PROVIDERS' NEWS

March 2017

A publication for participating providers and their office staff

Arkansas Prescription Drug Monitoring Program

Any new provider coming into our Arkansas Blue Cross and Blue Shield networks must be registered with the Arkansas Prescription Drug Monitoring Program if that provider holds a DEA certificate for controlled-substances prescribing.

All current network providers have until **April 1, 2017,** to register. Under the law, a prescriber may designate someone in the facility, such as a nurse, to be that prescriber's delegate for checking the Prescription Drug Monitoring Program database, once that delegate has also registered.

When a prescriber checks the Prescription Drug Monitoring Program, they become aware of patient issues and can begin discussions leading to safer drug use, better pain management, and treatment for addictions, when appropriate.

Arkansas Blue Cross requires contracted providers in Arkansas to register and encourages use of the Arkansas Prescription Drug Monitoring Program.

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2017 spring provider workshops

Providers interested in attending one of the workshops listed below can now register on-line. If you have any additional questions regarding a workshop in your area, contact your Network Development Representative.

Central Region

Little Rock
Chenal Country Club
10 Chenal Club Blvd
Wednesday, May 3
(Choose AM **or** PM session)

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Afternoon session:
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Northeast Region

Jonesboro
St. Bernard's Medical Center
- Auditorium
505 E Washington Ave
Wednesday, May 10
(Choose AM **or** PM session)

Morning session:
Registration 8: 30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Afternoon session:
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Northwest Region

Mountain Home
Baxter Regional Medical Ctr
- Lagerborg Conference Ctr
624 Hospital Dr
Friday, May 12

Morning session:
Registration: 8:30 – 9:00 a.m.
Workshop: 9:00 – noon

Northwest Region

Springdale
Jones Center for Families
- Auditorium/Chapel
922 East Emma Ave
Thursday, May 18

Afternoon session:
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 4:30 p.m.

South Central Region

Hot Springs
National Park Comm College
- Martin Eisele Auditorium
101 College Dr
Thursday, May 11

Afternoon session:
Registration 1:15 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Southeast Region

Pine Bluff
Pine Bluff Country Club
1100 W 46th Ave
Tuesday, May 2

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Southwest Region

El Dorado
El Dorado Country Club
101 Shady Side Street
Tuesday, May 9

Afternoon session:
Registration 1:15 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Southwest Region

Texarkana
Texarkana Convention Center
2910 S. Cowhorn Creek Loop
Thursday, May 4

Afternoon session:
Registration 1:15 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

West Central Region

Fort Smith
Sparks Regional Medical Ctr
- Shuffield Center
1001 Towson Ave
Friday, May 19

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – noon

To register on-line, please choose from the following locations:

El Dorado: https://www.surveymonkey.com/r/SWREGIONELDORADO

Fort Smith: https://www.surveymonkey.com/r/abcbs2017-FtSmith

Hot Springs: https://www.surveymonkey.com/r/abcbs2017-southcentral

Jonesboro: jdbailey@arkbluecross.com

Little Rock: https://www.surveymonkey.com/r/abcbs2017-central

Mtn. Home: https://www.surveymonkey.com/r/abcbs2017-MtnHome

Pine Bluff: https://www.surveymonkey.com/r/SERegion2017

Springdale: https://www.surveymonkey.com/r/abcbs2017-Springdale

Texarkana: https://www.surveymonkey.com/r/SWRegiontexarkana

Arkansas Blue Cross and Blue Shield's Health Insurance Literacy Campaign helps to make things clearer

Do you wish your patients better understood their health insurance? We do.

Arkansas Blue Cross and Blue Shield believes that the more our members know, the better equipped they are to make decisions about their healthcare and partner with their doctors. That's why we started a health insurance literacy communications campaign that covers everything from basic terms like premium, deductible, copay and coinsurance to "what's covered by my plan?"

We are posting articles, videos, definitions and more through our social media channels (see below for links) and we'd welcome your assistance in telling your patients about it!

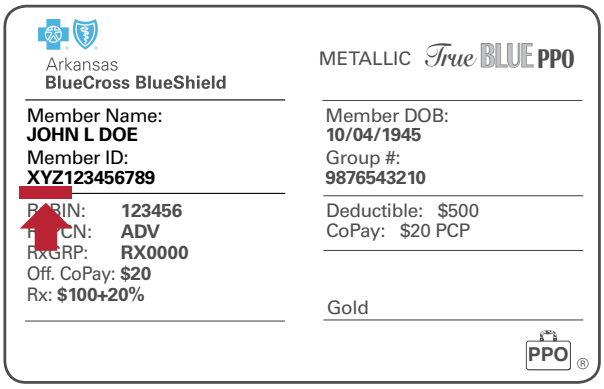
Our most recent video (link to https://youtu.be/gGFrNQQjGdE), "What's Covered on My Blueprint?" includes a step-by-step tutorial on how to access our members-only self-service website to learn more about copays, coinsurance, benefits documents, and coverage on common services.

Check us out at:
Facebook: @ArkansasBlueCross
Twitter: @ArkBlueCross
Instagram: @arkansasbluecross
YouTube: arkbluecross
LinkedIn: www.linkedin.com/company/arkansas-blue-cross-blue-shield

Alpha Numeric Prefixes coming in 2018

Background

The three-position alpha prefix of a Member's Identification Number (ID) is a foundational component of the BlueCard Program and Inter-Plan Teleprocessing Services (ITS). Although originally used primarily for claims routing, the functions/processes dependent on the alpha prefix have expanded along with the program.



Issue

With the potential for the current pool of alpha prefixes to run out as early as 2018, it is important to expand the pool and/or slow the rate of consumption.

Resolution

The Blue Cross and Blue Shield Association is changing the field from an alpha (only) prefix to an alpha numeric prefix. The move to an alpha numeric prefix solution increases the prefix pool and mitigates the risk of impacting the Plans business and new initiatives. The software update will be distributed in Release 17.5 which implements October 15, 2017, with utilization **effective on April 15, 2018**.

