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2016 open enrollment

please use AHIN

for verifying eligibility, benefits and claim status

2016 Open Enrollment Period began on November 1, 2015, and runs through January 31, 2016. Due to the anticipated enrollment of many new members and the renewal of current members effective on the same dates, we are expecting extremely high call volume through February 29, 2016. Arkansas Blue Cross and Blue Shield strongly encourages physician and other health care professional offices including facilities to use AHIN (Advanced Health Information Network) for verifying eligibility, benefits, and claims status. Several recent enhancements to AHIN will display additional information on benefits that should help providers when scheduling appointments, checking eligibility, and benefits. If a provider requires proof of coverage for their records, they may copy the screen to their files or print a paper copy.

Arkansas Blue Cross is planning and staffing to answer all calls, however there may be periods of time when the call volumes spike and exceed our ability to answer all of the calls. Because Arkansas Blue Cross recognizes how valuable our provider's time is, we want to remind our medical providers that the AHIN database uses the same information available to Arkansas Blue Cross customer service representatives and is continually updated.





Annual compliance training

As a contractor with Centers for Medicare & Medicaid Services (CMS) and a Qualified Health Plan (QHP) through the U.S. Department of Health and Human Services (HHS) through the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act) Arkansas Blue Cross and Blue Shield is required to develop and maintain a compliance program and ensure annual compliance

training is satisfied by our first-tier, downstream and related entities (FDRs) and delegated entities (DEs). According to the Federal Register Notice CMS-4124-FC and 45 C.F.R. Subpart D §156.340, Providers are considered first tier and/or delegated entities because there is a direct contract for Medicare/ACA Services between Arkansas Blue Cross and each provider.

Providers and staff must complete annual compliance training from a CMS

compliant source annually by December 31 or within 90 days of hire.

For more information and the annual compliance training, visit the website at arkbluecross.com/providers under “Resources” and select the link for the “2015 Annual Compliance Training for Providers.”

Questions?
Email Regulatory Compliance at: regulatorycompliance@arkbluecross.com

Medi-Pak[®] Advantage Part D prescriber requirements

The Centers for Medicare & Medicaid Services (CMS) has made changes for any physician or other eligible professional (collectively referred to as “Providers”) who prescribe Medicare Advantage (Part D) covered drugs. Providers must either enroll in the Original Medicare program or “opt out” in order to prescribe covered medications to their patients who have a Part D prescription drug benefit plan. Providers who are not enrolled should do so

before January 1, 2016, to allow for the processing of applications and to ensure enrollees will continue to receive their Part D covered prescriptions.

Please note: Part D benefit plans will not be allowed to cover drugs that are prescribed by Providers who have not enrolled with or have not opted out of the Medicare program.

To comply with the CMS change, Arkansas Blue Cross and Blue Shield will require

all providers to be enrolled in Original Medicare before they can be considered for participation in any of its Medi-Pak[®] Advantage networks, including the Private Fee-for-Service (PFFS), Local Preferred Provider Organization (LPPO) or Health Maintenance Organization (HMO).

This article was previously published in the September 2015 issue of *Providers’ News*.



Drug coverage changes for 2016

As drug costs continue to increase, it is estimated that up to 30 percent of total healthcare expense is for prescription drugs. As a health plan administrator, our job at Arkansas Blue Cross and Blue Shield is to make certain our members have access to safe and effective medicine at the lowest possible cost.

Almost every year, a number of our members receive a letter asking them to consider a change in their medication to help keep their cost at a minimum.

Members that were affected by 2016 formulary changes were notified by mail in October 2015. Letters are member specific and include information such as the member's specific drug that will not be covered in 2016 with formulary alternatives,

brand medications that will require trial of a generic alternative, medications that will require prior authorization, medications that will have a higher copayment and quantity limits for medications where members have higher dosages than recommended.

Members will be contacting their pharmacists and provider's offices regarding changes to alternatives. Members and providers with questions can contact Pharmacy Customer Service at 1-800-969-3983.

If the provider and member feel that the member's condition requires an exception based on medical necessity, the following steps can be taken:

- Providers can request exceptions for non-covered medications or to

bypass the requirement of a generic medication before a brand is covered, by faxing a letter of medical necessity with supporting clinical information to 501-378-6980.

- Prior authorizations for medications that require prior approval for payment and exceptions for medication dosages higher than the recommended limits can be requested by contacting CVS/Caremark at 1-877-433-2973 after December 1, 2015.

