PROVIDERS' NEWS

JUNE 2016

A publication for participating providers and their office staffs

INSIDE

REMINDER

Update your information

Arkansas Blue Cross and Blue Shield requires providers to update information when a change in address or data occurs. Up-to-date provider information ensures timely delivery of notifications, communication to providers, and an accurate directory. Centers for Medicare and Medicaid Services requires correct provider information when auditing program directories.

If you are not receiving correspondence from Arkansas Blue Cross, your correspondence may require updating. To report changes, please access the **Provider Change of Data Form** on our website at http://www.arkansasbluecross.com/doclib/forms/providers/110_prov_cod_4-28-2008.pdf.

Additional information is available on page two.

Have you moved? Expanded your staff or services?

Let us know so we can update our provider directory to accurately refer members to you and ensure payments arrive in a timely fashion.

Please visit **arkbluecross.com/providers/forms.aspx** to download a Provider Change of Data Form.

Mail or **fax** the completed form with supporting documents to:

Provider Enrollment
PO Box 2181
Little Rock, AR 72203

Fax: 501-378-2465

Please note:

- Completing this form does not create any network participation.
- If payment to a clinic or group is required, please complete an Authorization for Clinic Billing form.
- Practitioners wishing to use an Employer Identification Number (EIN) for payment must submit verification of EIN (Letter 147C, CP 575 E, or tax coupon 8109-C).

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MPI 5241 6/16

Taxonomy code requirement update

Over the years, a provider's taxonomy code has become more important in the payer industry. Healthcare Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers. Most providers developed awareness of the taxonomy codes through the requirement to obtain their national provider identifier ("NPI"). The National Plan and Provider Enumerator System ("NPPES") required providers to self- report and enter this 10 digit expanded specialty code when obtaining their NPI.

Many medical providers were likely, not very concerned with the self-reported taxonomy code and even less likely to have given their taxonomy a second thought since obtaining their NPI.

Arkansas Blue Cross and Blue Shield, its affiliates, and subsidiaries have at least two purposes for taxonomy codes requiring accuracy on the NPPES' record.

First, the Arkansas Insurance Department ("AID") will now be using a provider's taxonomy code to assist in determining the network adequacy of the payers involved in the Health Insurance Marketplace/ Exchange. In conjunction with the information being sent to the AID from the payers, the AID will utilize the taxonomy code attached to a provider's NPI that is on file at the NPPES. If a provider's taxonomy has changed or a provider believes his/her taxonomy codes need to be more specific, the provider should go to the NPPES and revise the taxonomy code.

Second, Arkansas Blue Cross will begin using a provider's taxonomy code that each Blues Plan has on file when processing claims in the Blue Card Program. Claims adjudication may be affected by the taxonomy code, as it is today with provider specialty codes. Arkansas Blue Cross has the taxonomy information providers submitted on their respective NPI notification from NPPES. We will continue to use taxonomy information on file within our provider data systems instead of any taxonomy information submitted on a claim record.

If your NPI needs to be revised, please do so through the NPPES. Next, send the NPPES information with the revisions and any taxonomy changes to Arkansas Blue Cross Blue Shield Provider Network Operations via providernetwork@arkansasbluecross.com.

A few of the many reasons a taxonomy code needs to be revised:

1. A physician might have completed an additional fellowship.
2. A Certified Nurse Practitioner may have started collaborating with a specialist and is no longer in the primary arena.
3. A facility may have built a new wing for additional services.

Please update any necessary information to ensure correct benefit adjudication, and Arkansas Blue Cross Blue Shield can accurately determine network adequacy.

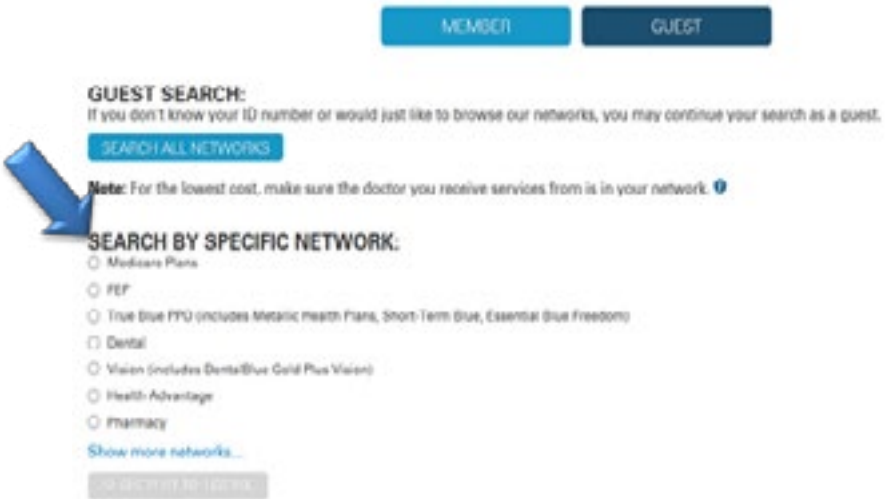
This article was previously published in the December 2015 and March 2016 issues of Providers' News.