Action Needed

Arkansas Blue Cross and Blue Shield is currently assessing the impact of this system change. If any providers have hard-coded system edits that may be impacted by this change, **please contact your network development representative** as soon as possible.

Frequently Asked Questions

1. **Will the alpha numeric prefix still be three positions?**
   Yes, the change to alpha numeric allows us to keep the current three position prefix most are accustomed to.
2. **Will all positions of the prefix be allowed to be numeric?**
   No, a prefix cannot be all numeric. The system edits will be modified to allow for numeric positions.
3. **With the move to numeric, is there an impact to the Federal Employees Program (FEP)?**
   FEP ID numbers start with an R, which has been taken into consideration and will be accounted for in the requirements and design process.
4. **Are there any restrictions on the numeric character?**
   Yes, zero and one will not be used. The numeric characters will be two through nine.
5. **How many prefixes does a numeric position add to the overall prefix pool?**
   This would add about 30,000 prefix combinations.
6. **What order will the alpha numeric prefix be released?**
   There are six combinations that will be released once the current set is exhausted:

Additional Alpha Numeric Prefix Combinations					
A2A	2AA	22A	AA2	2A2	A22

Further investments in value-based care

Starting in July 2012, Arkansas Blue Cross, along with other payers, began developing and implementing new value-based payment methodologies with input from hundreds of healthcare providers, patients and their family members across the state. Since that time, Arkansas Blue Cross also participated in the Comprehensive Primary Care (CPC) initiative which ended December 31, 2016, and the CPC Plus (CPC+) initiative that launches this year.

These initiatives are available to many Blue Plan members. Through the national Blue Cross and Blue Shield system's value-based program delivery platform (VBPDP), Arkansas Blue Cross and Blue Shield shares member, claim and care coordination information that is essential to supporting, efficient and quality-driven healthcare for our members residing or receiving care in Arkansas, but who have their coverage with a Blue Plan located outside Arkansas. This system enables these members to be attributed to the Arkansas Blue Cross's value-based transformation programs in Arkansas.

Arkansas Blue Cross began using VBPDP in January 2016, and it has already provided a significant impact to Arkansas' value-based initiatives. Through September 2016, 62,174 of these Blue Plan members have been attributed to a participating Arkansas provider. These value-based programs include new payment methodologies such as care-coordination payments and shared savings arrangements. The goal is to support and reward providers who consistently deliver high-quality, coordinated and cost-effective care.

Healthcare delivery is rapidly changing, and a **renewed focus on delivering value** — a combination of cost and quality — is critical. With a deep local presence, unprecedented national scale and the largest provider networks in the industry, no one is better positioned—or more committed—to drive value than the Blue Cross and Blue Shield system. Arkansas Blue Cross and its healthcare provider partners are leading a national shift to value-based reimbursement. Value-based programs refer to a partnership with healthcare providers in which a portion of total provider reimbursement is based on efficiency (cost management) and improved outcomes (better quality). While variation exists across the country, the ever-growing value-based programs at Arkansas Blue Cross include: patient-centered medical homes (PCMHs), episode-based payment (EBP) models, and collaborative health initiatives.

If you have questions or would like more information on participation in these programs, please contact your Network Development Representative.

New Care Management Portal LIVE for primary care physicians

If you are a primary care physician with patients aligned to you through Arkansas Blue Cross and Blue Shield and our family of companies, you have access to a tool through the Advanced Health Information Network (AHIN) that can help you manage your patients' care.

Overview of the Care Management Portal (CMP)

The Care Management Portal (CMP) provides clinically relevant data on three levels:

- Summary data at the practice/provider level
- Patient-level detail
- Referral data on facilities and specialists

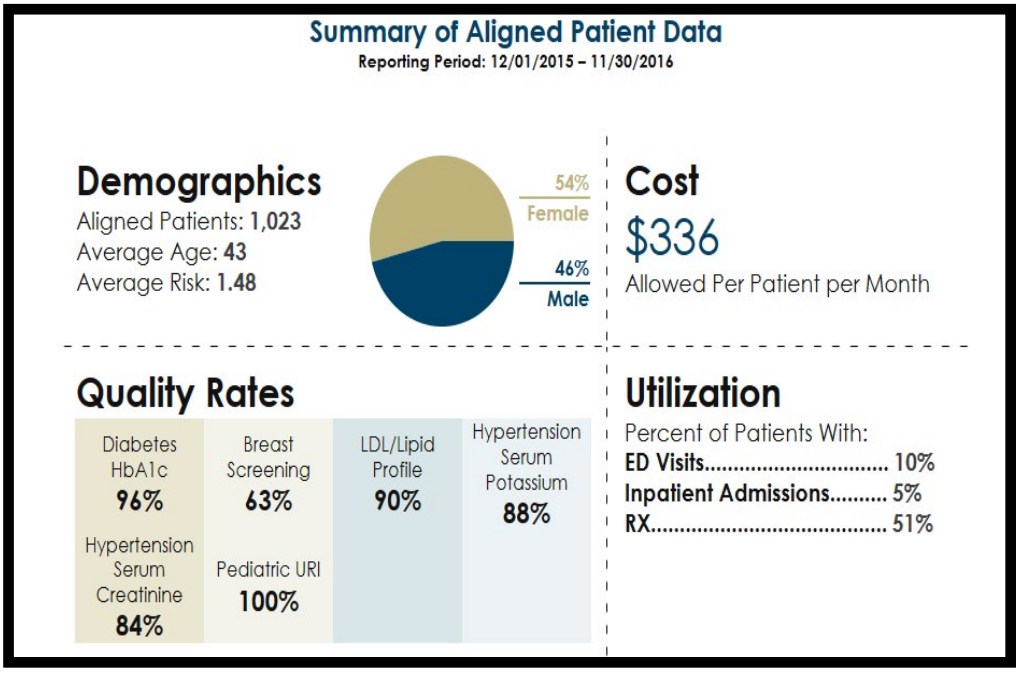
The CMP data is updated monthly and contains a rolling year's worth of information. Nurse practitioners and physician assistants in certain value-based programs with aligned patients also can access data on their patients through the CMP.