For your reference, copies of our 2016 formulary lists can be found at arkansasbluecross.com/pd_list/default.aspx.

Overpayment notification

Do you have an AHIN workstation? Providers are able to notify Arkansas Blue Cross and Blue Shield, Health Advantage, the Federal Employee Program (FEP), and BlueAdvantage

Administrators of Arkansas regarding overpaid claims. AHIN includes a function to allow electronic notification and response from the appropriate claims division.

For assistance with AHIN, please contact AHIN Customer Support at 501-378-2336.



Unsolicited medical records

Occasionally, Arkansas Blue Cross and Blue Shield receives medical records that have not been properly faxed with the bar-coded cover sheet. Sometimes medical records are submitted with claims and other times medical records are sent attached to corrected claim forms. **Arkansas Blue Cross will begin reinforcing previous notifications by returning all unsolicited medical records back to the provider's office.**

In the past, Arkansas Blue Cross has kept the unsolicited medical records

on file. However in most cases, when a provider's office calls regarding the status of an associated claim, the corresponding medical records cannot be located in the large file of unsolicited medical records. Since Customer Services representatives show no record of receipt, providers become frustrated. Please do not send medical records until requested. Please fax the medical records using the bar-coded sheet as the cover page.

If there is a specific reason to send medical records not

formally requested, please be sure to send the records to the attention of a specific person or area (e.g. Appeals Department, Medical Re-Review, etc.). It is the goal of Arkansas Blue Cross to provide the most effective and efficient administration of Customer Service in the industry. With the assistance of our providers, Arkansas Blue Cross will reach that goal and assure that our providers' claims and requests are processed in the most efficient manner.

Ambulance services for non-emergency transportation (NET)

Arkansas Blue Cross and Blue Shield has seen a significant increase in claims for ambulance services for our members whose policies are issued through the Health Care Independence Program (Private Option). Our internal review of these claims has revealed that many of these claims are for non-emergency transportation (NET).

Policies issued by Arkansas Blue Cross through the Private Option do not

provide coverage for NET ambulance services, and we have accordingly adjusted our claims processing procedures to identify and deny such claims.

Persons insured through the Private Option may be eligible for assistance in meeting their NET needs, but that assistance is not provided through claims submitted under their health insurance policies. NET services are provided through a

separate "wraparound" Medicaid benefit program administered by the Arkansas Department of Human Services. That service is provided through transportation brokers who are contracted by the State.

Private Option enrollees who need more information about the State's NET program should contact the Medicaid Transportation Help Line (toll free), at 1-888-987-1200.

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Ambulance Services for Non-Emergency Transportation (NET) (Continued from page 4)

Information about Medicaid NET services is also available on the Arkansas Foundation for Medical Care’s website

under “Medicaid Managed Services,” at <http://mmcs.afmc.org>.

Non-emergency transports claims will be

denied if billed to Arkansas Blue Cross and its family of companies.

CMS issues guidelines for online provider directories

The Centers for Medicare & Medicaid Services (CMS) is requiring all Medicare Advantage plans to provide its enrollees with the most up-to-date information regarding participating providers on their online provider directories. CMS has issued guidelines that all Medicare Advantage plans and participating providers must follow.

Under the new CMS program, Medicare Advantage plans must have regular, ongoing communications with providers to ascertain their availability and, more specifically, whether they are accepting new patients. Plans are required to maintain accurate online provider directories by:

- Displaying all active participating providers
- Identifying providers whose practice is closed or providers not accepting new patients
- Updating online provider directories in

- real-time
- Communicating with providers monthly regarding their network status and information accuracy

Medicare Advantage plans are expected to require participating providers to inform the plan of any change to street addresses, phone numbers, office hours or any other change that can affect their availability. Medicare Advantage plans are also required to develop and implement a protocol to effectively address inquiries and complaints related to enrollees being denied access to a participating provider and make immediate corrections to their online provider directory.

In order to meet these CMS requirements, providers participating in the Medi-Pak® Advantage PFFS, Medi-Pak® Advantage LPPO, and Medi-Pak® Advantage HMO

plans are now required to maintain and updated their information with Arkansas Blue Cross and Blue Shield.

To assist providers, Arkansas Blue Cross is developing an information update screen on the AHIN website. Providers will be able to update information such as their status of accepting new patients, joining or terminating from an existing clinic, and their hours of service. On the AHIN provider detail page, providers will be able to update their patient restrictions under the network tab and update their office hours under the provider association tab. Reminders will also be published in subsequent editions of the Providers’ News as well as monthly reminders on AHIN.