In-network laboratory reminder

Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators and Health Advantage requires contracted providers to use participating laboratories for payment of allowable services.

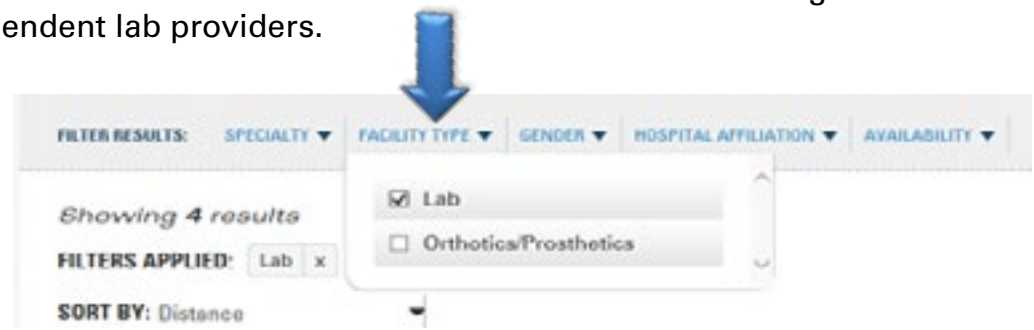
- To ensure the lab is in-network, complete a provider search at arkansasbluecross.com.

- Select the network.



- Enter the search location by city, state or zip code and "lab" for the search option.

- Select filter result "Lab" under the "FACILITY TYPE" heading to narrow the search to independent lab providers.



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In-network laboratory reminder (Continued from page 4)

In-network laboratories include:

- American Esoteric Laboratories
- AmeriPath Texas LP
- Arkansas Department of Health Public Health Lab
- Boyce & Bynum Pathology Lab
- Clinical Pathology Laboratories
- Consolidated Dermpath Inc.
- Dianon Systems
- DVA Laboratory Services Inc.
- Esoterix Genetic Laboratories LLC
- Gamma Healthcare Inc.
- Genoptix Medical Laboratory
- Laboratory Corporation of America
- Litholink Corporation
- Medical Laboratories of Arkansas
- Medtox Laboratories Inc.
- Micro Diagnostic Laboratories
- Monogram Biosciences Inc.
- Myeloma Health LLC
- Natera Inc
- Neogenomics Laboratories Inc.
- Pathgroup Labs LLC
- Physicians Laboratory of America
- Quest Diagnostics
- Total Renal Laboratories
- US Labs

If an out-of-network lab is used, members are financially responsible for all remaining balances of non-covered services.

Out-of-network labs commonly used by providers include:

- Ameritox
- Ambry
- Boston Heart Diagnostic
- Bostwick Labs
- Clinical Reference Laboratory
- Foundation Medicine
- Medical Diagnostic Laboratories
- Oxford Labs
- Phenopath
- Prometheus
- Veracyte

Guidelines for chromosomal microarray analysis of fetal tissue

Meets primary coverage criteria or is covered for contracts without primary coverage criteria

Chromosomal microarray analysis of fetal tissue meets member benefit certificate primary coverage criteria for the evaluation of pregnancy loss in patients with indications for genetic analysis of the embryo or fetus:

- in cases of pregnancy loss at 20 weeks of gestation or earlier; OR
- when there is a maternal history of recurrent miscarriage (defined as a history of two or more failed pregnancies).

Does not meet primary coverage criteria or is investigational for contracts without primary coverage criteria

Chromosomal microarray analysis of fetal tissue for the evaluation of pregnancy loss for any other reason than those indications listed above as covered, does not meet member benefit certificate primary coverage criteria. For members with contracts without primary coverage criteria, chromosomal microarray analysis of fetal tissue for the evaluation of pregnancy loss for any other reason than those indications listed above as covered is investigational. Investigational services are specific contract exclusions in most member benefit certificates of coverage.

