February 2024 **Special issue**

PROVIDERS' NEWS

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

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

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PROVIDERS' NEWS

What's inside?

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Post-Service Pre-Pay Review of Claims

This information is being provided to address some of the confusion brought about by Arkansas Act 575, commonly known as the Gold Card Law.

Previously, ABCBS allowed for some prior authorization (PA) for certain services, and ABCBS has always engaged in the process of post service prepay review of claims. In response to the Gold Card Law, and in an effort to reduce confusion among providers and our members, ABCBS will not require PA on medical services in this calendar year for plans subject to the Gold Card requirements. Instead, we will continue post service prepay reviews; and therefore, for those services for which providers may have become accustomed to submitting a PA, we may contact you to submit additional documentation during a post service prepay review to support the claim and to allow for a primary coverage criteria determination. If the primary coverage criteria has not been met, we will not pay for the service.

We understand that this move away from PA may be confusing for some. During this transition, we would like to provide you a list of services and procedures that formerly were subject to PA, but no longer have the PA requirement.

PROC_NBR	Description
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
19318	Breast reduction
21089	Unlisted maxillofacial prosthetic procedure
62280	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
62282	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thora
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thora

PROC_NBR	Description
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary proced
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to co
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code f
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling

PROC_NBR	Description
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
67908	Repair of blepharoptosis; conjunctivo tarso Muller's muscle levator resection (eg, Fasanella Servat type)
E0466	Home ventilator, any type, used with non invasive interface, (e.g., mask, chest shell)
E0784	External ambulatory infusion pump, insulin
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type

Organizational Determination/Benefit Inquiry

We also remind you that Arkansas law allows for a provider to make what is known as a Benefit Inquiry prior to the delivery of a healthcare service. This process is also known as an Organizational Determination. This means a provider can make a Benefit Inquiry to ABCBS about a service BEFORE it is performed. If agreed that the service meets our primary coverage criteria, the coverage terms and conditions, and limitations of the policy, and is not subject to specific plan exclusions, we will approve the service. The provider will be paid and there should be no further disruption to the claims process so long as none of the authorized reasons for rescission of the approval are present when the claim is submitted. You may seek a Benefit Inquiry if you choose, but you are not required to do so. Benefit Inquiry forms can be accessed using the appropriate link below.

BAA: https://www.blueadvantagearkansas.com/providers/resource-center/provider-forms

HA: https://www.healthadvantage-hmo.com/providers/resource-center/provider-forms

FEP/ABCBS: https://www.arkansasbluecross.com/providers/resource-center/provider-forms

Note that Act 575 Gold Card law DOES NOT apply to every line of business that is offered by Arkansas Blue Cross and Blue Shield, Health Advantage, Arkansas Blue Medicare, Arkansas Blue Medicare Plus, and Octave Blue Cross and Blue Shield. For your convenience, we are offering a "cheat sheet" with a list of health insurance cards and logos to make it easier to identify members of these plans to which the Gold Card legislation does not apply, and our prior authorization process will continue. If you submit a PA request, and one is not required, you will be informed.

Inpatient Admissions

For the fully insured lines of business listed below, although a prior authorization is not required, we do request prenotification for inpatient admissions using the organizational determination/benefit inquiry form so that the admission can be followed through discharge.

- **Arkansas Blue Cross and Blue Shield (ABCBS)**
- **ABCBS Exchange**

- **Health Advantage**
- **Health Advantage Exchange**
- **Octave**

Inpatient Prior Authorization and Organizational Determination/Benefit Inquiry Requests

Please mark all inpatient requests as "urgent" to ensure the quickest turnaround time on the determination. Note: Please only do this for Inpatient requests. Submitting all requests as urgent will only delay processing and review times for critical and time-sensitive treatment and services.

Outpatient Prior Authorization and Organizational Determination/Benefit Inquiry Requests

Outpatient requests should be submitted 5-7 business days prior to the scheduled date of service to allow adequate time for our request and receipt of information needed to process and review the request.

Specialty Medicine Prior Authorization and Organizational Determination/ Benefit Inquiry Requests

To ensure the quickest turnaround time on specialty medicine requests, mark the specialty med. box on the form for all specialty med. requests, and do not use Outpatient request type. Failing to do so will delay processing and review of the request.