This article was previously published in the September 2015 issue of *Providers’ News*.



Coverage policy manual updates

Since September 2015, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our website at arkansasbluecross.com.

New / Updated policies:

| Policy# | Policy Description |
|---------|---|
| 1998043 | Biofeedback for Miscellaneous Indications |
| 1998153 | Cardiac Event Recorder, Insertable Loop Recorder |
| 2003055 | Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric Disorders |
| 2005003 | Genetic Test: Cytochrome p450 Genotyping |
| 2005024 | Nesiritide (Natrecor) for Use in the Outpatient Setting |
| 2006039 | Artificial Vertebral Disc, Cervical Spine |
| 2009034 | Intensity Modulated Radiation Therapy (IMRT), Prostate |
| 2009047 | Hormone Pellet Implantation for Hormone Replacement Therapy |
| 2010014 | Genetic Test: Chromosomal Microarray (CMA) Analysis for the Genetic Evaluation of Patients with Developmental Delay/Intellectual Disability or Autism Spectrum Disorder |
| 2012049 | Genetic Test: Prenatal Analysis of Fetal DNA in Maternal Blood to Detect Fetal Aneuploidy |
| 2015022 | Urinary Metabolite Tests (SOF-Adhere) for Adherence to Direct-Acting Antiviral Medications for Hepatitis C |
| 2015023 | Daclatasvir (Daklinza) |
| 2015024 | Prostatic Urethral Lift (UroLift System) |
| 2015025 | Nutritional Panel Testing (NutrEval®, ONE FMV™) |



FEP benefit changes for 2016

The following benefits changes apply to Federal Employee Program (FEP) members for 2016.

Changes for the Standard Option:

- The copayment for preferred primary care or other health care professions have been increased to \$25 for office visits, physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services, and foot care.
- The copayment for preferred specialist has been increased to \$35 copayment per visit for office visits, physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services, and foot care.
- The copayment for manipulative treatment performed by a Preferred provider is \$25 per visit.
- The copayment for professional mental health care and substance abuse services performed by a preferred provider is now \$25 per visit.
- FEP now provides benefits for Self Plus One, you have a \$350 deductible per calendar year.
- The cost share for inpatient hospital for preferred facilities, have a \$350 co-payment per admission for unlimited days. For participating facilities, there is a \$450 co-payment per admission for unlimited days, plus 35% of the plan allowance. . For non-participating facilities, you have a \$450 co-payment per admission for unlimited days plus 35% of the Plan allowance and any remaining balance after our payment.
- The Self Plus One and Self and Family contracts, when one covered family member reaches the Self Only catastrophic out-of-pocket maximums (\$5000 preferred, or \$7000) for a combination of Preferred and Non-preferred providers) during the calendar year, that member's claim will no longer be subjected to associated cost share amounts for the rest of the year.
- Catastrophic Protection out of pocket maximum for Self Plus one, and Self and Family enrollment, Preferred providers is \$10000 and for a combination of preferred and Non-participating providers is \$14000 per calendar year.
- Members now pay a copayment of \$350 for outpatient observation services billed by a Preferred facility for unlimited days. The cost share when admitted to a Member or Non-member hospital or other covered facility, is \$450 copayment for unlimited days, plus 35% of the Plan allowance. For non-member providers, the member is responsible for any remaining balance after our payment.
- The cost-share for continuous Home Hospice care performed by preferred providers is \$350 per episode copayment. When performed by Member or Non-member provider you cost share is \$450 per episode copayment. For non-member providers, the member is responsible for 35% of the Plan allowance, plus any remaining balance after or payment.
- FEP dental benefits are now limited to coverage for clinical oral evaluations, diagnostic imaging, palliative, treatment, and preventive procedures.

(Continued on page 8)

The following benefits changes apply to Federal Employee Program (FEP) members for 2016.