"The Care Management Portal is designed to assist primary care providers across the state in succeeding in value-based programs through the sharing of information," said David Greenwood, vice president of Enterprise Business Intelligence & Health Information Network. "We plan to continue to enhance the portal and will soon add new capabilities to AHIN to allow providers to satisfy program requirements electronically with the goal of reducing provider hassle and expense."

Objectives

The CMP can be used to help you manage your patients in a variety of ways. You can view a number of metrics concerning your aligned patients, such as:

- Care gaps
- Cost of care
- Emergency department visits
- Prescription utilization



Functions

The summary of aligned patient data screen includes your patient demographics, total cost of care per patient per month, quality rates and utilization.

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Care Management Portal now active (Continued from page 6)

A list of your aligned patients will be provided and you will have the ability to select a patient for additional information. On the patient detail screen, a "Find Patient" option allows you to search for an aligned patient using his/her first name, last name, date of birth or contract number.

The only patients displayed in the CMP are those aligned to you. That means the member did one of the following:

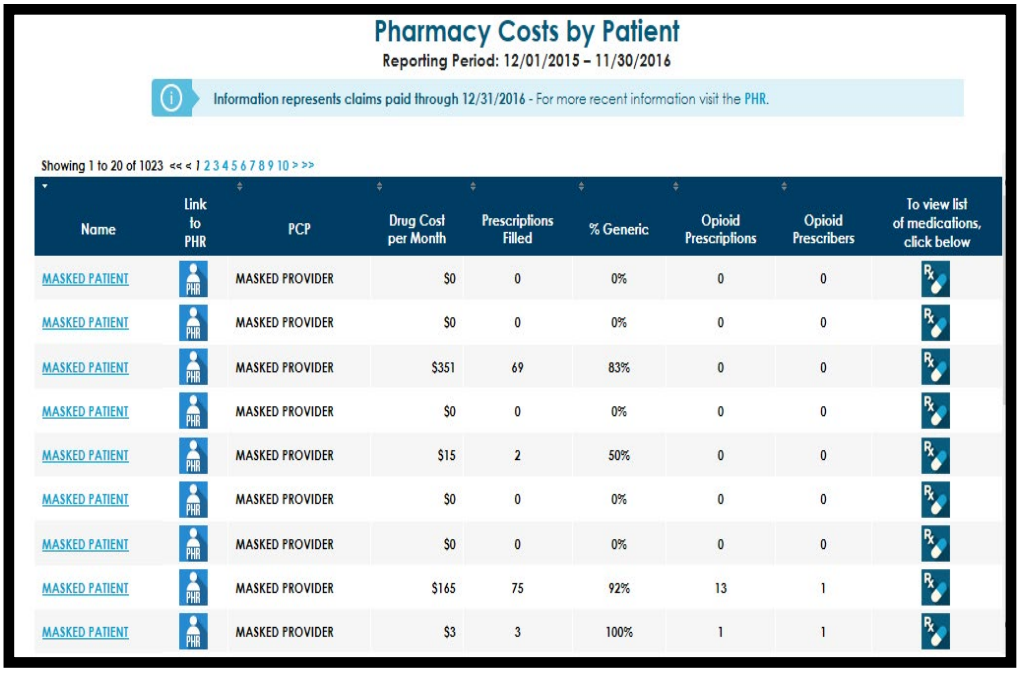
- Selected you through customer service
- Selected you through My Blueprint, our customer self-service web portal
- Had more office visits with you than any other PCP in the previous two years

Currently, Medi-Pak Advantage and Federal Employee Program patients are not included in the portal. However, A Medi-Pak Advantage portal will be available in spring 2017.

Quality metrics chosen are based on HEDIS national standards and collaboration between Arkansas Blue Cross and our provider partners.

The costs shown on the CMP include all costs incurred by your patients, regardless of which provider performed the service or where the service was performed. These costs are displayed in order to assist you in managing the total picture of your patients' care.

New information within the CMP enables practices to provide better patient care. For example, the portal provides patient-specific information to combat the prescription opioid epidemic.



Pharmacy Costs by Patient

Reporting Period: 12/01/2015 – 11/30/2016

Information represents claims paid through 12/31/2016 - For more recent information visit the PHR.

Showing 1 to 20 of 1023 << < 1 2 3 4 5 6 7 8 9 10 > >>

Name	Link to PHR	PCP	Drug Cost per Month	Prescriptions Filled	% Generic	Opioid Prescriptions	Opioid Prescribers	To view list of medications, click below
MASKED PATIENT	PHR	MASKED PROVIDER	$0	0	0%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$0	0	0%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$351	69	83%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$0	0	0%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$15	2	50%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$0	0	0%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$0	0	0%	0	0	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$165	75	92%	13	1	Rx
MASKED PATIENT	PHR	MASKED PROVIDER	$3	3	100%	1	1	Rx

The "Pharmacy Costs by Patient" screen identifies the number of opioid prescriptions filled by the patient. It also will identify the number of unique providers who prescribed opioids to the patient, which enables you to better understand the patient's patterns in obtaining opioid prescriptions.

Training on this valuable tool is underway. You can select to attend training online or in person in one of our regional offices. Several dates and times are available. If you have questions or would like to schedule training for you and your staff, please contact AHIN customer service at 501-378-2336 or call toll free, 855-822-AHIN.