Prior Authorization Reminder

Please note that we will no longer take prior authorization (PA) requests over the phone or through mail. Arkansas Blue Cross went live with our new UM platform on December 11. Long term, our strategy will be that Availity will house the primary intake portal for PA requests. Until that is implemented, please complete and return the appropriate PA form:

BAA: https://www.blueadvantagearkansas.com/providers/resource-center/provider-forms

HA: https://www.healthadvantage-hmo.com/providers/resource-center/provider-forms

FEP/ABCBS: https://www.arkansasbluecross.com/providers/resource-center/provider-forms

to IntakeTeam@arkbluecross.com. Please note this email is for submissions only and will not be monitored for messages or questions. Before submitting any forms, please make sure to complete all fields and attach the necessary clinical documentation. **Ensuring the information is complete and accurate (as well as including all relevant clinical records) will allow the fastest turnaround time on decisions.**

Our team is currently seeing extremely high volumes of PA and Organizational Determination requests across all areas. We appreciate your patience as we work diligently to process and review your requests as quickly as possible. Please refrain from submitting duplicate requests, as that will only result in a longer processing and turnaround time.

Tyson Run Out

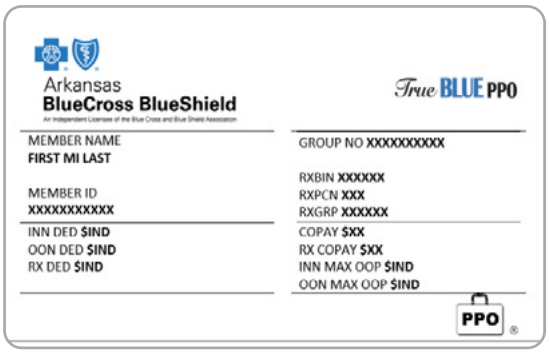
Effective January 1, 2024, we are no longer processing prior authorization (PA) or Organizational Determinations for Tyson Foods. We are processing the run out claims from 2023.

Insurance Card Logo Examples

Included below is an example of our insurance cards and the different logos that correspond to different lines of business. There are cases where different lines of business have unique phone numbers and web resources, so please ensure you are using the correct resources for each line of business.

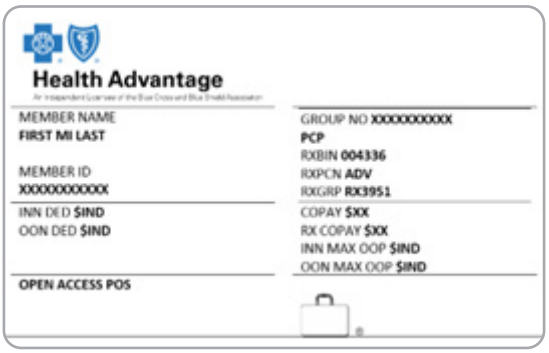
Arkansas BlueCross BlueShield plans do not have any prior approval requirements except for specialty medications.

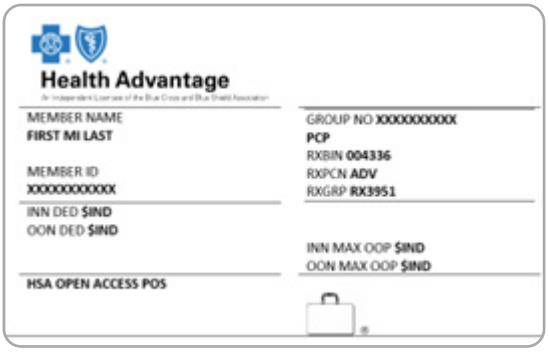
- There is no requirement for the provider to submit a prior approval unless it is for specialty medications.
- Prenotification for inpatient admissions is encouraged, but not required. Providers are encouraged to submit prenotification of an inpatient admission via the Organization Determination Benefit Inquiry form.
- In accordance with AR Act 815 we do offer a formal benefit inquiry via the Organization Determination Benefit Inquiry form. This is optional for the provider and is not required.



Health Advantage *fully insured group* plans do not have any prior approval requirements except for specialty medications.

