **ALL** the following criteria are met:

- The patient has arrived at the Health Care Facility/Hospital Emergency Department or Inpatient Setting by emergent transport; **AND**
- The patient has received sufficient care to become stabilized; **AND**
- The stabilized patient cannot safely travel to the receiving Health Care Facility/Hospital Emergency Department or Inpatient Setting by any other means.

F) **Non-emergency** air ambulance medical transportation **provided primarily for the convenience of the patient, the patient's family/caregivers or physician, or the transferring facility**, including situations where long distances exist between the transferring and receiving facilities, **are considered not meeting primary coverage criteria. PLEASE NOTE that not all self-insured employer Plans will cover non-emergency transportation. Please review your Plan document as other restrictions may apply. Providers are encouraged to use Availity for benefit verification.**

G) Air ambulance transport for patients seeking hospice care closer to home and for any unusual or uncommon circumstances involving frequent or recurrent air transport must be reviewed for appropriateness by the prior authorization services Medical Director.

Prior authorized air ambulance request may be submitted and reviewed for additional circumstances not detailed above. An authorized Medical Director may approve services based on the individual's needs to manage the overall care of the member, including but not limited to:

- Support continuity of care - where previous treatment involving the current or related condition occurred in a facility that is further away than the closest capable facility, and transport via ground ambulance or commercial means is not an option and will not be an option for at least two weeks
- When there is documentation or Attending Physician attestation that the transported patient requires a specialized service that cannot be provided by a closer facility.
- The patient will likely require either acute care or rehabilitation for over 3 months and appropriate care is available closer to support system
- Patient is being returned to original hospital after initial transport for specialized care and continued inpatient hospitalization is likely to be required for at least an additional two weeks

Ground ambulance policy

Notice of Material Amendment

Description:

Ambulance services typically involve the assessment and administration of care to an ill or injured patient by specially trained personnel and the transportation of the patient in a specially designed and equipped ground vehicle within an appropriate, safe, and monitored environment. This policy provides medical guidelines that are appropriate for most individuals who need ambulance and medical transport services in both emergency and nonemergency situations. Unique clinical circumstances may justify individual consideration for coverage, based on a review of applicable medical records.

Ambulance services must have the necessary permits and licenses in compliance with all the local, state, and

federal laws and regulations.

Policy/Coverage:

For some contracts, this service is a contract specific benefit. Additional restrictions may apply to members with contracts with limitations or exclusions for air medical transport.

A) Emergency **ground** ambulance transport services **may meet coverage criteria** when **ALL** the following criteria are met:

- The medical transport services must comply with all local, state, and federal laws and must have all the appropriate, valid licenses and permits; **AND**
- The ambulance or other medical transport services must have the necessary patient care equipment and supplies; **AND**
- The patient's condition must be such that any other form of transportation would be medically contraindicated; **AND**
- Any of the following circumstances exists:
  - Transportation from the scene of a life-threatening accident or site of emergency to the **nearest** hospital with appropriate facilities for treatment of an individual's illness or injury is required; or
  - Transportation to or from one hospital or medical facility to another hospital or medical facility, in order to obtain **emergent** medically needed diagnostic or medical therapeutic services is required provided such services are unavailable at the facility where the individual initially resides. The patient must be transported to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury or, in the case of organ transplantation, to the approved transplant facility, unless the nearest appropriate hospital is on divert or has no available beds or accepting physician. **OR**
  - Transportation of an individual who has received care at a specific prior institution for a condition not normally managed at the originating facility (for example, organ transplant recipient) and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.

Emergency ambulance services do not meet primary coverage criteria for transfer of a deceased individual to funeral home, morgue, or hospital when pronounced dead at the scene prior to dispatch of ground ambulance.

As per Arkansas Code § 23-99-1107, no prior authorization for transport services shall be required when the requested transportation is in response to the presence of a medical emergency. Any situations not meeting the criteria for emergency ground ambulance transport from scene/site of accident or from hospital/medical facility are considered non-emergency situations and require prior authorization.

B) **Non-emergency** ground ambulance medical transportation from one acute care hospital to another acute care hospital for diagnostic or therapeutic services (e.g., MRI, CT scan, acute interventional cardiology, intensive care unit services, etc.) **may meet primary coverage criteria** when ALL the following criteria are met:

- The patient is a registered inpatient; **AND**
- The services are medically necessary for the immediate care of the patient; **AND**
- The services are unavailable at the originating facility; **AND**
- The receiving hospital is the nearest one with the required capabilities

C) **Non-emergency** ground ambulance medical transportation services provided primarily for the convenience of the patient, the patient's family/caregivers or physician, or the transferring facility **are**

considered as not meeting coverage criteria. PLEASE NOTE that not all self insured employer Plans will cover non-emergency transportation. Please review your Plan document as other restrictions may apply. Providers are encouraged to use Availity for benefit verification.

Benefit certificate updates

When the new Benefit Certificates come out for Jan. 1, 2023, you will notice some changes to the prior approval (PA) requirements. Medicare Advantage PA changes will be effective for dates of service starting Jan. 1, 2023. All other lines of business PA changes will not be effective until dates of service starting April 1, 2023.

Coverage policy manual updates

Since June 2021, Arkansas Blue Cross has added or updated several policies in its Coverage Policy manual. The table below highlights these additions and updates. If you want to view the entire policies, you can access the coverage policies located on our website at **arkansasbluecross.com**.

Policy ID	Policy Name
1997113	Immune Globulin, Intravenous and Subcutaneous
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1998031	Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Conditions
1998039	Temporomandibular Joint Dysfunction
1998039	Temporomandibular Joint Dysfunction
1998051	Genetic Test: BRCA1 or BRCA2 Mutations
1998109	Chimeric Antigen Receptor Therapy for Hematologic Malignancies (CAR-T) (e.g., Kymriah™, Yescarta™, Tecartus™, Breyanzi®, Abecma®, Carvykti™)
2001035	PET or PET/CT for Prostate Cancer
2002005	Biventricular Pacemakers for the Treatment of Congestive Heart Failure
2002029	Implantable Bone Conduction Hearing Aids
2003015	Intensity Modulated Radiation Therapy (IMRT)
2003018	Genetic Test: Fecal DNA to Detect Colorectal Cancer, Screening
2004053	Circulating Tumor Cells in the Management of Patients with Cancer, Detection of
2005003	Genetic Test: Cytochrome p450 Genotype Guided Treatment Strategy
2006030	Balloon Ostial Dilation (Balloon Sinuplasty)
2006039	Artificial Vertebral Disc, Cervical Spine
2007024	Genetic Test: HER2 Testing
2009001	Radiation Therapy, Real Time Intra-Fraction Target Tracking
2010016	Electrical Stimulation, Occipital and Transcutaneous Peripheral Nerve Stimulation for Treatment of Headaches
2010038	Pneumatic Compression Devices and Non-Elastic Compression Garments for Treatment of Lymphedema, Burns, and Venous Ulcers
2010046	Intravitreal, Punctum Corticosteroid Implants and Ranibizumab (e.g., Susvimo)
2011008	Left Atrial Appendage, Closure Device, Percutaneous
2011019	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: BREASTFEEDING COUNSELING