Mepolizumab (Nucala) prior authorization

The Mepolizumab Coverage Policy # 2016010 lists coverage criteria for use to treat severe persistent asthma (as defined below by American Thoracic Society)* as an add-on maintenance treatment of patients > 12 y/o with an eosinophilic phenotype. The FDA recommends this drug not be used for other eosinophilic diseases). Arkansas Blue Cross and Blue Shield requires prior authorization be obtained for this drug prior to initial administration and concurrent authorization as specified for those members previously approved. This request must contain medical record documentation verifying coverage criteria are met.

1. Symptoms are inadequately controlled with use of either combination therapy: 12 months of high-dose inhaled corticosteroid (ICS) given in combination with a minimum of three months of controller medication (either a long-acting beta2-agonist [LABA], or leukotriene receptor antagonist [LTRA], or theophylline), unless the individual is intolerant of, or has a medical contraindication to, these agents; OR
2. Six months of ICS with daily oral glucocorticoids given in combination with a minimum of three months of controller medication (either a LABA, or LTRA, or theophylline), unless the individual is intolerant of, or has a medical contraindication to, these agents; AND
3. Independent of other therapies, in patients with atopic severe asthma, who have a serum IgE level of 30 to 700 IU/mL and documented sensitivity to a perennial allergen, the patient must first have either failed or is intolerant of omalizumab for a minimum of four months. [If asthma control does not improve after a reasonable trial, omalizumab should be discontinued]. AND
4. Has one of the following blood eosinophil counts (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection):
   - Greater than or equal to 150 cells/microliter at initiation of therapy; OR
   - Greater than or equal to 300 cells/microliter in the prior 12 months; AND
5. Evidence of asthma as demonstrated by both of the following:
   - A pretreatment forced expiratory volume in 1 second (FEV1) less than 80% predicted; AND
   - FEV1 reversibility of at least 12% and 200 milliliters (ml) after albuterol (salbutamol) administration. AND
6. Patient has a history of two or more exacerbations in the previous year, requiring bursts of systemic steroids and commonly requiring urgent care visits, ER visits and/or hospitalizations, despite regular use of high-dose inhaled corticosteroids (such as those listed in the table under "Policy Guidelines" section), plus at least one additional controller (such as long-acting beta agonists (LABAs) salmeterol or formoterol.

Initial treatment requests may be approved for 12 months at a time.

Continuation of therapy with mepolizumab after 12 months must demonstrate the following in submitted medical records:

Treatment with mepolizumab has resulted in clinical improvement as documented by

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one or more of the following:

- Decreased utilization of rescue medications; OR
- Decreased frequency of exacerbations (defined as worsening of asthma that requires an increase in ICS dose or treatment with systemic corticosteroids).

European Respiratory Society/American Thoracic Society definition of severe asthma for patients aged ≥ 6 years*

The definition of severe asthma requires that one or both of the following levels of treatment for the previous year has been needed to prevent asthma from becoming uncontrolled, or asthma that remains uncontrolled despite this level of treatment:

- Treatment with guidelines suggested medications for GINA steps 4-5 asthma (high dose inhaled glucocorticoid and long-acting beta agonist [LABA] or leukotriene modifier/theophylline) for the previous year
- Treatment with systemic glucocorticoid for ≥50% of the year

Uncontrolled asthma is defined as at least one of the following:

- Poor symptom control: ACQ (Asthma Control Questionnaire) consistently >1.5, ACT (Asthma Control Test) <20 (or "not well controlled" by NAEPP/GINA guidelines)
- Frequent severe exacerbations: two or more bursts of systemic glucocorticoids (more than three days each) in the previous year
- History of serious exacerbation: at least one hospitalization, intensive care unit stay, or mechanical ventilation in the previous year
- Airflow limitation: after appropriate bronchodilator withhold FEV1 <80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal)

The ERS/ATS definition of high doses of various inhaled glucocorticoids in relation to patient age (in mcg/day):

Age 6 to 12 years

Beclomethasone > or = 320 (HFA MDI)
Budesonide > or = 800 (MDI or DPI); (> or = 720 mcg/day of US labeled budesonide DPI)
Ciclesonide > or =160 (HFA MDI)
Fluticasone propionate > or = 500 (HFA MDI or DPI); (> or = 440 mcg/day of US labeled fluticasone HFA MDI)
Mometasone > or = 500 (DPI); (> or = 550 mcg/day of US labeled mometasone DPI)