Changes for the Basic Option:

- The copayment for home nursing visits performed by a preferred provider is \$30 per visit.
- The copayment for manipulative treatment services performed by preferred provider is \$30 per visit.
- The copayment for mental health care and substance abuse services performed by preferred providers is \$30 per visit.
- The copayment for dental care services performed by preferred providers is \$30 per visit or evaluation.
- The copayment for office visits, reproductive services, allergy care, treatment therapies, physical therapy, speech therapy, occupational therapy, cognitive therapy, hearing services, vision services, foot care services, alternative treatments or diabetic education performed by Preferred primary care performer or other health care professional specialist is \$30 per visit.
- Members now pay a copayment for outpatient observation services billed by a Preferred hospital or freestanding ambulatory facility \$175 per day to a maximum of \$875.
- The copayment for office visits, reproductive services, allergy care, treatment therapies, physical therapy, speech therapy, occupational therapy, cognitive therapy, hearing services, vision services, foot care services, alternative treatments or diabetic education performed by Preferred specialist is \$40 per visit.
- The Self Plus One and Self and Family contracts, when one covered family member reaches the Self Only catastrophic out-of-pocket maximums (\$5500) during the calendar year, that member's claim will no longer be subjected to associated cost share amounts for the rest of the year.

Changes for Both the Standard and Basic Options:

- After completion of the Blue Health Assessment (BHA), you are entitled to receive up to \$120 on your health account by achieving up to 3 Online Health Coach goals.
- FEP now limits benefits for Preventive care for an ultrasound for abdominal aortic aneurysm to adults ages 65 to 75 to one test per lifetime.
- FEP now provides Preventive care benefits for osteoporosis screening once per calendar year, for women age 65 and over, and for women ages 50 to 65 that have increased risk for osteoporosis.
- FEP now providing benefits for hepatitis B screening, for adults, and for adolescents, age 13 and over.
- FEP now provides benefits for Preventive care benefits for the application of fluoride varnish, up to two per calendar year for children through age 5, when administered by a primary care provider.
- FEP now provides Preventive care benefits for low-dose aspirin as a preventive medication for pregnant women who are at risk for preeclampsia.



Changes for Both the Standard and Basic Options (continued):

- FEP now provide Preventive care benefits for the following BRCA related testing for members age 18 and over. BRCA1 and BRCA2 testing for individuals from a family with a known BRCA1/BRCA2 mutation; BRCA1 and BRCA2 testing for members who have a personal history of breast, ovarian, fallopian tube, peritoneal, pancreatic, and/or prostate cancer, who have not received BRCA testing, when genetic counseling and evaluation supports BRCA testing and testing for large genomic rearrangement in the BRCA1 and BRCA2 genes. Prior approval is required for testing.
- FEP now provides allergy care and prescription drug benefits for specific FDA approved drugs for sublingual allergy desensitization.
- FEP does not required to obtain prior approval for outpatient intensity modulated radiation therapy (IMRT) services related to the treatment of anal cancer.
- FEP now uses the Local Plan allowance as our Plan allowance for outpatient dialysis services performed by Non-member facilities. The member is responsible for the total charge.
- FEP now provide benefits for inpatient admissions to residential treatment centers for treatment of medical, mental health, and or substance abuse conditions when performed and billed by a licensed and accredited residential treatment center based on specific criteria. Precertification of inpatient admission and Case Management approval are required.
- FEP provides Prescription drug benefits for the treatment of gender identity/gender dysphoria, these benefits are only available through the retail Pharmacy Program, Specialty Pharmacy Program or Mail Service Prescription drug Program.
- FEP Members with high blood pressure who complete the BHA may receive a free blood pressure monitor every two years through our Hypertension Management Program.
- FEP provides a Pregnancy Care Incentive Program for pregnant members age 18 and over who received prenatal care in the 1st trimester of their pregnancy and submit a copy of the provider's medical record documenting the prenatal care visit.



2016 Medi-Pak[®] Advantage utilization management

Beginning January 2016 Arkansas Blue Cross and Blue Shield Medi-Pak[®] Advantage HMO and Medi-Pak[®] Advantage PPO will implement a new utilization management program. The program is designed to promote quality, cost effective and medically appropriate services. Medi-Pak[®] Advantage will review and approve select services before they are provided. The primary reason for clinical review is to determine whether the service is medically necessary, whether it is performed in the appropriate setting and whether it is a benefit.