Policy ID	Policy Name
2011026	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: TYPE 2 DIABETES MELLITUS SCREENING FOR ADULTS
2011045	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: COLORECTAL CANCER SCREENING
2011061	Genetic Test: Melanoma and Glioma, Testing to Predict Response to Targeted Therapy
2011066	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: OVERVIEW
2012026	PET Scan for Alzheimer's Disease, Dementia, or Cognitive Impairment Using Beta Amyloid Imaging
2014021	Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis (e.g., SureSwab, NuSwab)
2015004	Genetic Test: Breast Cancer Risk Assessment (PALB2, CHEK2, ATM)
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Nivolumab) (Durvalumab) (Cemiplimab)
2016012	Daratumumab (e.g., Darzalex) / Daratumumab and Hyaluronidase-fihi (e.g., DARZALEX FASPRO)
2016013	C 5 Complement Inhibitors [(Eculizumab (e.g., Soliris®) and Ravulizumab-cwvz (e.g., Ultomiris™)]
2016014	Genetic Test: Use of Common Genetic Variants (Single Nucleotide Polymorphisms) to Predict Risk of Nonfamilial Breast Cancer
2017012	Nab-Paclitaxel (e.g., Abraxane™)
2017020	Pemetrexed (e.g., Alimta)
2018000	Leadless Cardiac Pacemakers
2018002	Chemodenervation, Botulinum Toxins
2019005	Pembrolizumab (e.g., KEYTRUDA®)
2020005	Self-Administered Medication
2020006	Luspatercept-aamt (e.g., Reblozyl)
2020007	Eptinezumab-jjmr (e.g., VYEPTI™)
2020029	Covid-19 Monoclonal Antibody Therapy
2021009	Romidepsin (e.g., ISTODAX)
2021024	White Blood Cell Growth Factors (Colony Stimulating Factors)
2021027	Evinacumab-dgnb (Evkeeza)
2021034	Rituximab (e.g., Rituxan) and Biosimilars – Non-Oncologic Indications
2022001	Efgartigimod (e.g., Vyvgart)
2022002	Plasminogen [e.g., Ryplazim]
2022003	Cabotegravir ER inj susp (e.g., Apretude)
2022005	Non-Invasive Positive Airway Pressure for Chronic Obstructive Pulmonary Disease
2022006	Remdesivir (e.g., Veklury)
2022013	Medical Technology Assessment, Non-Covered Services
2022014	Lutetium Lu 177 vipivotide tetraxetan (e.g., Pluvicto)
2022015	Tezepelumab-ekko (e.g., Tezspire)
2022016	Inclisiran (e.g., Leqvio)
2022019	Asparagine Specific Enzymes (e.g., Rylaze, Asparlas, Oncaspar)
2022020	Tumor-informed Circulating Tumor DNA Testing (e.g., Signatera) for Cancer Management
2022021	Uterus Transplantation for Absolute Uterine Factor Infertility
2022022	Sirolimus protein-bound particles for injectable suspension (e.g., FYARRO)
2022023	Tebentafusp-tebn (e.g., Kimmtrak)
2022024	Sutimlimab-jome (e.g., Enjaymo)

Policy ID	Policy Name
2022025	Tisotumab vedotin-tftv (e.g., Tivdak™)
2022026	Difelikefalin (e.g., Korsuva)
2022027	Pilot Policy: Percutaneous Arteriovenous Fistula (pAVF)
2022028	PPACA: Prevention Of Human Immunodeficiency Virus (HIV) Infection, Preexposure Prophylaxis
2022029	Bortezomib (e.g., Velcade)
2022030	Remote Electrical Neuromodulation for Migraines
2022031	Risankizumab (e.g., Skyrizi)

CMS requirement for provider certification on National Plan and Provider Enumeration System (NPPES)

The Centers for Medicare and Medicaid Services (CMS) will begin issuing reminders to all provider types to update and certify the accuracy of the National Provider Identifier (NPI) data and provider demographic information maintained on the **National Plan and Provider Enumeration System (NPPES)**. Providers are legally required to maintain the accuracy of this data to not only validate their demographic information, but to reduce the number of verification outreaches to providers by Arkansas Blue Cross and Blue Shield (ABCBS). CMS will continue to monitor and audit the ABCBS and Health Advantage provider directories to enforce action and compliance with the data maintain on the NPPES website. ABCBS will continue to issue quarterly provider demographic verification forms via Advanced Health Information Network (AHIN) or by mail to validate, correct, sign, date and return to ABCBS Provider Network Operations via providernetwork@arkansasbluecross.com.

The quarterly provider demographic update requests will be converted to Availity's Provider Data Management module in the 4th quarter of 2022.

Using NPPES as a centralized primary data resource will allow Arkansas Blue Cross and Blue Shield and Health Advantage to provide reliable information to our commercial and Medicare Advantage members. As of January 1, 2020, NPPES allows providers to log in and attest to the accuracy of the data. This attestation will be reflected and recorded with a certification date that CMS will publish. The core elements maintained on NPPES are:

- **Provider Name**
- **Provider Specialty**
- **Provider Address(es)** – Multiple addresses are allowed to list all active practice locations at which members can be seen.
- **Provider Telephone and Fax Number(s)**
- **National Provider Identifier ("NPI")**
- **Provider Status (Active or Inactive)**
- **Other Identifiers** – i.e., Medicare and Medicaid Ids
- **Taxonomy**

The NPPES website can be found at NPPES (hhs.gov). If you have any questions pertaining to NPPES, you may reference NPPES help at https://nppes.cms.hhs.gov/webhelp/nppeshelp/HOME%20PAGE-SIGN%20IN%20PAGE.html.

CMS References: 45 CFR §162.410(a); **Data Dissemination | CMS**

Finding hidden chronic kidney disease (CKD)

Earlier this year, Arkansas Blue Cross Blue Shield embarked on a pilot project with a company called Healthy.io. This company has created a home test to measure a spot urine albumin creatinine ratio where the patient dips a stick into a collected urine sample, then places the completed test strip into a cardboard "holster" surrounded printed colored dots. They take a cell phone photo of the result and submit. This process solves for variation in color interpretation by the camera and yields a result which correlates with the ACR. Urine ACR is considered superior to eGFR to determine the presence or absence of CKD. The normal urine albumin to creatinine ratio is less than 30 mg/g, moderately abnormal 30 to 299 and highly abnormal 300 or higher.

In the pilot, members were identified who had a diagnosis of diabetes mellitus, hypertension or both but no claim for CKD. They received a kit and 44% of the kits were completed. Of these, 35% tested in the moderately abnormal or highly abnormal range. At the time of testing, the kit did not have FDA approval for home use so was suggestive of, but not diagnostic for CKD. Since the time of the pilot, the kit has been approved by the FDA for home use.

This population health pilot has demonstrated that we can assist the provider community and members with identifying those who may have CKD but are unaware. Multiple intervention strategies are available to reduce the progression of early CKD to end stage disease, but you can't help someone until you know they might have a problem. We are developing communication tools to inform both members and their providers of these results.