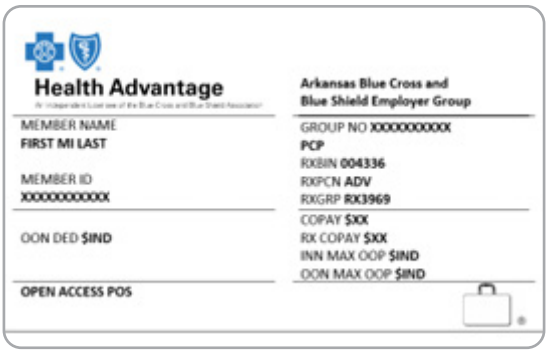
- There is no requirement for the provider to submit a prior approval unless it is for specialty medications.
- Prenotification for inpatient admissions are encouraged, but not required. You may submit these prenotifications via the Organization Determination Benefit inquiry form.
- In accordance with AR Act 815 we do offer a formal benefit inquiry via the Organization Determination Benefit Inquiry form. This is optional for the provider and is not required

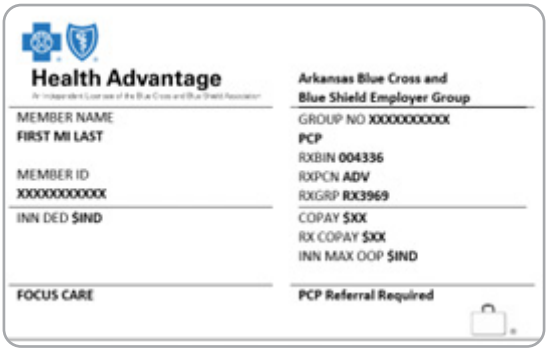


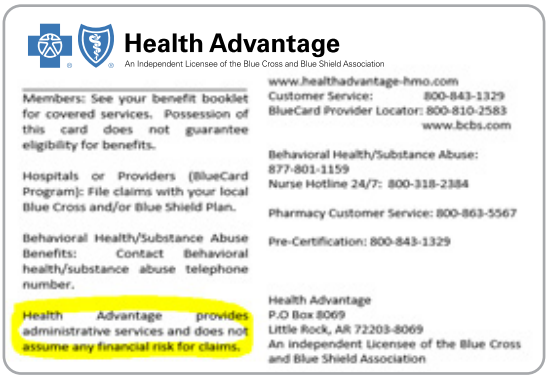


Health Advantage *self-insured group* plans will have prior approval requirements, so you should always submit the prior approval requests for these groups:

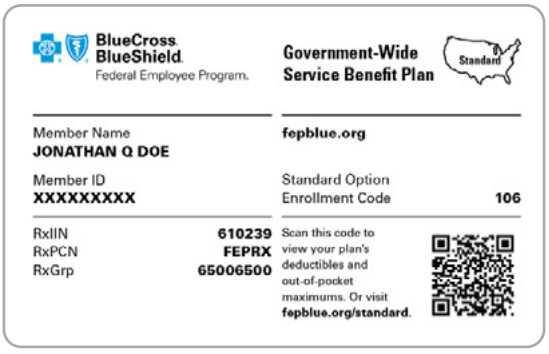
1) Arkansas Blue Cross and Blue Shield Employer Group is notated in the upper right corner of the ID card.
2) Arkansas State Police is notated in the upper right corner of the ID card.
3) Arkansas State Employee and Public-School Employee – can be identified with **PXGY** at the beginning of the member ID.

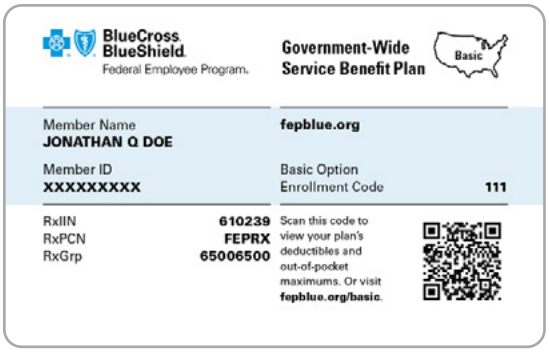


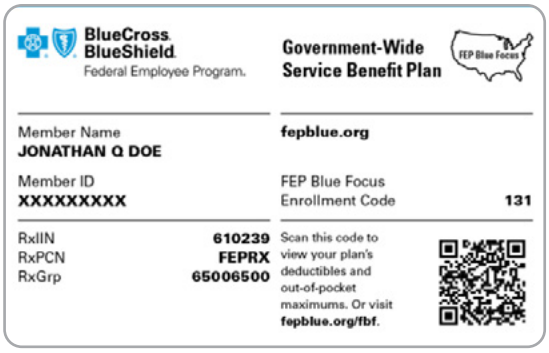




Federal Employee Program: FEP members do have prior approval requirements and can be identified with one of the following ID card templates.