The services that will require clinical review include Acute Care Management, Transitions of Care and Pharmacy Care Management. The activities will include:

1. Prior Authorization Services for Inpatient Admissions, Skilled Nursing Facility (SNF) Admissions, Long-Term Acute Care Hospital (LTACH) Admissions, and Inpatient Rehabilitation admissions
2. 14 day Bundling for Readmissions
3. Prior Authorization for Medicare Part B covered medication

Inpatient Admissions and Observation

Contracted facilities must notify Medi-Pak[®] Advantage of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure Medi-Pak[®] Advantage members receive care in the most appropriate setting, that Medi-Pak[®] Advantage is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Medi-Pak[®] Advantage of admissions by telephone or fax as follows:

- Telephone: 1-866-427-8680 Monday –Friday 8:30am-4:30 PM CST
- Fax: 1-844-869-4073
- Post-service requests can also be initiated by contacting Medi-Pak[®] Advantage Care Management.
- Medi-Pak[®] Advantage nurses conduct admission reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Medi-Pak[®] Advantage nurses also speak to attending physicians when necessary to obtain information.

Skilled Nursing, Long Term Acute Care and Inpatient Rehabilitation Facilities

Facilities must notify Medi-Pak[®] Advantage of all post-acute admissions and provide clinical information prior to the admission for initial requests and prior to the expiration of approved days for continued stay review requests. Timely notification helps ensure that Medi-Pak[®] Advantage members receive care in the most appropriate setting, that Medi-Pak[®] Advantage is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Medi-Pak[®] Advantage of admissions by telephone or fax as follows:

- Telephone: 1-866-427-8680
- Fax: 1-844-869-4073

(Continued on page 11)



2016 Medi-Pak® Advantage utilization management (Continued from page 10)

Medi-Pak® Advantage requires that requests for transitional or discharge planning services be handled during the business hours. In the event that an emergent need arise for these services after the hours noted above or on weekends or holidays, providers can call 1-866-427-8681 to reach an after-hours care manager.

Medi-Pak® Advantage nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Medi-Pak® Advantage nurses also speak to attending physicians when necessary to obtain information.

Clinical information includes relevant information about the member in regard to the following: A copy of the forms used to submit clinical information for Inpatient acute and post-acute admissions can be found at arkansasbluecross.com/providers/forms.aspx.

14 day Bundling of Readmissions

Medi-Pak® Advantage reviews inpatient readmissions that occur within 14 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member has the same or a similar diagnosis. Medi-Pak® Advantage reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of, or inadequate, discharge planning
- A planned readmission
- Surgical complications

In some instances, Medi-Pak® Advantage combine the two admissions into one for purposes of the DRG reimbursement. Medi-Pak® Advantage guidelines for bundling a readmission with the initial admission are available at arkansasbluecross.com/providers/forms.aspx.

Medications covered under the medical benefit (Part B Medications)

Certain medications covered under the medical benefit (Part B medications) require clinical review (Prior Authorization). These medications are not self-administered and are typically administered in a specialty clinic or physician office. These drugs are managed by Medi-Pak® Advantage through the Pharmacy department.

Drugs that are subject to clinical review and the clinical information required for a decision are listed on the <https://secure.ahin-net.com/ahin/logon.jsp> for Medi-Pak® Advantage AHIN website

For these drugs, providers may submit the clinical review request in one of the following ways:

- By calling Care Management at 866-427-8680
- By faxing a completed Medical Benefit Drug Request Form along with supporting documentation to the fax 844-667-8909. This form can be found at arkansasbluecross.com/providers/forms.aspx.

Note: For medications covered under the pharmacy benefit (Part D medications), providers must contact the Medi-Pak® Advantage Clinical Pharmacy Help desk at 1-800-437-3803; PDP - 1-866-230-7264; HMO - 1-888-249-1595; PFFS - 1-888-249-1556; PPO 1-877-277-7928.



Remittance advice balancing instructions and guidelines related to coordination of benefits

There has been an increase in inquiries due to the calculation on the remittance when two or more policies are involved on a claim. Below are examples of some of the more common calculations used in the coordination of benefits. However, due to the differences in COB policies and rules for other Blue Cross and Blue Shield carriers, an example cannot be provided for all instances.

Therefore, when in doubt, bill the member the amount indicated in Member Liability on the remittance advice. If there is an error in payment, the member's Home Plan will initiate any necessary adjustments. The following examples should assist providers in determining patient liability on claims.

Example 1: Charges Discount Paid Payment

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

Providers bills patient is \$201.17

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

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

Example 2: Charges Allowed Discount Coinsurance Payment

Total Charges = \$ 1190.85
 Less Blue Cross discount = (\$ 538.48)
Less payment on Remittance Advice = (\$ 489.29)
 Difference is coinsurance = \$ 163.08

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

Example 3: Charges Discount Paid Payment

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

No payment was made on this claim to subtract. Providers will need to bill the patient for \$31.16.