Full Independent Practice for Certified Nurse Practitioners

Arkansas Act 412 of 2021 allows a pathway for certified nurse practitioners (CNPs) to apply for full independent practice after having practiced 6,240 hours under a collaborative practice agreement and uploading required documents as indicated by the Arkansas State Board of Nursing.

Applications shall be submitted through the Arkansas Nurse Portal. Once all required documents have been received, applications will be sent for review by the Full Independent Practice Credentialing Committee (FIPCC). The FIPCC will meet at least quarterly to review all applications.

Until a CNP has been issued an approval from the FIPCC and Arkansas Blue Cross **and** Blue Shield is able to primary source verify **full independent practice** on Nursys, our credentialing standards will still require a Collaborative Practice Agreement.

Health Advantage pricing changes

Notice of Material Amendment

Effective January 1, 2023, the withhold program in all commercial Health Advantage (HMO Partners, Inc, d/b/a Health Advantage) provider network agreements will cease. This applies to agreements with all medical

professionals, facilities, and organizations. Please note that not all counites have had a withhold program.

The withhold program had been placed on hold during the height of the public health emergency and was still on hold with a few exceptions. Effective on dates of services January 1, 2023 and after, the program will cease completely for commercial business.

In addition, on January 1, 2023, the Health Advantage reimbursement will change for some medical professionals. While most of the changes will be in the Central, Northwest and West Central regions there may be revisions in other areas of the state. Please refer to the Provider tab at arkansasbluecross.com if you are unsure about which region you are located.

EXHIBIT A PROVIDER AGREEMENT REVISIONS:

For all MDs/DOs, Chiropractors, DPMs and Psychologists, all E/M codes will be reimbursed at the lesser of Usual Charge or 100% of the ABCBS. Reimbursement for these professionals will not change for laboratory services, medication/ injections (e.g., J codes), or physical medicine and rehab services. All other services will be reimbursed at the lesser of Usual Charge or 90% of the Arkansas Blue Cross Blue Shield fee schedule.

High Deductible Health Plans and Health Savings Accounts

Notice of Material Amendment

As a reminder, high deductible health plans (HDHPs) that are health savings account (HSA) eligible are not allowed to have first dollar coverage for services that are not A or B recommended services under the United States Preventative Service Task Force. Act 939 of 2021 also codified that HDHPs are not required to cover with $0 cost sharing items that are not preventative services that could cause the HDHP to lose HSA eligibility. It has come to the Company's attention that some HDHPs may have experienced a change, brought about by the adoption of this act, that caused certain codes related to breast ultrasounds (Act 553) and colonoscopies (Act 779) to pay without cost sharing. Though this is likely to impact the member and does not change the provider contract, we are giving providers 90-day notice to direct any questions to the Company related to the upcoming corrections and to discuss what options could be pursued with their patients. You may direct your questions to your Arkansas Blue Cross Blue Shield Network Development Representative.

Injectable medication fee schedule

As previously published on July 14, 2022, Arkansas Blue Cross and Blue Shield and Health Advantage will be updating provider contracts effective October 11, 2022, to clarify that injectable drug rates are tied to CMS/ Medicare pricing and schedules. Arkansas Blue Cross and Health Advantage have utilized the CMS/Medicare pricing and quarterly time schedule for injectable drugs for years. However, it has never been acknowledged within the contract itself despite the observable tie to the CMS/Medicare Quarterly publication. This is a clarification that Arkansas Blue Cross and Health Advantage do not believe meets the statutory definition of "material amendment." Regardless, the companies are using the notice terminology to ensure that you are aware of the upcoming clarification to the provider contract. Beginning October 11, 2022, all provider contracts will be clarified to state:

Arkansas Blue Cross and Blue Shield and Health Advantage will utilize the CMS/Medicare pricing and quarterly

time schedule for all injectable drugs. The rate for all injectable drugs following CMS quarterly publication of rates will be effective at the beginning of each quarter in concert with CMS and will not exceed 120% of the CMS published rates.

This clarification to the provider contract will become effective on October 11, 2022.

Medical specialty medications prior approval update

On April 1, 2018, Arkansas Blue Cross and Blue Shield and its family of companies enacted prior approval for payment of specialty medications used in treating rare, complex conditions that may go through the medical benefit. Since then, medications have been added to the initial list as products come to market.

The table below is the current list of medications that require prior approval through the member's medical benefit. It is also indicated when a medication is required to be processed through the pharmacy benefit. Any new medication used to treat a rare disease should be considered to require prior approval. **ASE/PSE, and Medicare are not included in this article but have their own prior approval programs.**

Drug	Benefit
Abecma (idecabtagene vicleucel)	Medical
Actemra (tocilizumab)	Medical & Pharmacy
Adakveo (crizanlizumab-tcma)	Medical
Aldurazyme (laronidase)	Medical
Apretude (cabotegravir)	Medical
Arcalyst (rilonacept)	Medical
Asparlas (calaspargase pegol)	Medical
Avsola (infliximab-axxq)	Medical
Benlysta (belimumab)	Medical & Pharmacy
Berinert (c1 esterase, inhib, human)	Medical
Botox (onabotulinumtoxin a)	Medical & Pharmacy
Breyanzi (lisocabtagene maraleucel)	Medical
Brineura (cerliponase alfa)	Medical
Cabenuva (cabotegravir & rilpivirine)	Medical
Cablivi (caplacizumab-yhdp)	Medical & Pharmacy

Drug	Benefit
Carvykti (ciltacabtagene autoleucel)	Medical
Cinqair (reslizumab)	Medical
Cinryze (c1 Esterase, inhib, human)	Medical
Crysvita (burosumab – twza)	Medical & Pharmacy
Duopa (levodopa-carpidopa intestinal gel)	Medical
Durysta (bimatoprost)	Medical
Dysport (abobotulinumtoxin a)	Medical
Elaprase (idursulfase)	Medical
Elzonris (tagraxifusp-erzs)	Medical
Enjaymo (sutimlimab-jome)	Medical
Enspryng (satralizumab-mwge)	Medical & Pharmacy
Entyvio (vedolizumab)	Medical
Evenity (romosozumab-aqqg)	Medical
Evkeeza (evinacumab-dgnb)	Medical
Fabrazyme (agalsidase beta)	Medical
Fasenra (benralizumab)	Pharmacy
Firazyr (icatabant acetate)	Pharmacy
Fyarro (sirolimus protein-bound particles)	Medical
Gamifant (emapalumab-lzsg)	Medical
Givlaari (givosiran)	Medical
Haegarda (c1 esterase, inhib, human)	Pharmacy
Ilaris (canakinumab)	Medical & Pharmacy
Inflectra (infliximab-dyyb)	Medical
Invega Sustenna or Invega Trinza (paliperidone palmitate)	Medical & Pharmacy
Ixifi (infliximab-qbtx)	Medical