Octave: The New Brand for Individual Coverage

Arkansas Blue Cross and Blue Shield has established a new brand that represents its non-Medicare* individual coverage options – **Octave Blue Cross and Blue Shield**.

This new brand – which launched on January 1, 2024 – covers individual policy policyholders (not part of an employer-sponsored group health plan) and their covered dependents who are enrolled in Arkansas Blue Cross-affiliated plans offered on the Healthcare Marketplace and via ARHOME (Arkansas Health & Opportunity for Me), the state's Medicaid expansion offering.

Octave Blue Cross members access the **True Blue PPO** network.

Octave Blue Cross members will have member **ID cards** bearing the Octave Blue Cross logo.

Octave
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Claims should be filed using the **EXX prefix**.

Other than that, not much else changes for healthcare providers. Claims may be filed in the same manner as those for Arkansas Blue Cross, Health Advantage and BlueAdvantage Administrators of Arkansas, and the Arkansas Blue Cross fee schedule applies.

Providers who have questions about Octave Blue Cross may contact their assigned Arkansas Blue Cross network development representative.

Note:* *Individual policyholders covered under a Medicare Advantage plan* ***are not* *part of the Octave Blue Cross portfolio.*

PaymodeX and Bottomline Technologies emails are legitimate

Arkansas Blue Cross and Blue Shield's Accounts Payable team is implementing a new payment solution – **PaymodeX** – through US Bank.

Many healthcare providers, vendors and agents recently received email communications from either **PaymodeX** and/or **Bottomline Technologies** requesting their enrollment, and these communications understandably resulted in questions as to their legitimacy.

The uncertainty was compounded by the presence of a spelling error in our address. This was simply a typographical error by PaymodeX / Bottomline Technologies.

We want to reassure you that these emails ***are not*** **scams or phishing attempts** and were legitimately sent on our behalf.

For the provider community, this solution is ***only*** related to ***nonclaim*** **payments made from Accounts Payable**. No other payments will be impacted. All nonclaim payments are made by the Accounts Payable team. This could include things like refunds, value-based payments, primary care initiative payments or similar payments that are not the direct result of a filed claim.

Types of payments sent by Accounts Payable (with some specific examples)

- Baptist Health Physician Partners (BHPP)
- Medicare Advantage HMO shared savings
- Medicare Advantage value-based payments
- Patient-Centered Medical Home (PCMH) program
- Prescription rebates
- Clinically Integrated Networks (CINs)
- Peer-to-peer (P2P) payments
- Primary Care First (PCF) program

Remittance advices (RAs)

All electronic or virtual card payments issued by Paymode-X will also come with a detailed remittance advice (RA).

RAs will include at least the same level of detail that is currently being provided for payments from Accounts Payable.

Any payments made from a claims payment system (such as AMISYS) will not be handled by PaymodeX.

Nonclaims payments not handled by PaymodeX

Any payment made by a **third party** on behalf of or in association with Arkansas Blue Cross (**Stellar Health**, for example) will not be changed.

Payees who have multiple payment methods

In our current process, we use **unique vendor IDs** for different payment types, and each vendor ID could potentially have different payment methods/accounts attached. This should still be a possibility with Paymode-X, as they have stated that a provider will have the ability to add multiple bank accounts and determine where they want individual types of payments to flow. PaymodeX is willing to have someone from their team collaborate with affected providers to make sure everything is routed correctly.

Refunds

All **claims-associated refunds** generally are issued from Accounts Payable because AMISYS cannot issue claims refunds.

One exception would be if a provider sends in a refund request, and Arkansas Blue Cross agrees that it is an overpayment, Arkansas Blue Cross does place that refund on a check control memo (CCM), and it can be applied on the next provider payment run through the claims payment system.

However, when Arkansas Blue Cross does not agree that the company is owed the money by a provider, Accounts Payable deposits the funds and reissues the refunded amount to the provider via an Accounts Payable check, which now will be issued electronically by PaymodeX.

We apologize for any confusion that these communications may have produced and are committed to making this process is as seamless as possible going forward.

Questions about **PaymodeX may** be directed to **Geneva Miller** at **gemiller2@arkbluecross.com**