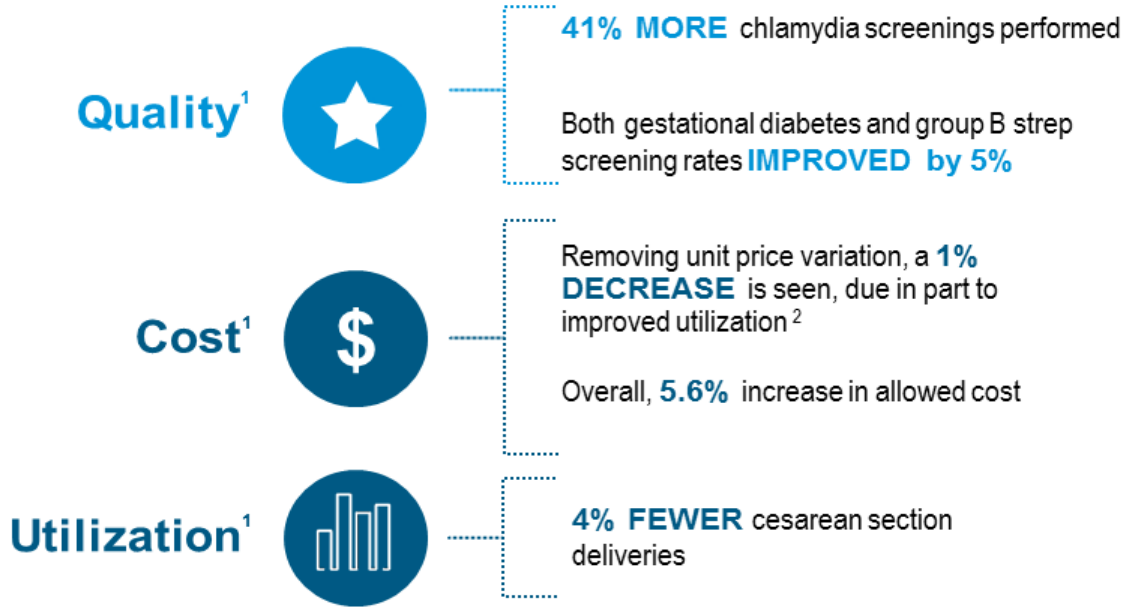
AHCPII episode of care celebrates success

Since its implementation in January 2013, Arkansas Blue Cross and Blue Shield's perinatal episode of care in the Arkansas Health Care Payment Improvement Initiative (AHCPII) has added great value to the healthcare system of our state.

The overall goals of this program are to improve the health of the population, improve patient experience, of care (quality and access) and to reduce, or at least control, the cost of healthcare. Simply, episode-based care delivery aims to reward coordinated, team-based care for a patient. This multi-payer initiative includes Arkansas Blue Cross, Arkansas Medicaid and QualChoice.

We're excited to share the results of a recent analysis of the program's impact since its implementation in 2013 through the 2015 final settlement data. By re-pricing each year's claims to the same allowed amount as the initial cost to remove outside factors from the program analysis, we discovered the following program successes.

Proven Results - Perinatal



[1]Comparision between the preparatory period (2012) to the 2015 final settlement ; [2]Each year's claims were re-priced to the same allowed amount as the initial cost to remove outside factors within the program analysis

In its third year of performance, the majority of perinatal principal accountable providers (PAPs) kept costs within or below the acceptable cost thresholds. Specifically, the 2015 annual settlement process identified a total of 121 PAPs that reached the Acceptable and Commendable levels in the perinatal episode of care model. Each of these physicians demonstrated a strong commitment to the AHCPII by controlling costs, and, in many cases, meeting the pre-defined quality metrics.

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AHCPII episode of care celebrates success (Continued from page 8)

Success in these programs couldn't be achieved without partnerships with the PAPs throughout the state. The 54 PAPs in the chart below reached the commendable level in cost and met all quality metrics in the 2015 performance period.

PAP	City	PAP	City
Phillip R Alston, MD	N. Little Rock	Margaret B Larrimer, MD	Hot Springs
John V Baka, MD	Benton	Debra C Lawrence, MD	Conway
John H Barrow, MD	Mountain Home	Lorna M Layton, MD	Jonesboro
Christie M Beck, MD	Little Rock	Dicey G Lee, MD	Little Rock
Dandra D Bingham, MD	Texarkana	Kristin L Markell, MD	Fayetteville
Gaylon L Brunson, MD	Little Rock	Stephen R Marks, MD	N. Little Rock
Mary J Burch, MD	Clarksville	Brandie M Martin, MD	Conway
Jerry A Burns, MD	Searcy	Paul McChristian, MD	Conway
Dominique M Butawan Ali, MD	Jonesboro	Renee P McGraw, MD	Hot Springs
Shannon L Case, MD	N. Little Rock	Ashley L Mitchell, MD	Jonesboro
Charles D Cesare, MD	Jonesboro	Fred E Newton, MD	Little Rock
Jimmy C Chang, MD	N. Little Rock	Lindsay H Osleber, MD	Little Rock
James K Citty, MD	Searcy	Amy M Phillips, MD	Little Rock
Holly D Cockrum, MD	N. Little Rock	Stacy L Ulmer Pinter, MD	Benton
Jason C Coletta, DO	Jonesboro	Michael E Potts, MD	Rogers
Angela K Curry, MD	Jonesboro	Estelle A Rutledge, MD	Little Rock
E A Deed, MD	Little Rock	Joseph O Sams, MD	Jonesboro
Norbert W Delacey, MD	Jonesboro	Matthew A Sellers, MD	Little Rock
Carl B Edwards, MD	Jonesboro	Vernon C Shaffer, MD	Texarkana
Bryan D Fuller, MD	N. Little Rock	Kenneth G Singleton, MD	Little Rock
Amy B Galdamez, MD	Little Rock	Kim N Smith, MD	Bryant
Meriden A Glasgow, MD	Batesville	Mary Z Thaxton, MD	Hot Springs
David E Greathouse, MD	Texarkana	Joanna D Twombly, DO	Mountain Home
Frederick W Hanson, MD	Stuttgart	Joshua L Ward, MD	Conway
Cindy A Hubach, MD	Little Rock	Thomas L Wilson, MD	Texarkana
Clint T Hutchinson, MD	Little Rock	Sarah M Woodruff, MD	Clarksville
Carole L Jackson, MD	Conway	Richard A Wyatt, MD	Little Rock

"I'd like to thank and congratulate the physicians who have shown that high quality can be provided to patients in an efficient way," said Steve Spaulding, executive vice president and chief health management officer for Arkansas Blue Cross. "These physicians not only provided great care for their patients, but coordinated the total care of the patient for services that they did not directly provide. The choices made for the delivery of all of the care for an episode, whether through the facility where the care was provided, or through other care providers, are important. The work these physicians have done benefits everyone involved in team-based care."