Age >12 years

Beclomethasone > or = 1000 (HFA MDI)
Budesonide > or = 1600 (MDI or DPI) ;(> or = 1440 mcg/day of US labeled budesonide DPI)
Ciclesonide > or = 320 (HFA MDI)
Fluticasone propionate > or = 1000 (HFA MDI or DPI); (> or = 880 mcg/day of US labeled fluticasone HFA MDI)
Mometasone > or = 800 (DPI); (> or = 880 mcg/day of US labeled mometasone DPI)

Note: Designation of high doses is provided from manufacturers' recommendations where possible. Equivalent high doses may be expressed differently between countries and some products (e.g., beclomethasone) are available in multiple formulations with different dosing recommendations. Medication inserts should be carefully reviewed by the clinician for the equivalent high daily dosage.

Mepolizumab for the treatment of other allergic conditions or any other condition is not covered.

Prior authorization requests with all necessary documentation may be faxed to 1-501-378-6647.

New claims editing software – Claims Xten

Arkansas Blue Cross and Blue Shield will be implementing a new claims editing software, Claims Xten (CXT), during September and October.

Claims Xten is designed to:

- Evaluate billing information and coding accuracy on submitted claims
- Reduce wasteful medical cost
- Increase auto-adjudication rates
- Decrease appeals, rework, and rule creation/maintenance
- Set the foundation to handle new payment methods
- Automate administrative procedures, correct coding and data validation
- Allow for more robust use of history in editing

With a strong clinical foundation, CXT is guided by the coding criteria and protocols in the CPT Manual that are published by the American Medical Association, National Correct Coding Initiative (NCCI), Specialty Society guidelines and industry standards and reflects Arkansas Blue Cross' medical policies. It also incorporates code editing rules based on the HCPCS coding system. CXT will introduce additional automation to aid in the proper editing of claims. This will help evaluate claims for coding accuracy. Claims that are coded inappropriately will continue to be denied as incorrect coding. As with the current claims editing product, not every claim adjudication can be automated; many will continue to require manual review.

CXT is designed to spot irregularities, such as unbundling, mutually exclusive procedures and integral procedures. The software evaluates the coding accuracy of the procedure(s), not the medical necessity of the procedure(s). The types of services that will be evaluated include, but are not limited to:

- Policies based on the CPT manual
- Policies based on healthcare coding standards
- Multiple procedures performed on the same day
- Appropriateness of assistants at surgery
- The proper use of modifiers

Arkansas Blue Cross has always performed this type of review, and this software will allow us to do so in a much more consistent and efficient way. Claims will process with more consistency and accuracy. CXT is essential for keeping pace with the complex developments in medical technology and the increasingly more specific coding required today.

As claims are edited, the software may create additional lines for the claim if warranted. Please note that the NCCI will be used in CXT and these edits will fire before medical policy edits. This may result in some differences in payment from what you receive today. A revised, but similar, Clear Claim Connection tool will be available for entry of claims scenarios.

Allergen specific IgE In Vitro testing

Coverage policy 1997188: Allergen Specific IgE In Vitro Testing has been updated.

If there is a contraindication to skin testing, up to 25 screening allergen specific in vitro IgE tests meet primary coverage criteria for effectiveness and are covered only for the evaluation of rhinitis (not related to foods or preservatives), extrinsic asthma, extrinsic allergic alveolitis, pulmonary eosinophilia, atopic dermatitis, urticaria or anaphylactic shock due to adverse food reactions, venom or serum. Even then, they are covered only when certain conditions prevent the performance, or adversely affect the interpretation, of skin tests.

Those conditions are:

- Erratic wheezing
- Hyperreactive skin
- Urticaria
- Dermatographism
- Severe eczema
- Food anaphylaxis
- Allergy to latex
- Patient non-cooperative or refuses skin testing
- Patient taking pharmacological drugs that interfere with the interpretation of skin tests and the drugs cannot be discontinued (i.e., antihistamines, tricyclic antidepressants or beta blockers)
- Children under 4 years old

Medical record documentation must state which of the above conditions precludes skin testing.

If the above conditions are present, up to 25 screening allergen specific in vitro IgE tests will be covered. If one or more of these is unequivocally positive, up to 15 additional tests may be covered. A maximum number of 40 tests will be allowed.