Drug	Benefit
Kalbitor (ecallantide)	Medical & Pharmacy
Kimmtrak (tebentafusp-tebn)	Medical
Krystexxa (pegloticase)	Medical
Kymriah (tisagenlecleucel)	Medical
Lemtrada (alemtuzumab)	Medical
Leqvio (inclisiran)	Medical
Lumizyme (alglucosidase alfa)	Medical
Lutathera (lutetium Lu 177 Dotatate)	Medical
Mepsevii (vestronidase-Alfa)	Medical
Myalept (metreleptin)	Pharmacy
Myobloc (rimabotulinumtoxin b)	Medical
Nagalzyme (galsulfase)	Medical
Nexviazyme (avalglucosidase alfa-ngpt)	Medical
Nucala (mepolizumab)	Pharmacy
Oncaspar (pegaspargase)	Medical
Orencia (abatacept)	Medical & Pharmacy
Oxlumo (lumasiran)	Medical
Pluvicto (Lutetium Lu 177 vipivotide tetraxetan)	Medical
Reblozyl (luspatercept)	Medical
Remicade and Unbranded Infliximab (infliximab)	Medical
Renflexis (infliximab-abda)	Medical
Rethymic (allogeneic processed thymus tissue–agdc)	Medical
Revatio (sildenafil)	Medical
Riabni (rituximab-arrx)	Medical
Rituxan (rituximab)	Medical

Drug	Benefit
Ruconest (c1 esterase, inhib, recombinant)	Medical
Rylaze (asparaginase erwinia chrysanthemi)	Medical
Ruxience (rituximab-pvvr)	Medical
Ryplazim (plasminogen)	Medical
Saphnelo (anifrolumab-fnia)	Medical
Simponi Aria (golimumab)	Medical
Skyrizi (risankizumab)	Medical & Pharmacy
Soliris (eculizumab)	Medical
Spinraza (nusinersen)	Medical
Spravato (esketamine)	Pharmacy
Stelara (ustekinumab)	Medical & Pharmacy
Strensiq (asfotase alfa)	Pharmacy
Susvimo (ranibizumab)	Medical
Takhzyro (lanadelumab)	Pharmacy
Tecartus (brexucabtagene autoleucel)	Medical
Tepezza (teprotumumab)	Medical
Testopel (testosterone pellet)	Medical
Tezspire (tezepelumab)	Medical
Tivdak (tisotumab vedotin-tftv)	Medical
Truxima (rituximab-abbs)	Medical
Tysabri (natalizumab)	Medical
Ultomiris (ravulizumab-cwyz)	Medical
Uplizna (inebilizumab)	Medical
Vimizim (elosulfase alfa)	Medical

Drug	Benefit
Vyepti (eptinezmab-jjmr)	Medical
Vyvgart (efgartigimod alfa-fcab)	Medical
Xeomin (incobotulinumtoxin a)	Medical
Xolair (omalizumab)	Pharmacy
Yescarta (axicabtagene ciloleucel)	Medical
Zolgensma (onasmnogene abeparvovec-XIOI)	Medical
Zulresso (brexanolone)	Medical

For more information on how to submit a request for prior approval of one of these medications, call the appropriate customer service phone number on the back of the member ID card.

Customer service will direct callers to the prior approval form specific to the member's group. BlueAdvantage members can find the form at the following link: https://www.blueadvantagearkansas.com/providers/forms.aspx.

Pharmacy Update

In recent months we have seen an increase in utilization of medications in the GLP-1 Agonist drug class, in particular Ozempic and Victoza. We have discovered that these medications, that are FDA approved only for treatment of diabetes, are being used for the treatment of weight loss. All of Arkansas BlueCross Summary of Plan Documents state that weight loss drugs are not covered **AND** that drugs being used for non-FDA approve use are not covered.

To address this, we have recently sent letters to all members that do not have medical claims for diabetes letting them know that, after October 1, these drugs will not be covered for them unless their provider sends in medical records indicating they do indeed have diabetes. The letter includes direction on how to notify AR BlueCross.

Removal of Dexilant and dexlansoprazole from formularies

Dexlansoprazole, the generic for Dexilant, a proton pump inhibitor (PPI), has recently been released to the market. Since there are many other generic PPI options, both Dexilant and dexlansoprazole have been removed from the formularies.

CGRP Inhibitors for treatment and prevention of migraines

CGRP Inhibitor prescriptions for the treatment and prevention of migraines, have dramatically increased over the past year. The Metallic formulary, used for the AR Home and Exchange members, only covers the prophylactic CGRP Inhibitors. They require Step Therapy or a PA if a member has not tried other prophylactic medications used to treat migraines. There are both oral and injectable CGRP Inhibitors on the Standard formulary, used for

commercial clients.

Samples do not guarantee coverage if member does not meet criteria or if the drug is not covered on the members formulary.

Please check the members benefit and formulary for specific drug coverage before prescribing these medications.

Metformin 850mg added to the ACA Preventive List

Metformin 850mg has been added to the Affordable Care Act (ACA) Preventive List for the indication of preventing diabetes for adults ages 35-70 who are overweight or obese. All fully-insured members and most self-insured plans cover medications on the ACA Preventive list at $0 cost to their members.

Below is a list of Drug Classes on the ACA Preventive Drug List that have some drugs covered at $0 cost, only for preventive treatment according to formulary coverage.

Preventive Services – at no cost for members with ACA benefits

Fluoride Supplements to help prevent cavities (dental caries) in children five years or younger whose water is low in fluoride.
All oral dosage forms up to 0.5 mg
Fluoride products (Rx):

- Sodium fluoride chew tab 0.25 mg to 0.5 mg
- Sodium fluoride soln 0.125 mg/drop
- Sodium fluoride soln 0.5 mg/mL
- Sodium fluoride tab 0.5 mg

Folic Acid Supplements to help prevent birth defects in women† age 55 or younger who are planning to become pregnant or can become pregnant.

Generic dosage forms
Folic acid products (OTC):

- Folic acid cap 0.8 mg (800 mcg)
- Folic acid tab 0.4 mg (400 mcg)
- Folic acid tab 0.8 mg (800 mcg)

Bowel Preparation Medicine for cleaning out the bowel before colonoscopy procedures for adults age 45 through 75. Colonoscopies screen for colon and rectal cancers.

Bowel preparation products (Rx):

- CLENPIQ (sodium picosulfate, magnesium oxide and anhydrous citric acid) oral solution

- PEG-PREP KIT (bisacodyl, PEG 3350, potassium chloride, sodium bicarbonate and sodium chloride) for oral solution

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Statins to help prevent serious heart and blood vessel problems (cardiovascular disease) in adults age 40 to 75 who are at risk.

Generic low to moderate intensity statins (Rx):

- Atorvastatin 10 mg, 20 mg
- Fluvastatin 20 mg, 40 mg
- Fluvastatin ER 80 mg
- Lovastatin 10 mg, 20 mg, 40 mg
- Pravastatin 10 mg, 20 mg, 40 mg, 80 mg
- Rosuvastatin 5 mg, 10 mg
- Simvastatin 5 mg, 10 mg, 20 mg, 40 mg

Antiretroviral therapy for preexposure prevention of human immunodeficiency virus (HIV) infection in people who are at an increased risk.