AHCPII episodes now include individual metallic members

Episodes now include individual metallic members
Effective January 1, 2017, the Arkansas Blue Cross AHCPII payment system will have financial and quality targets for the individual metallic business sold through the Arkansas Marketplace (also known as Qualified Health Plans (QHP)). These services are reimbursed at different fee rates than usual commercial business, thus the need for separate financial targets.

Providers must have five or more eligible cases of an episode to be considered principal accountable providers (PAPs). Individual metallic members (QHP members) will not count toward a provider's count for regular commercial members (non-QHP members). The following chart demonstrates that five or more eligible cases must be present for in QHP and non-QHP membership for a provider to qualify as a PAP in both. It is possible, based on patient mix, for a provider to be a PAP for one group, but not for another.

Eligible Episodes of Care		PAP Eligibility for Gain/Risk Sharing
QHP Members	Non-QHP Members	
4 or less	4 or less	Not eligible for either
4 or less	5 or more	Non-QHP Members ONLY
5 or more	4 or less	QHP Members ONLY
5 or more	5 or more	Eligible for both

Principal accountable providers (PAPs) have preparatory reporting available in 2016 for this membership available on the AHIN "APII Portal" under "Episodes."

The provider manual at www.arkansasbluecross.com (under Doctors & Hospitals) contains detailed information for each active episode; including individual episode details and algorithms, gain and risk share requirements, appeal process, and the report glossary.

This notification was previously published in the December 2016 edition of *Providers' News*.

DME in the emergency room

Some patients need to receive items such as splints, crutches, and braces during their visit to the emergency room, urgent care centers, or physician's offices. These services should not be split off and billed by another provider. Arkansas Blue Cross and Blue Shield is being billed by other organizations for DME and medical supplies that have been supplied in emergency rooms. This is especially troubling for our members when the services are billed by DME companies that are not in the networks of Arkansas Blue Cross or its family of companies. With the exception of physician services, it is expected that our contracted hospitals bill for all services rendered or received at the hospital.

Coverage policy manual updates

Since December 2016, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The table highlights the additions and updates. To view entire policies, access the coverage policies located on our website at arkansasbluecross.com.

Policy ID#	Policy Name
1997126	Low Level Laser Therapy (LLLT)
2004017	Genetic Test: Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
2006022	Genetic Test: Cardiac Ion Channelopathies (Long QT Syndrome, Brugada Syndrome, CPVT, Short QT Syndrome)
2009013	Testing for Drugs of Abuse or Drugs at Risk of Abuse including Controlled Substances
2010017	Aqueous Shunts and Devices for Glaucoma
2014006	Sofosbuvir (Sovaldi)
2014009	Endovascular Procedures for Intracranial Arterial Disease and Extracranial Vertebral Artery Disease
2015008	Genetic Test: Miscellaneous Genetic and Molecular Diagnostic Tests
2015034	Telemedicine
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab)
2016023	Eteplirsen (Exondys-51)
2016024	Gender Reassignment Surgery for Gender Dysphoria
2017001	Alpha-1 Proteinase Inhibitor Therapy
2017002	Telemedicine Pilot for Applied Behavioral Analysis in the Treatment of Autism Spectrum Disorder
2017003	Ziv-aflibercept (Zaltrap)
2017004	Asfotase alfa (Strensiq®)
2017005	Noninvasive Fractional Flow Reserve Using Computed Tomography Angiography

Organ or disease-oriented panel pricing

CPT codes require all of the individual codes in an organ or disease panel to be performed for providers to bill the organ or disease panel procedure code. Some providers bill seven of the eight components individually, despite the fact that tests are done on multi-channel analyzers that commonly provide all eight results.

Beginning November 1, 2007, Arkansas Blue Cross and Blue Shield began limiting the total allowance of multiple laboratory procedures included in an organ and disease panel to the allowance of the organ/disease panel procedure code. If less than the number of required tests for a panel is reported, the maximum allowance for the reported individual tests will be equivalent to the allowance for the panel.

See the coding example provided at the end of this article.

The following panel codes with the individual CPT codes included in the panel code will be impacted:

80048 Basic metabolic panel:
- Calcium (82310)
- Carbon dioxide (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Potassium (84132)
- Sodium (84295)
- Urea Nitrogen, BUN (84520)

80050 General health panel:
- Comprehensive metabolic panel (80053)
- Blood count, complete CBC, automated and automated differential WBC count (85025 or 85027 and 85004)

OR
- Blood count, complete CBC, automated (85027) and appropriate manual differential WBC count (85007 or 85009)
- Thyroid stimulating hormone, TSH (84443)

80051 Electrolyte panel:
- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

80053 Comprehensive metabolic panel:
- Albumin (82040)
- Bilirubin, total (82247)
- Calcium (82310)
- Carbon dioxide, bicarbonate (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947
- Phosphatase, alkaline (84075)
- Potassium (84132)
- Protein, total (84155)
- Sodium (84295)
- Transferase, alanine amino, ALT, SGPT (84460)
- Transferase, alanine amino, AST, SGOT (84450)
- Urea Nitrogen, BUN (84520)

80074 Acute hepatitis panel:
- Hepatitis A antibody - HAAb, IgM antibody (86709)
- Hepatitis B core antibody - HbcAb, IgM antibody (86705)
- Hepatitis B surface antigen - HbsAg (87340)
- Hepatitis C antibody (86803)