A copy of the positive screening allergen specific in vitro IgE test is the only documentation needed with the claim for coverage of the additional 15 tests.

This article was previously published in the March 2016 issue of Providers' News.

PCSK9 Inhibitors not covered under medical benefit

The use of PCSK9 inhibitors evolocumab (Repatha) and alirocumab (Praluent) is addressed under the Arkansas Blue Cross and Blue Shield Pharmacy Benefit. Per coverage policy 2016011, the use of evolocumab and alirocumab are not covered under the medical benefit. Claims submitted for reimbursement for the administration of either of these drugs in a physician's office will be denied.

Benefit changes for cervical cancer screenings

In 2013, the U.S. Preventive Services Task Force (USPSTF) determined there was no evidence indicating that healthy women needed to be screened annually for cervical cancer. This change is supported by a broad coalition of medical specialty societies, including the American Cancer Society, the American College of Physicians and the American Congress of Obstetrics and Gynecology.

Effective January 2016, these recommendations replaced cervical screening guidelines for all members of Arkansas Blue Cross and Blue Shield and its family of companies, unless noted below.

Cervical Screening Policy Effective January 1, 2016	
Age	Recommendation/Benefit
Under 21	No screening
21-65	Pap test every three years
OR	
30-65	Pap test and co-testing for HPV every five years
65 and older	No screening
A Pap test is not necessary for women who have had a hysterectomy with removal of cervix for a benign disease.	

Exceptions

These recommendations do not apply to women who:

- Are at high risk for cervical cancer because they:
  1. Have had in-utero exposure to diethylstilbestrol (DES)
  2. Are immunocompromised (such as those who are HIV positive)
- Are being followed for an abnormality on a Pap test.

In these situations the test would be considered diagnostic and would not be covered under preventive services.

How does this change affect coverage?

Our medical policy regarding these screenings changed on January 1, 2016, and our coverage will change on January 1, 2017.

If a woman is between the ages of 21-65 and received a Pap test as a screening service in 2016, she will not have 100 percent preventive coverage of another screening until three years from the date of her last screening. If a doctor thinks a test is needed for health reasons, it will be covered as a diagnostic test (not a screening), which may require a copayment. If she had a Pap test last year, and an HPV test, she will not have coverage for screening purposes for five years from the date of her last screening.

Many doctors began switching patients to this schedule in 2013 when the recommendation was announced by the USPSTF. Arkansas Blue Cross reviewed the information from the USPSTF thoroughly before determining that our medical policy should reflect the recommendation.

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As we transition to an electronic communications platform, we invite you to email us at **ProvidersNews@arkbluecross.com**.

Please include:
PROVIDER NAME
NPI
EMAIL ADDRESSES FOR ADDITIONAL STAFF TO RECEIVE A COPY

If you have previously provided a correspondence email address for credentialing, that address will remain primary unless a change of data form is received.

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Changes in radiology codes for chiropractors

The 2016 AMA CPT Manual has deleted several radiology codes. Those codes cannot be used on any claims submitted in 2016 and forward dates of service.

New 2016 CPT codes have been added to replace many of these old codes. The new codes that are eligible for reimbursement for chiropractors by Arkansas Blue Cross include: 72081, 72082, 72083, 72084, 73501, 73502, 73503, 73521, 73522, 73523, 73551, and 73552.

TrOOP reminder for metallic medical policies

When viewing benefits for metallic medical policies on AHIN, please remember when true out of pocket (TrOOP) is met, the patient responsibility for allowed charges is also satisfied. Since medical and pharmacy copayments, deductibles and coinsurance are all included in the TrOOP, it is possible for your patient to have their out of pocket met before the deductible is satisfied. A satisfied TrOOP will always supersede the deductible requirements.

Improving FEP HEDIS scores through prenatal care

In an effort to improve our HEDIS scores, the Federal Employee Plan is incentivizing expectant mothers to see their healthcare providers within the first three months of pregnancy. Please assist us in this effort by completing and returning the form in a timely manner. A copy of the form is available on page two of this newsletter or by visiting fepblue.org/maternity.

FEP 2016 benefit change for digital breast tomosynthesis as a preventive screening

Digital breast tomosynthesis (DBT) is an additional mammogram screening tool that offers a 3D image of the breast. Today, FEP provides medical/diagnostic benefits for DBT when the procedure is medically necessary. DBT is represented by CPT codes 77061, 77062, or 77063, and HCPCS code G0279.