Generic antiretroviral therapy (Rx):

- Emtricitabine/tenofovir disoproxil fumarate 200 mg-300 mg

Diabetes Prevention Medicine for preventing or delaying diabetes for adults age 35 to 70 who have overweight or obesity.

Generic diabetes prevention product (Rx):

- Metformin 850 mg
  Note: Effective August 1, 2022

Tobacco Cessation Products to help adults who are not pregnant quit tobacco use to prevent health problems. Tobacco use includes smoking or chewing tobacco.

Generic nicotine replacement products—patch, gum and lozenges
Brand-name Nicotrol (nicotine inhalation system)
Brand-name Nicotrol NS (nicotine nasal spray)
Generic bupropion (generic of brand-name, Zyban)—Zyban is NOT covered
Generic and Brand-name Chantix/Varenicline (varenicline tartrate)
Tobacco cessation products (OTC and Rx):

- Bupropion HCl tab SR 12 hr 150 mg
- Nicotine polacrilex gum 2 mg and 4 mg

- Nicotine polacrilex lozenge 2 mg and 4 mg
- Nicotine TD patch 24 hr 21 mg, 14 mg and 7 mg
- Nicotrol inhaler system 10 mg
- Nicotrol NS nasal spray 10 mg/mL
- Varenicline/Chantix tab 0.5 mg and 1 mg
- Varenicline tab 0.5 mg x 11 tabs and 1 mg x 42 pack

Vaccines (Immunizations) to prevent certain illnesses in people of all ages. Recommended doses, ages and populations may vary (Rx)

Children

- COVID-19[1]
- Diphtheria, Tetanus, Pertussis
- Haemophilus Influenzae Type B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

Adults

- COVID-19[1]
- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

Women's Health Preventive Services*

Generic Oral Contraceptives – MOST BRANDS ARE NOT COVERED

Brand-Name Products for Reference Only	Brand-Name Products Generic Equivalent(s)
NORETHINDRONE	NORETHINDRONE TAB 0.35 MG
DESOGESTREL/ETHINYL ESTRA	DESOGESTREL & ETHINYL ESTRADIOL TAB 0.15 MG-30 MCG
JASMIEL	DROSPIRENONE-ETHINYL ESTRADIOL TAB 3-0.02 MG
DROSPIRENONE/ETHINYL ESTR	DROSPIRENONE-ETHINYL ESTRADIOL TAB 3-0.03 MG
KELNOR 1/35	ETHYNODIOL DIACETATE & ETHINYL ESTRADIOL TAB 1 MG-35 MCG
KELNOR 1/50	ETHYNODIOL DIACETATE & ETHINYL ESTRADIOL TAB 1 MG-50 MCG
LUTERA	LEVONORGESTREL & ETHINYL ESTRADIOL TAB 0.1 MG-20 MCG
PORTIA-28	LEVONORGESTREL & ETHINYL ESTRADIOL TAB 0.15 MG-30 MCG
VYFEMLA	NORETHINDRONE & ETHINYL ESTRADIOL TAB 0.4 MG-35 MCG
WERA	NORETHINDRONE & ETHINYL ESTRADIOL TAB 0.5 MG-35 MCG
NYLIA 1/35	NORETHINDRONE & ETHINYL ESTRADIOL TAB 1 MG-35 MCG
JUNEL 1/20	NORETHINDRONE ACE & ETHINYL ESTRADIOL TAB 1 MG-20 MCG
JUNEL 1.5/30	NORETHINDRONE ACE & ETHINYL ESTRADIOL TAB 1.5 MG-30 MCG
CRYSELLE-28	NORGESTREL & ETHINYL ESTRADIOL TAB 0.3 MG-30 MCG

Brand-Name Products for Reference Only	Brand-Name Products Generic Equivalent(s)
MILI	NORGESTIMATE & ETHINYL ESTRADIOL TAB 0.25 MG-35 MCG
DROSPIRENONE/ETHINYL ESTR	DROSPIRENONE-ETHINYL ESTRAD-LEVOMEFOLATE TAB 3-0.02-0.451 MG
	DROSPIRENONE-ETHINYL ESTRAD-LEVOMEFOLATE TAB 3-0.03-0.451 MG
WYMZYA FE	NORETHINDRONE & ETHINYL ESTRADIOL-FE CHEW TAB 0.4 MG-35 MCG
GENERESS FE	NORETHINDRONE & ETHINYL ESTRADIOL-FE CHEW TAB 0.8 MG-25 MCG
TAYSOFY	NORETHINDRONE ACE-ETHINYL ESTRADIOL-FE CAP 1 MG-20 MCG (24)
TARINA FE 1/20	NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TAB 1 MG-20 MCG
TARINA 24 FE	NORETHINDRONE ACE-ETHINYL ESTRADIOL-FE TAB 1 MG-20 MCG (24)
JUNEL FE 1.5/30	NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TAB 1.5 MG-30 MCG
CHARLOTTE 24 FE	NORETHINDRONE ACE-ETH ESTRADIOL-FE CHEW TAB 1 MG-20 MCG (24)
MIRCETTE	DESOGEST-ETH ESTRAD & ETH ESTRAD TAB 0.15-0.02/0.01 MG(21/5)
CAZIANT	DESOGEST-ETHIN EST TAB 0.1-0.025/0.125-0.025/0.15-0.025MG-MG
ENPRESSE-28	LEVONORGESTREL-ETH ESTRA TAB 0.05-30/0.075-40/0.125-30MG-MCG
NYLIA 7/7/7	NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/0.75-35/1-35 MG-MCG
ARANELLE	NORETHINDRONE-ETH ESTRADIOL TAB 0.5-35/1-35/0.5-35 MG-MCG
TRI-LO-MILI	NORGESTIMATE-ETH ESTRAD TAB 0.18-25/0.215-25/0.25-25 MG-MCG
NORGESTIMATE/ETHINYL ESTR	NORGESTIMATE-ETH ESTRAD TAB 0.18-35/0.215-35/0.25-35 MG-MCG
TRI-LEGEST FE	NORETHINDRONE AC-ETHINYL ESTRAD-FE TAB 1-20/1-30/1-35 MG-MCG
LEVONORGESTREL AND ETHINY	LEVONORG-ETH EST TAB 0.1-0.02MG(84) & ETH EST TAB 0.01MG(7)
JOLESSA	LEVONORGESTREL & ETHINYL ESTRADIOL (91-DAY) TAB 0.15-0.03 MG
LEVONORGESTREL/ETHINYL ES	LEVONORG-ETH EST TAB 0.15-0.03MG(84) & ETH EST TAB 0.01MG(7)
LEVONORGESTREL/ETHINYL ES	LEVONOR-ETH EST TAB 0.15-0.02/0.025/0.03 MG &ETH EST 0.01 MG
LEVONORGESTREL AND ETHINY	LEVONORGESTREL-ETHINYL ESTRADIOL (CONTINUOUS) TAB 90-20 MCG

Other Contraceptives†

Generics and brand name only if a generic isn't available.
Generics are in *italics*. Brand names are CAPITALIZED.
Brand name will no longer be supplied at no cost when the generic becomes available.
Brand names listed in **[red]** and in brackets are for your reference only.