80076 Hepatic function panel:
- Albumin (82040)

(Continued on page 13)

Organ or disease-oriented panel pricing (Continued from page 12)

- Bilirubin, total (82247)
- Bilirubin, direct (82248)
- Phosphatase, alkaline (84075)
- Protein, total (84155)
- Transferase, alanine amino, ALT, SGPT (84460)
- Transferase, alanine amino, AST, SGOT (84450)

Example: The codes included in CPT 80048 and the corresponding allowances are:

- Calcium (82310) $10.80
- Carbon dioxide (82374) $10.25
- Chloride (82435) $ 9.63
- Creatinine (82565) $10.74
- Glucose (82947) $ 8.22
- Potassium (84132) $ 9.63
- Sodium (84295) $10.08
- Urea Nitrogen, BUN (84520) $ 8.27

If providers bill any combination of the above codes in this example, the most providers will be paid for all of the codes listed will be $17.75. The only combination in this example that would not result in a reduction is 84520 and 82947.

Modifiers impacting pricing

Some modifiers impact pricing. Listed below are modifiers and their applicable pricing adjustments in the Arkansas Blue Cross and Blue Shield Fee Schedule.

- Modifiers TC and UE point to the technical component fee schedule amounts.
- Modifiers 26 and RR point to the professional component fee schedule amounts.
- Modifier NU points to the total component fee schedule amount.
- Modifier 22: Increased Services - 25% of allowable charges based on documentation that the surgical service provided is greater than that usually required for the procedure.
- Modifier 50: Bilateral Surgery - 50% of allowable charges and services must be billed on two lines.
- Modifer 51: Multiple Surgery - 50% of allowable charges.
- Modifier 52: Reduced Services - 67% of allowable charges based on documentation.
- Modifier 53: Discontinued Procedure - 25% of allowable charges.
- Modifier 62: Co-Surgery - 62.5% of allowable charge.
- Modifier 63: Infant Procedure - 120% of allowable charge.
- Modifier 73: Discontinued Procedure - 50% of allowable charge (limited to facility billings).
- Modifier 78: OR Return - 70% of allowable charge.
- Modifier 80: Assistant Surgeon - 20% of allowable charge.
- Modifier 81: - 20% of allowable charge.
- Modifier 82: - 20% of allowable charge.
- Modifier AS: 20% of allowable charge (limited to specialties 50 and 89; in combination with specialty discount of 75%, results in payment of 15% of allowable).

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

Claims filing reminders for counties bordering Arkansas

Reminder on the claims filing process for health care providers located in other states in counties that border Arkansas.

1) If you contract with Arkansas Blue Cross and Blue Shield or one of its family of companies; if a member has insurance coverage with Arkansas Blue Cross and Blue Shield; and if that member receives services from a healthcare provider located in a bordering county who is contracted to be in the provider networks of Arkansas Blue Cross, the provider must submit the claim directly to Arkansas Blue Cross. This rule also applies to Health Advantage, its members and contracted providers, as well as to health plans administered by BlueAdvantage Administrators of Arkansas (hereafter known as Arkansas Blue Cross).

> An example would be a physician in Memphis, Tennessee, who provides care to a patient with insurance coverage from Arkansas Blue Cross. If that physician is in the Arkansas Blue Cross provider network, the claim must be submitted to Arkansas Blue Cross in Little Rock and the preferred submission is through our provider portal AHIN.

2) If a healthcare provider in a bordering county is not in the provider networks of Arkansas Blue Cross, but is participating in the networks of the Blue Cross and Blue Shield (Blue) plan where the provider is located and that provider renders services to a member with coverage from Arkansas Blue Cross and its family of companies, the provider must file claims to the local Blue plan as the host plan.

> An example would be a physician in Memphis, Tennessee, who provides care to a patient with insurance coverage from Health Advantage. This physician is NOT in the Health Advantage provider network but is in the BlueCross BlueShield of Tennessee provider networks. This claim must be submitted to BlueCross BlueShield of Tennessee.

3) Look for the "suitcase" in the lower right corner of the member's ID card. What if there isn't a suitcase on the Arkansas Blue Cross or Health Advantage ID card? A missing suitcase indicates that there are NO out-of-area benefits available through the Blue Card program for any out-of-area services except in emergency situations. If you are not contracted with Arkansas Blue Cross, and there is no suitcase on the Arkansas Blue Cross member's ID card, then you will not receive payment for these services. There are provisions for prior authorizations; check the member's ID card for information.

4) If a healthcare provider located in a county bordering Arkansas, who participates in the provider networks of Arkansas Blue Cross and its family of companies renders care to a member with insurance from a Blue plan other than Arkansas Blue Cross, the provider must file the claim to the local Blue plan, as the host plan.

> An example would be a physician in Branson, Missouri, (on the Arkansas border) who provides care to a member with insurance coverage from Blue Cross and Blue Shield of Montana. This claim must be submitted to the local plan which is Anthem Blue Cross and Blue Shield (Missouri). It does not matter whether the physician is in the Anthem provider networks, it still must be submitted to the host plan.

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Claims filing reminders for counties bordering Arkansas (Continued from page 14)

The exceptions to these rules apply to healthcare providers for lab, durable medical equipment/medical supplies.

Lab claims are submitted to the local Blue plan where the specimen was obtained.

DME/medical supply claims are submitted to the Blue plan where the supply was shipped to (usually where the member lives) or where the supply was purchased (i.e. location of the retail store).

New ID cards coming for Arkansas Blue Cross group members

Arkansas Blue Cross and Blue Shield group members will receive new ID cards, with new member ID numbers, beginning in April as part of an improvement to our internal systems. The new ID cards will be issued as each group is renewed, which means you may have patients receiving new member ID cards over the course of a 14-month span. As a reminder, you should continue to check AHIN to verify a member's eligibility and coverage.