Recent negotiations with the Office of Personnel Management have been approved to provide preventive benefits for DBT services, retroactive to January 1, 2016, in order to improve access to this breast cancer screening technology. DBT services will be included as a preventive benefit effective January 1, 2016, limited to one breast cancer screening service per benefit year. This benefit change is effective with claims processed July 16, 2016.

BlueCross BlueShield
Federal Employee Program

Pregnancy Care Incentive Program

An important step in your pregnancy:

See your healthcare provider during the first three months and earn $75

Member:

This cover sheet outlines the medical record information your doctor will need to provide in order to verify your first trimester visit.

Step 1: Take this sheet to your doctor. Ask your doctor's office to provide a copy of your medical record* with the required information outlined below and have them submit it to us by fax or mail.

Note: Your doctor may charge fees for providing, mailing, or faxing your medical record.

If your doctor is unable to submit your medical record, you can submit your record yourself. Please see our website for details.

Step 2: Once your doctor visit is verified, you'll **receive $75 on your MyBlue® Wellness Card.**

Physician:

Please send this form and a signed medical record* verifying the patient's first trimester exam. Please send one form per patient and make sure the following information is included:

- Patient Name
- Patient Date of Birth
- Date of First Visit
- Provider Name
- Provider Address
- Provider Signature
- Patient Expected Date of Delivery or Last Menstrual Period

Member Name: **Transaction ID:**

Fax this form to:
1-877-760-7083

FROM:

FAX:

Mail this form to:
BCBS FEP Pregnancy Care Incentive Program
P.O. Box 540606
Waltham, MA 02454

Note: Health information could be exposed if mailed or faxed to the wrong location

For more information, visit **www.fepblue.org/maternity**

*Accepted types of medical records include a prenatal flow sheet, prenatal progress/visit notes and electronic medical record.

A letter, disability statement or prescription note from your healthcare provider does not meet the program requirements for earning $75 on your MyBlue Wellness Card.

Updated list of ASE/PSE specialty drugs requiring prior authorization and exclusions

September 1, 2014, prior authorization became a requirement for specialty drugs covered under medical. Periodically the list will be updated with additional specialty drugs that are excluded and those requiring prior authorization. If a prior authorization is not obtained, the service will be denied without member responsibility. For prior authorization on medications obtained from the pharmacy or administered in the physician's office, please contact EBRx at 866-564-8258.

The updated list of excluded drugs and those requiring prior authorization is available at https://secure.ahin-net.com/ahin/logon.jsp.

ASE/PSE – anesthesia for screening colonoscopy

Effective June 1, 2016, the ASE/PSE plan will cover general anesthesia for screening colonoscopy as preventive. Prior dates of service will continue to deny general anesthesia for screening colonoscopy pending appeal and medical review.

2016 Retrospective chart review project

Arkansas Blue Cross and Blue Shield and ChangeHealth, previously known as Altegra Health, are working together to assist in validating member diagnoses according to the Centers for Medicaid and Medicare Service (CMS) guidelines, as part of our annual retrospective chart review. Specifically, Medicare Advantage plans are required to ensure member diagnoses are documented appropriately and according to CMS defined guidelines and supported with valid documentation in the member's medical record. A representative of ChangeHealth will be contacting your office to coordinate/schedule medical record retrieval for our Medi-Pak® Advantage members. Please review the "Right to Access and Audit" clause in the provider contractual agreement to become familiar with your responsibility to make member records available to Arkansas Blue Cross (or its designated representative upon request). Thank you in advance for your assistance. Should you have any questions or concerns, please contact Natasha Minnie, Arkansas Blue Cross clinical quality informatics analyst, at 501-378-2338 or at nbminnie@arkbluecross.com.

Documentation is key when coding morbid obesity

With increasing numbers of our population suffering from obesity, it's crucial for physicians to recognize severity of weight and the degree to which obesity, and its ever-present complications, negatively impacts health.

"Overweight," "obesity" and "morbid obesity" are distinct diagnoses that should be properly documented.

The Centers for Medicare & Medicaid Services includes morbid obesity (ICD-10-CM code E66.01) and its associated body mass index values (40 and above, ICD-10-CM code range; Z68.41-Z68.45) in its ICD-10 hierarchical condition categories for calendar year 2016. This inclusion substantially impacts the way providers should document the condition. From a coding perspective, documentation indicating morbid obesity in the medical record makes it easy to assign code E66.01 with an associated Z-code. A problem arises when only "obesity" is noted in the medical record, but evidence indicates that the patient is morbidly obese.