Intrauterine Devices, Subdermal Rods and Vaginal Rings (Rx)

- *Ethinyl estradiol 15 mcg/Etonogestrel 120 mcg vaginal ring, EluRyng* **[NUVARING]**
- ANNOVERA

Spermicides (OTC)

- *Nonoxynol-9 vaginal gel 4%, VCF Vaginal Contraceptive Gel* **[CONCEPTROL GEL 4%]**
- ENCARE VAGINAL SUPPOSITORIES
- GYNOL II GEL 3%
- SHUR-SEAL GEL 2%
- VCF VAGINAL FILM 28%
- VCF VAGINAL FOAM 12.5%

Transdermal Patches (Rx)

- *Zafemy*

Injectables (Rx)

- *Medroxyprogesterone acetate 150 mg* **[DEPO-PROVERA]**
- DEPO-SUBQ-PROVERA 104

Vaginal pH Modulators (Rx)

- PHEXXI

Barrier Methods (Rx)

Cervical Caps

- FEMCAP

Diaphragms

- CAYA
- OMNIFLEX COIL SPRING SILICONE
- WIDE-SEAL SILICONE DIAPHRAGM

Emergency Contraception (Rx or OTC)

- *Levonorgestrel 1.5 mg tablet, AfterPill, Aftera, Econtra EZ, Econtra OS, My Choice, My Way, New Day, Opcicon, Option 2, Take Action, React* **[PLAN B]**
- ELLA

Female Condoms (OTC)

- FC-2

Vaginal Sponge (OTC)

- TODAY

Breast Cancer Prevention

Primary prevention of breast cancer in women†† 35 years of age and older, who are at an increased risk.

Breast cancer prevention products (Rx):

- Anastrozole tab 1 mg
- Exemestane tab 25 mg
- Tamoxifen citrate tab 10 mg and 20 mg

Provider availability and accessibility

Arkansas Blue Cross and Blue Shield is certified as a Qualified Health Plan (QHP), which is required to be a payer in the Affordable Care Act (ACA) metallic business (AR HOME and Exchange). As part of that QHP certification, we are accredited by URAC. Network adequacy of various specialties and provider types has always been a required measurement, but availability and accessibility are being added. It will be important for you to track

how quickly patients are able to get in to see providers. We plan to capture measures in a new or recredentialing provider/facility site visit or provider surveys that will ask about the maximum wait times for appointments with practitioners. Specifically, we will be required to report wait times for the following provider types

- Primary care
- Specialty care
- Behavioral Health
- Hospitals
- Non-hospital inpatient facilities
- Outpatient facilities

Primary Care Programs

Open enrollment begins October 3, 2022

Arkansas Blue Cross and Blue Shield will offer two Primary Care programs in 2023: Patient-Centered Medical Home and Primary Care First. Network providers and practices can elect to participate in either program, and open enrollment begins October 3, 2022, and closes on October 14, 2022.

Eligible Specialties include:

- Family medicine
- General practice
- Geriatric medicine
- Internal medicine
- Pediatric medicine
- Primary Care nurse practitioners
- Primary Care physician assistants
- Primary Care clinical nurse specialists

Eligible Networks:

- Arkansas Blue Cross Blue Shield PPP
- Health Advantage HMO
- Arkansas' First Source PPO or True Blue PPO

Primary Care First (PCF)

Primary Care First aims to improve quality, improve patient experience of care, and reduce expenditures by increasing access to advanced primary care services. PCF practices will deliver patient-centered, comprehensive, and continuous care. The specific approaches to care delivery will be determined by practice priorities.

PCF rewards participants with additional revenue for taking on limited risk based on easily understood, actionable outcomes. PCF is an advanced payment model along the path to value. Practices may participate in the Arkansas Blue Cross and Blue Shield PCF program even if they are not participating with CMMI's PCF model.

Care Management Fees

Practices participating in PCF will receive per-member-per-month (PMPM) care management fees to support practice redesign and care coordination efforts. These fees are non-visit based monthly payments to support staffing and training demands of transforming a practice. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses, lower PMPM for patients with lower risk.

Professional Population-Based Payments

Clinics receive monthly professional population-based payments to allow flexibility in caring for patients, in exchange for reduced fee-for-service allowed amounts on Evaluation and Management services. Professional Population-Based Payments are risk adjusted.

Performance Based Adjustments (PBA)

Arkansas Blue Cross will pay performance-based adjustments (PBA) to practices to encourage and reward quality metric performance. Practices will have the opportunity to earn a PBA on their commercial members for performance on Utilization measures as well as Clinical Quality measures.

2023 Utilization PBA will be calculated quarterly and applied to care management fees the second quarter following the performance period. Meeting at least one utilization target will result in an increase in care management fees. Meeting additional targets will increase the PBA. Poor performance will result in a decrease in care management fees.

Clinical quality measures will continue to be calculated and paid annually. Clinics must meet a minimum number of metrics to earn a PBA. Meeting additional metrics will increase the PBA.

This is a voluntary program. There are no penalties for providers who choose not to participate. For more information on the Arkansas Blue Cross and Blue Shield 2023 PCF program, contact us at **primarycare@arkbluecross.com**.

Patient-Centered Medical Home (PCMH)

A Patient-Centered Medical Home (PCMH) is a care team that manages the overall health and coordinates the care of a patient. The PCMH program is designed to assist primary care providers (PCPs) in transitioning to become PCMH practices through guidance and support, while rewarding them for high-quality, coordinated, and efficient care.

Care Management Fees

Practices participating in PCMH will receive per-member-per-month (PMPM) care management fees to support practice redesign and care coordination efforts. These fees are non-visit based monthly payments to support staffing and training demands of transforming a practice. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses, lower PMPM for patients with lower risk.

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Clinical quality measures will continue to be calculated and paid annually. Clinics must meet a minimum number of metrics to earn a PBA. Meeting additional metrics will increase the PBA.

This is a voluntary program. There are no penalties for providers who choose not to participate. For more information on the Arkansas Blue Cross and Blue Shield 2023 PCMH program, contact us at primarycare@arkbluecross.com.

Notice of Material Amendment

For providers currently participating in the PCMH program, the following changes to the PCMH program will be effective January 1, 2023:

- Performance on Utilization measures could result in an increase or decrease in Care Management fees. Meeting at least one utilization target will result in an increase in monthly care management fees, but failure to meet at least one target would result in a decrease in monthly care management fees.
- Some Utilization Performance-Based Adjustment tier amounts have increased over 2022. A tier has been added to the Payment Schedule for meeting zero targets, resulting in a $1 reduction in Care Management Fees if the practice does not meet any Utilization targets.
- Some Quality Performance-Based Adjustment tier amounts have increased over 2022.

Provider Data Management implementation

Arkansas Blue Cross plans to implement Availity's Provider Data Management (PDM) in fourth quarter 2022. A testing pilot program is underway with a few organizations and assuming the testing is successful, full implementation for ALL providers will be scheduled fourth quarter.

PDM will be used for all providers to add new providers or terminate existing providers, change any demographic information of current providers, provide details such as office hours and languages spoken, add or change locations, etc. PDM is tax ID oriented, and the user will build all information within PDM that is covered by a tax ID.