Why is this happening?
By moving all lines of business to a newer claims system, we will improve productivity and processes, provide consistent security measures and lower administrative and maintenance costs. Claims will process by date of service, using the ID for that respective coverage period.

What should you do?
Beginning in April, please ask your patients with Arkansas Blue Cross member IDs if they have recently received a new member ID card. If they have, please update your information to ensure your patient's claims are handled efficiently. It's important that the claim is filed with the correct ID number, including the alpha prefix. If they haven't, let them know that if they are with a group health plan, they may be receiving a new ID card, with a new number, soon.

New Payment Cycle
Due to the change in claims systems, a new payment cycle for these Arkansas Blue Cross and Blue Shield members will begin in early April. The EFT number format will be 'BC BC' and check numbers will begin with 'BC'. The claim payment cycles are scheduled to run once a week with the exception for holidays and month-end processing.

Revisions to the notice of Network Terms and Conditions – Exclusion for False or Misleading Claims

Effective December 19, 2016, the Network Terms and Conditions of participation applicable to all individual network participants and applicants for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage PFFS network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage LPPO network, Health Advantage Medi-Pak® Advantage HMO network, USAble Corporation Arkansas' FirstSource® PPO network, USAble Corporation True Blue PPO network, and Health Advantage HMO network (collectively, the Networks) have been updated by adding a new subsection II (c) (2) to define a limited exception to permanent ineligibility for a practitioner who has engaged in false or misleading claims and coding billing practices.

Previously, the Networks have permanently excluded any practitioner who engaged in any such fraudulent/misleading claims practices, with no exceptions. Going forward, the new subsection II(c)(2) defines certain circumstances and conditions under which a Network applicant or participant who engaged in fraudulent/misleading claims practices may qualify for re-consideration after a minimum, mandatory five-year ineligibility period expires.

Please note that nothing in this revised standard addresses a fraudulent claims case that also involves criminal charges or convictions; other parts of the Terms and Conditions address criminal charges and their effect on Network eligibility, and the Networks' credentialing standards also specifically address felony convictions. One or more of these separate Network standards may apply in any given case.

The following is the revised wording for section II(c) of the Networks' Terms and Conditions, including the new subsection II(c)(2) language:

(c) <u>Exclusion for False or Misleading Claims</u>

(1) Permanent Ineligibility

If a participating provider is excluded from the network for filing any false or misleading claim, or engaging in or assisting any other person or individual in the presentation of any false or misleading information (including but not limited to any claims data, medical background or records, employment history or status, or other coverage eligibility information) to any insurer, HMO, government program, third party administrator or self-funded payer, such excluded provider shall not be eligible to apply for re-admission to the Networks, and shall be permanently disqualified from participation.

NOTE: Providers are deemed responsible for all actions of any employee or agent of the provider, including but not limited to nursing or administrative staff, office managers or personnel, billing clerks, billing services, practice management agents or vendors, software vendors or others working on provider's behalf to file any claims data or to otherwise furnish any information to insurers, HMOs or other claims administrators or payers. If false or

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misleading claims (or any other data) are sent to any insurer, HMO, claims administrator or payer accessing the Networks, participating providers may be excluded and permanently disqualified from network participation even though such providers contend or could show that participating provider was not personally aware of or involved in the presentation of such information. The Networks cannot conduct continual, full-scale audits of all claims or all providers, and must therefore be able to rely on providers to appropriately monitor their staff and vendors, and to take prompt corrective action if any problem is identified.

(2) Limited Exception to Permanent Ineligibility

Any practitioner who has engaged (either directly or via any billing agent or staff member responsible for submission of claims on behalf of the practitioner) in fraudulent claims, fraudulent claims coding or fraudulent billing practices (whether such activity relates to a Network member or Network payer, or to third parties such as other payers and their member, or to government programs) shall be permanently ineligible for network participation unless the following additional conditions apply, as determined in the sole judgment and discretion of the Networks:

1. **Minimum Network Exclusion Period.** At least five years have elapsed between the date that the Networks first issued final notice (including any period for appeals) of termination or rejection of network participation due to fraudulent actions and the date of any application or re-application for admission to the networks; and

2. **Complete Restitution.** Practitioner must, prior to submitting any application or re-application, have made full restitution to any defrauded insurer, health plan or government program (including but not limited to Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation and/or their self-funded health plan customers) of all amounts paid with respect to any fraudulent claims, coding or billing activities of practitioner; and

3. **Evidence of Rehabilitation.** Practitioner must present evidence, satisfactory to the Networks in their sole discretion, demonstrating that in the past five years (or longer period, as applicable), Practitioner has been rehabilitated and has conducted all personal and professional activities with the utmost integrity, showing exemplary conduct with no further or additional infractions of law or ethics, including but not limited to absence of any other allegations or incidents of fraudulent conduct or activities involving any persons or entities. The Networks may require the submission of personal and professional references but shall not be bound to give weight or credence to any such references.

4. **Lack of other issues/disciplinary actions.** Practitioner must not have been subject, during the five years (or longer period, as applicable) intervening between Practitioner's termination or rejection for network participation and Practitioner's application or re-application to the network, to any other legal, regulatory or disciplinary investigations, proceedings, citations, fines, penalties, mandatory appearances, voluntary or involuntary monitoring or oversight, proctoring, revocation of license, restrictions on licensure or scope, location or manner of practice, voluntary or involuntary

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surrender or suspension of any license, permit, certificate or authorization of any practice activities, or any other form of disciplinary action, reprimand or sanction by any regulatory or disciplinary authority in any state or jurisdiction.

5. **Full compliance with all other network standards.** Practitioner must, at the time of consideration under this exception to permanent ineligibility for past fraudulent activities, be qualified and capable and demonstrably ready to meet all other terms and conditions of network participation, including but not limited to network credentialing standards and network participation contract terms.