Who is morbidly obese?

- Patients with a BMI greater than 35 who are seen with co-morbid conditions, such as osteoarthritis, sleep apnea, diabetes, coronary artery disease, hypertension, hyperlipidemia and/or gastroesophaegeal reflux disease.
- Patients with a BMI equal to or above 40.

"Obesity is a serious concern in Arkansas, and the BMI value becomes an important factor in identifying and treating this serious condition," says Dr. Creshelle Nash, Arkansas Blue Cross medical director. "All clinical complications should be evaluated and treated when assessing morbid obesity. Accurately and consistently addressing, documenting and coding member diagnosis assists in identifying appropriate disease and care management programs, thereby increasing the quality of care for patients." Additionally, we can better partner with providers and care managers to ensure patients have access to education, programs and additional interventions that can impact the total health of the patient.

Documentation is the key to coding morbid obesity. As our partners, coders must review the medical record thoroughly when only obesity is documented with a BMI of 40 or above with co-morbid conditions affecting the patient's overall health. To ensure the member's record is accurate, a code for the BMI (the same HCC as morbid obesity) should be used to support morbid obesity.

Medicare Advantage annual compliance training requirements

Arkansas Blue Cross and Blue Shield is required to develop and maintain a compliance program as a contractor with the Centers for Medicare & Medicaid Services (CMS) and a 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). The compliance program requires ensuring 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 when there is a direct contract for Medicare/ACA Services between Arkansas Blue Cross and each provider. The Office of Inspector General (OIG) has issued guidance with reference to "effective compliance programs" for specific healthcare providers. The guidance is available at oig.hhs.gov/fraud/complianceguidance.asp.

As a CMS Plan Sponsor, Arkansas Blue Cross and Blue Shield must ensure that our FDRs/DEs receive general compliance training as well as fraud, waste, and abuse (FWA) training. FDRs deemed to have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS are NOT exempt from the general compliance training requirement.

Methods for Completing the Training

Guidance states that FDRs/DEs have three (3) options ensuring that general compliance training requirement is satisfied:

1. FDRs/DEs can complete the general compliance and/or FWA training modules located on the CMS MLN. Once an individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be accepted by Plan Sponsors.
2. Sponsors and FDRs/DEs can download and incorporate the content of the CMS standardized training modules from the CMS website into their organizations' existing compliance training materials/systems.
3. Sponsors and FDRs/DEs can incorporate the content of the CMS training modules into written documents for providers (e.g. Provider Guides, Participation Manuals, Business Associate Agreements, etc.).

To ensure this requirement is met and to largely reduce the duplicative training required of FDRs/DEs by multiple organizations with whom you contract, CMS developed web-based compliance training. The CMS compliance training module contains general compliance and FWA training courses. Training courses are available on the CMS Medicare Learning Network® (MLN): http://www.cms.gov/MLNProducts. While the training does not qualify for continuing education credits through CMS, the contact hours are included on the certificate of completion. This training provides separate content for compliance and FWA, and is available through web-based or downloadable versions for the learner. The

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training content is generic since various entities (e.g., health plans, labs, hospitals, etc.) complete the training. A certificate of completion is generated upon passing a short test with a score of 70% or higher at the end of the training module.

Who must complete the training?
Annual compliance training should be completed by the provider, the provider's staff who have contact (indirect or direct including billing, receptionist, lab, and clinical staff) with Medicare beneficiaries and ACA members.

What do we do with our training records?
All training documents, including a copy of the training materials and training logs, must be retained by your organization for 10 years, in accordance with CMS/HHS record retention guidelines. *No documentation should be returned to Arkansas Blue Cross at this time.* However, Arkansas Blue Cross is developing an attestation that will be administered through AHIN, for a representative to attest that each FDR/DE has completed the appropriate general compliance and FWA training either through their organization or through the Medicare Learning Network® (MLN).

When should the training be completed?
The general compliance training must occur within 90 days of initial hiring and annually thereafter. The annual training can be completed any time between January 1 – December 31 of any given contract year. All documentation is subject to random audit by Arkansas Blue Cross or may be requested as part of a Compliance Program Audit by CMS/HHS or CMS/HHS designees.

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.