If you already have Availity PDM access, please ensure all your organization's data have been updated to help ensure an easier transition.

Per the Consolidated Appropriations Act (CAA), **all providers MUST attest to their information every 90 days**. This will be performed through PDM.

This is a good opportunity to remind the provider community that the CAA is very serious about the accuracy and timely updates of provider data. If providers do not attest to the accuracy of their data every 90 days, the CAA recommends that payers remove these providers from paper and on-line directories. If providers continue to be noncompliant, more severe action can be taken, such as termination from the provider networks.

Currently provider data is managed through AHIN, but this process will be sunset. Please watch for upcoming

PDM training sessions and more information about the implementation of the Availity Provider Data Management module.

Postponing go-live date for utilization management platform & submission

A recent announcement was made that all lines of business would go live with our new utilization management (UM) platform, Affinitē, on December 15. It was also mentioned that the submission methods would change, too; however, the decision was made to implement a phased approach. Considering there are so many system interdependencies that would require temporary workarounds, implementation has been pushed back until the end of the first quarter for most lines of business so that the transition will be smoother for our providers. In other words, we want to make this transition as easy on you as possible.

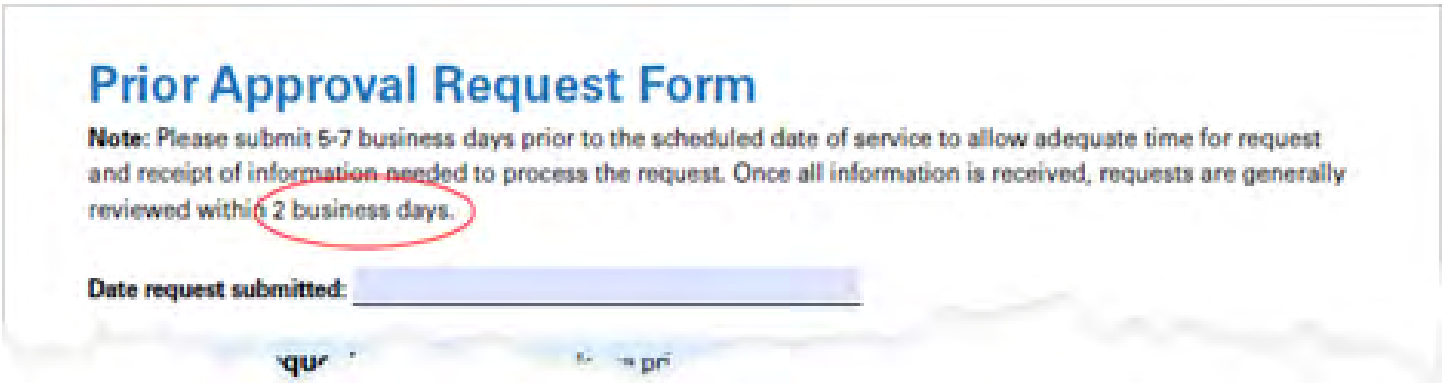
New Timeline

Dec. 15, 2022 – Medicare Advantage will go live in new platform. The current PA submission processes for Arkansas Blues Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and Health Advantage will remain the same until April 1.

April 1, 2023 – Arkansas Blues Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, and Health Advantage will go live in the new platform. Phone submission option will be discontinued.

Two-Day turnaround times for prior approval responses not applicable to self-funded groups

AR Act 815 requires a two-day turnaround time for a prior approval (PA) response. This timeframe has historically been noted on all our PA forms. However, this state law **does not apply** to self-funded groups. For that reason, we have removed this verbiage from the BlueAdvantage fax forms.


Prior Approval Request Form

Note: Please submit 5-7 business days prior to the scheduled date of service to allow adequate time for request and receipt of information needed to process the request. Once all information is received, requests are generally reviewed within 2 business days.

Date request submitted: _____

Standard formulary changes effective October 1, 2022

Arkansas Blue Cross and Blue Shield large groups, Health Advantage large groups, and Blue

Advantage plans that have selected our prescription drug benefits use the standard formulary.

Drug	Change	Alternatives
BETAMETHASONE DIPROPIONATE	No Longer Covered	"desoximetasone (except desoximetasone ointment 0.05%), fluocinonide (except fluocinonide cream 0.1%), BRYHALI"
LANSOPRAZOLE ODT	No Longer Covered	lansoprazole DR capsules, omeprazole DR, pantoprazole DR tablets

Value Formulary Changes Effective 10/1/2022

Drug	Change	Alternatives
BETAMETHASONE DIPROPIONATE	No Longer Covered	amcinonide cream, lotion, ointment 0.1%, betamethasone dipropionate augmented cream, lotion 0.05%, betamethasone dipropionate cream, lotion 0.05%, desoximetasone cream (except 0.05%), ointment 0.25%, gel 0.05%, fluocinonide cream, gel, ointment, solution 0.05%, triamcinolone acetonide cream 0.5
LANSOPRAZOLE ODT	No Longer Covered	lansoprazole DR capsules, omeprazole DR, pantoprazole DR tablets

Metallic formulary changes effective October 1, 2022

On Exchange, Off Exchange, Arkansas Works, Arkansas Blue Cross and Blue Shield small group, Health Advantage small group and USAble Mutual small group members use the metallic formulary.

Drug	Change	Alternatives
ESBRIET	Brand No Longer Covered	generic pirfenidone
VASCEPA	Brand No Longer Covered	generic icosapent ethyl
VIMPAT	Brand No Longer Covered	generic lacosamide

Arkansas School & State / Public School Employees

Change for some ASE/PSE retirees

Effective Jan. 1, 2023, the Employee Benefits Division that oversees the benefits for Arkansas State Employee and the Public School Employee groups, will contract with United Healthcare (UHC) for the administration of a Medicare Advantage Prescription Drug Plan. Some existing Medicare primary retirees will transition coverage from Health Advantage to UHC. UHC will send notifications to providers and advise of the upcoming contract with additional details that will include contact information.

Federal Employee Program (FEP)

FEP adds new policy for low back pain imaging studies

On January 1, 2023, a new policy for low back pain Xray imaging studies will go into effect for the Federal Employee Program (FEP) members. Providers should review the new policy before ordering an Xray imaging study for FEP members with a principal diagnosis of uncomplicated lower back pain. **Advanced imaging such as MRI, CT and PET scan will continue to go through AIM for prior Approval.

Please remember that FEP members can be identified as their member identification number begins with the letter "R."

Qualifying claims are for members between the ages of 18 through 75 with an Xray imaging study performed within 28 days for a principal diagnosis of uncomplicated low back pain in any of the following settings:

- Outpatient
- Observation
- Osteopathic or Chiropractic Manipulation
- Physical Therapy
- Telehealth

The policy requires use of modifier KX. Modifier KX indicates the requirements specified in the medical policy have been met. Claims submitted without modifier KX will be denied, and the member will not be financially responsible for any amount if the Xray imaging study does not meet specific exclusionary criteria outlined in the policy. **AIM prior approval submissions for advanced imaging such as CT, MRI or PET do not require a KX modifier.