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

Example 4: Charges Discount Paid Payment

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

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

This article was previously published in the June 2009 and June 2011 issues of *Providers' News*.



PPACA provider agreement requirements

The Patient Protection and Affordable Care Act (ACA) requires additional language be included in the agreements between its Qualified Health Plans (those providing benefits per the ACA) and its participating providers. [Therefore, the following is considered an amendment to all of the USABLE Corporation True Blue PPO network agreements.](#)

Qualified Health Plan Regulatory Addendum

This Addendum is entered into effective this 1st day of January, 2016 (the Effective Date”) by and between all currently contracted participating providers and USABLE Corporation.

WHEREAS, USABLE Mutual Insurance Company d/b/a Arkansas Blue Cross and Blue Shield (“ABCBS”) is a Qualified Health Plan (QHP) as that term is defined by the Patient Protection and Affordable Care Act (ACA); and

WHEREAS, the Secretary of Health and Human Services (HHS) requires that all QHP Issuers maintain responsibility for compliance of any of its delegated or downstream entities (DEs) with certain applicable standards; and

WHEREAS, Provider has executed a Provider Participation Agreement with USABLE Corporation the provisions of which are hereby incorporated herein by reference as if set forth word for word herein (the Provider Contract) and, as such, Provider is a member of the USABLE Corporation True Blue PPO Provider Network;

WHEREAS, Provider delivers health care services to ABCBS members in exchange for reimbursement and, as such, is a DE of ABCBS; and

WHEREAS, the purpose of this Addendum is to insure that Provider is contractually obligated to comply with all applicable standards as set forth in the ACA and its regulations:

NOW THEREFORE, for and in consideration of the mutual promises and obligations as set forth herein, the receipt and sufficiency of which are hereby acknowledged, ABCBS and Provider agree as follows:

1. DELEGATION OF ACTIVITIES.

ABCBS hereby delegates the following activities to Provider:

Health care services to ABCBS members with reporting as outlined in the True Blue PPO Participating Provider Agreement.

(Continued on page 14)



2. RIGHT OF REVOCATION.

CMS and the QHP reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the QHP determines that such parties have not performed satisfactorily.

3. MONITORING.

The QHP will monitor the credentials of Providers affiliated with it by reviewing the credentials of Provider directly and approving or denying Provider participation in its network based on such review. The QHP will audit its credentialing process on an ongoing basis.

4. CONFIDENTIALITY.

Provider shall comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

5. COMPLIANCE WITH LAWS AND REGULATIONS.

Provider and any related entity, contractor or subcontractor shall comply with all applicable Medicare laws, regulations, and CMS instructions.

6. RIGHT TO AUDIT.

HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with ABCBS, the QHP through 10 years from the final date of the final contract period of the contract entered into between CMS and the QHP or from the date of completion of any audit, whichever is later.

7. ORDER OF PRECEDENCE.

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.



Telemedicine coverage policy to take effect 1/1/2016

Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries has had a pilot telemedicine policy in place since April 2014. Effective January 1, 2016, a new policy will take effect. With few exceptions, services covered in a face-to-face setting will be covered when performed via telemedicine. Please refer to coverage policy 2015034 for details, as there are a number of specific requirements for reimbursement. Telemedicine reimbursement requires that the provider have a professional relationship with the member, and that the member be physically present in a credentialed facility or office.

There are requirements regarding documentation and the network used for data transmission. **The telemedicine provider at both the originating and at the distant site **must attest** they meet all requirements of the new policy and that they have read and understand the coverage policy to be eligible for reimbursement.**

The attestation may be accessed at the following link: arkansasbluecross.com/doclib/documents/providers/telemed_attestation111815.pdf. It is located in the "Forms" section of the "Doctors and Hospitals" resources on the website. The completed and signed attestation may be returned via email as an attachment to: ProviderNetwork@arkbluecross.com.

The professional service allowable for telemedicine is equivalent to the allowable for the same service when done face-to-face, and this service should be billed with a -GT modifier in the first modifier position. The originating site (where the patient is located) should bill Q3014 for the same date of service. The allowable for Q3014 is \$32.50.

HOME

LOOKING FOR INSURANCE ▾

MEMBERS ▾

DOCTORS AND HOSPITALS ▾



FORMS



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PLEASE NOTE

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

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