Arkansas Blue Cross and Blue Shield to use Matrix Medical Network© for In-Home Assessments

Arkansas Blue Cross and Blue Shield will continue to work with Matrix Medical Network, an independent company that conducts in-home assessments for eligible Arkansas Blue Cross Medi-Pak Advantage members. The health assessments are part of our members' coverage and completely voluntary. Licensed health care professionals from Matrix Medical Network provide the personalized in-home assessments. These assessments will include a medical history review, simple health screenings, such as blood pressure measurement, and documentation of any existing medical conditions. These assessments are not intended to replace the care our members receive from their physicians, in fact Matrix works directly with our members to assist in scheduling a follow up visit with the member's selected primary care provider. This type of outreach helps better support our members' overall health and your ongoing care, especially to those members who are homebound. It also provides documentation of any current medical condition, identifies member needs in the home, and helps to guide our care management programs.

We will share a copy of this assessment with you to support your patient care efforts. Please place a copy of this assessment in your patients' medical record.

If you have any questions, please do not hesitate to contact Natasha Minnie, Arkansas Blue Cross clinical quality informatics analyst, at 1-501-378-2338 or at nbminnie@arkbluecross.com.

Coverage policy manual updates

Since December 2015, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The next two pages of this newsletter highlights the additions and updates. To view entire policies, access the coverage policies located our website at arkansasbluecross.com.

(Continued on page 20)

Coverage polocy manual updates (Continued from page 19)

Policy#	Policy Description
1999022	Percutaneous Angioplasty, Stenting and Atherectomy of the Lower Extremity, Abdominal Aortic and Visceral Arteries
2001009	Glucose Monitoring, Continuous
2003002	Whole Gland Cryosurgical Ablation of Prostate Cancer
2008010	Certified Nurse Practitioners
2008013	Certified Nurse Midwives
2008014	Physician Assistants
2008015	Clinical Nurse Specialist
2009019	Sleep Apnea, Testing
2011003	Chemodenervation, Botulinum Toxin for the Treatment of Chronic Migraine Headache
2011021	Preventive Services for Non-Grandfathered (PPACA) Plans: Cervical Cancer Screening
2011024	Preventive Services for Non-Grandfathered (PPACA) Plans: Tobacco use, Screening, Counseling and Interventions
2011029	Preventive Services for Non-Grandfathered (PPACA) Plans: Dental Caries Prevention in Preschool Children
2011033	Preventive Services for Non-Grandfathered (PPACA) Plans: Visual Impairment Screening In Children
2011045	Preventive Services for Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening
2011063	Scleral Contact Lens, Gas Permeable
2011066	Preventive Services for Non-Grandfathered (PPACA) Plans: Overview
2012031	Preventive Services for Non-Grandfathered (PPACA) Plans: Well-Woman Visits for Adult Women
2012036	Preventive Services for Non-Grandfathered (PPACA) Plans: Anemia, Screening in Infants, Children and Adolescents

Coverage polocy manual updates (Continued from page 20)

Policy#	Policy Description
2012041	Preventive Services for Non-Grandfathered (PPACA) Plans: Pregnancy Screening, Sexually Active Females Without Contraception, Late Menses or Amenorrhea
2012055	Preventive Services for Non-Grandfathered (PPACA) Plans: Prevention of Falls in Community-Dwelling Older Adults
2013015	Treatment of Varicose Veins/Venous Insufficiency
2014003	Telemedicine Services-Pilot Policy
2014008	Infertility Services
2015001	Omalizumab (Xolair) for Chronic Urticaria
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients with Non-Small-Cell Lung Cancer
2015011	Vedolizumab (Entyvio) for Inflammatory Bowel Disease
2015012	Alcohol Injections for Treatment of Peripheral Neuromas
2015013	Genetic Test: Fanconi Anemia
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015015	Vagal Nerve Blocking Therapy for the Treatment of Obesity
2015016	Focal Treatments for Prostate Cancer
2015017	Genetic Test: Mutation Testing for Limb-Girdle Muscular Dystrophies
2015018	Electronic Brachytherapy for Nonmelanoma Skin Cancer
2015019	Vegf Inhibitors for the Treatment of Ocular Conditions (Bevacizumab) (Aflibercept) (Ranibizumab)
2015020	Genetic Test: Chek2 Mutations for Breast Cancer
2015021	Genetic Testing: Chek2 Mutations for Breast Cancer

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P.O. Box 2181
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PROVIDERS' NEWS STAFF

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Editor: Suzette Weast • 501-378-2002 • FAX 501-378-2464 • ProvidersNews@arkbluecross.com

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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