The KX modifier must be present on the Xray service being billed or it will not be paid. The modifier is the provider's attestation that the Xray imaging study meets medical necessity criteria, based on the new FEP Low Back Pain Operational Policy.

Here is a link to the upcoming policy change and a letter from Dr. Mark Jansen CMO Arkansas Blue Cross and Blue Shield explaining the necessary changes.

Testosterone Review

For initial review of testosterone, all related office records and lab results will be requested to include the following:

- Two morning total testosterone levels less than 300 ng/dl on different days

- PSA level – patients over 40 years of age must have baseline PSA less than 4 ng/ml (prostatectomy patients excluded from this requirement)
- HCT level – less than 54%

Please note that all lab values must be prior to the administration of testosterone.

For renewal of testosterone the following will be requested:

All related office records and lab results to include the following:

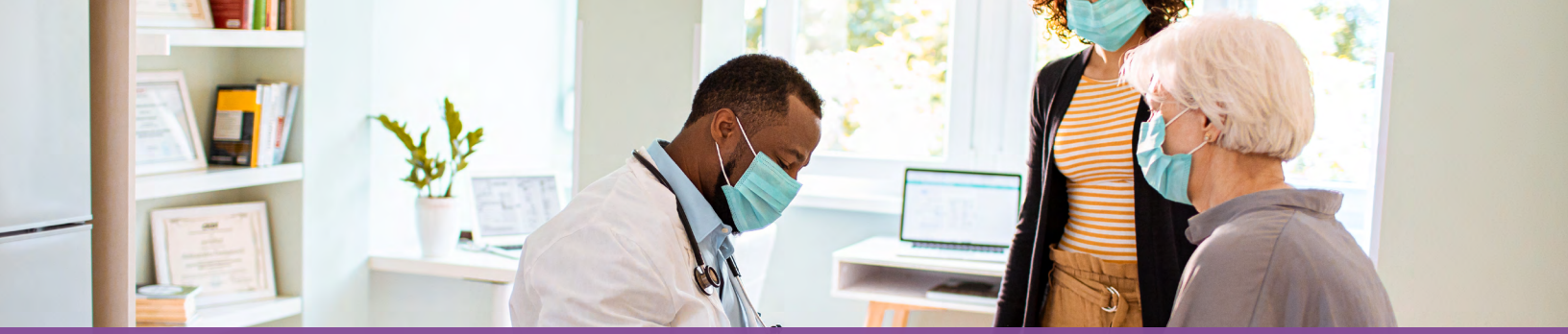
- Total testosterone levels of 800 ng/dL or less
- PSA level – to verify absence of worsening effects of BPH if present. (Prostatectomy patients excluded)
- Hematocrit levels

Please note:
Approvals for testosterone are valid for six months. After six months of administration updated lab results will be requested for renewal.

Denials for testosterone are valid for six months unless additional qualifying medical information is received.

If requested information is not received, FEP will deny the entire claim stating additional information has been requested from the provider.

When submitting medical records please ensure the correct barcode sheet is attached, as each are case/date of service specific. The barcode sheet must be the top page of the fax for it to attach properly. **Please do not reuse the barcode sheet for other patients.**



Medicare Advantage

Medicare Advantage genetic testing prior authorization reminder

Arkansas Blue Medicare and Medicare Advantage Health Advantage have seen a significant increase in the submission of genetic testing claims. The purpose of this communication is to remind Medicare Advantage providers and members that all genetic testing is subject to prior approval, whether the test is performed for preventive or for diagnostic reasons. The prior approval request for each genetic testing claim must include: 1) the name of the genetic test; 2) all applicable diagnostic code(s); and 3) any significant modifier(s) required by applicable billing guidelines and policies as directed by the Centers for Medicare & Medicaid Services (CMS). Upon review, any claim submitted without prior approval or submitted incorrectly, the claim will be denied, and the member will not be held financially responsible.

How to receive prior authorization:

Providers may obtain prior authorization by calling Customer Service at 1-800-287-4188 or completing the online Arkansas Blue Medicare or Medicare Advantage Health Advantage HMO form online at **Provider forms - Arkansas Blue Cross and Blue Shield**. Please follow the instructions in the link to determine status of priority.

Please note that the genetic testing prior authorization requirement applies only to the following Arkansas Blue Cross and Blue Shield – Medicare Advantage members plans:

- BlueMedicare Premier HMO
- Health Advantage Blue Premier HMO
- Health Advantage Blue Classic HMO
- BlueMedicare Saver Choice PPO
- BlueMedicare Value Choice PPO
- BlueMedicare Premier Choice PPO

You can find the specific prior authorization requirements online using the **Medicare Advantage Prior Authorization Guide (arkansasbluecross.com)** or find this resource on Availity within the Payer Space platform.

Reminder on billing qualified Medicare beneficiaries

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

QMBs who are enrolled in any Medicare Advantage plan to administer their Medicare benefits would have Medicare Advantage as their primary coverage and Medicaid as their secondary coverage. Payments are considered accepted in full even if the provider does not accept Medicaid. Providers are subject to sanctions if billing a QMB patient for amounts not paid by any Medicare Advantage plan and Medicaid.

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

Requirements for outpatient observation care

In compliance with the Centers for Medicare and Medicaid Services (CMS) Medicare Outpatient Observation Notice (MOON), Arkansas Blue Medicare and Health Advantage Medicare Advantage require all acute care and critical access hospitals to provide written notification and an oral explanation of the notification to patients receiving outpatient observation services for more than 24 hours and no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.
- Beneficiaries for whom Medicare is either the primary or secondary payer.

For some Medicare Advantage members, observation stays have pre-authorization or pre-notification requirements.

- The notice should explain the following using contemporary language:
- The patient is classified as outpatient
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage for services furnished by a skilled nursing facility
- Advise patients to contact his or her insurance plan with specific benefit questions

The notice and accompanying instructions are available at

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Blue & You Fitness Challenge

Want to start making some healthy changes for your mind, body, and soul? Well, let the Blue & You Fitness Challenge help. It is a great way to get you and your friends, family, and co-workers on the right track to living a healthier lifestyle. Start 2023 strong and register your group for the Blue & You Fitness Challenge.

Group registration for the 2023 Blue & You Fitness Challenge is open. You can register your group now by scanning this QR code.

Important Deadlines for 2023 Challenge

- **January 24** – deadline for group registration
- **February 1** – individual participant registration opens
- **February 28** – deadline for individual registration in groups
- **March 1** – Challenge begins

What is the Blue & You Fitness Challenge?

The Blue & You Fitness Challenge, founded in 2004 and hosted by Arkansas Blue Cross and Blue Shield, the Arkansas Department of Health and the Arkansas Department of Human Services, is a free three-month fitness competition in which participants exercise and log their activity. The Challenge is held March 1 through May 31. Companies and organizations participate in the event as part of their wellness programs, while friends and family use the contest to focus on fitness goals, infuse new energy into their routines, remain connected and have fun! Points gained from logging activity lead to contest recognition and rewards. Better health and fitness is the best bonus.

For more information, call 1-800-686-2609.

Strong starts here!