Special Note 1: The preceding exception to the network's permanent ineligibility standard for past fraudulent activities is primarily intended to address the situation in which a practitioner is re-applying after a network termination or rejection for network participation that was based on fraudulent activity. However, in the event that any first-time applicant to the network should be found to have engaged in past fraudulent activities, and seeks to be considered for an exception to the permanent ineligibility standard, the terms of this exception shall apply to such applicants as well, i.e., any such first-time applicant shall not be eligible to be considered for any exception to the permanent ineligibility standard for fraudulent activities until all of the above-stated conditions are met (in the sole discretion of the network), including but not limited to lapse of five years following the submission of a network application.

Special Note 2: The preceding notwithstanding, the Networks reserves the right to refuse network participation to any practitioner in a given case, based on an assessment of all the available data and known circumstances, in the sole judgment and discretion of the Networks. Factors that may be considered in this regard (in the sole judgment and discretion of the Networks) include but are not limited to whether practitioner has engaged in a pattern of deception, misrepresentation, abusive or fraudulent claims practices, impact of past misconduct on third parties or entities, including but limited to any impact on the Networks or their customers or members, and general personal or business reputation and conduct.

NOTE: For a complete copy of the Networks' Terms and Conditions, see the published version as revised, posted to the websites of Arkansas Blue Cross Blue Shield, USAble Corporation and Health Advantage under the heading "Network Participation Guidelines and Listing Changes".

Provider office hours of service requirement

The Arkansas Insurance Department holds Arkansas Blue Cross and Blue Shield liable for posting every provider's hours of operation. Providers should verify, correct, and add missing information monthly. Please add or update office hours of service on AHIN upon receipt of this request.

Dental Xtra: making the connection

Dental Xtra is a program that enhances benefits for Arkansas Blue Cross and Blue Shield dental members who have a qualifying group dental plan.* The program offers two additional cleanings per year to members who have diabetes, coronary artery disease (CAD), oral cancer or who are pregnant. It may include periodontal scaling and root planing if it is part of their dental plan.

The Benefits of the Dental Xtra program include:

- Education about dental health
- Help and encouragement for members who seek dental care
- Benefits are paid at 100% for members who are pregnant or who have diabetes, coronary artery disease (CAD) or oral cancer, meaning:
  1. No coinsurance
  2. Coinsurance will apply when visiting a non-participating dentist
  3. No deductible
  4. Does not count toward your Calendar-Year Maximum

There is a growing body of evidence that oral inflammation can play a role in the management of diabetes, coronary artery disease, or the likelihood of a woman having a pre-term low birth weight baby. Diabetes has been reported to have a two-way connection with periodontal disease. Diabetic patients are more susceptible to periodontal disease and periodontal disease typically affects their glycemic control.

Patients with periodontal disease are up to twice as likely to have a heart attack. Research suggests that people with these conditions may significantly improve their health when they receive dental prophylaxis or other periodontal services to reduce oral inflammation.

The treatment of oral cancer can lead to side effects including a dry mouth due to diminished salivary flow. Dental Xtra provides the same preventive benefits mentioned above along with additional regular fluoride treatment and pre-diagnostic oral cancer screenings to help you identify new primary oral cancers at an early stage.

Both physicians and dentists are partners in the care of their patients. We welcome you to encourage your patients with these additional dental benefits to use them.

For more information about Dental Xtra please visit: https://secure.arkansasbluecross.com/members/dental/dentalxtra.aspx

*Dental Xtra is not currently available for individual plans on or off the Federally Facilitated Marketplace.

References:

https://nidcr.nih.gov/DataStatistics/SurgeonGeneral/sgr/chap5.htm

http://www.ada.org/en/science-research/science-in-the-news/dental-treatment-before-cardiac-surgery-studied

Credentialing standards updates for all networks sponsored by Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation

Effective October 1, 2016 the following sections of the networks' credentialing standards for all eligible disciplines and applicants for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage PFFS network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage LPPO network, Health Advantage Medi-Pak® Advantage HMO network, USAble Corporation Arkansas' FirstSource® PPO network, USAble Corporation True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been either revised or deleted as indicated below:

I. Revised Standards:

The following standards have been revised and re-stated.

Collaborating and Supervisory Physician Agreements Required for APNs and PAs: All wording under this heading is revised and replaced with the following new wording, under the new heading of "Collaborating and Supervisory Physician Agreements Required for APRNs, PAs and certain other practitioners":

"Certified Nurse Practitioners (CNPs), Certified Nurse Midwifes (CNMs), Clinical Nurse Specialists (CNSs) and Physician Assistants (PAs), collectively referred to as Extender, must maintain a Collaborating Practice Agreement, with Quality Assurance Plan, or Physician Assistant Protocol and Delegation of Services Agreement, which meets all the requirements of their respective licensing board, with a collaborating/supervising physician that is currently a participating provider in good standing in the [network]. The collaborating or supervising physician must be skilled and trained in the same scope of practice as the care that will be provided by the CNP, CNM, CNS or PA, i.e., [network] requires that the practice specialty or scope of actual practice of the collaborating or supervising physician must match the practice specialty or scope of actual practice in which the CNP, CNM, CNS or PA is engaged or intends to engage.

If at any time the network participation status of the collaborating/supervising physician is terminated, the network participating status of the Extender will also be terminated (unless an acceptable replacement collaborating practice agreement or supervisory agreement, as outlined above, with another participating physician is obtained and in place prior to the termination of the current collaborating/supervising physician).

Upon request, each Extender shall be obligated to provide a complete copy of the current agreement with the collaborating/supervising physician to [the network], including any information or documentation regarding the circumstances or status of any collaborative or supervisory agreement or relationship with a collaborating or supervising physician, including but not limited to access to all related records to verify the status, nature or extent of the collaborative or supervisory agreement

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or relationship. [Network] is not obligated to accept all collaborating practice or supervisory agreements, as written, but reserves the right to evaluate whether the terms of such agreements are adequate to ensure proper oversight and management by the collaborating or supervising physician of the activities of the Extender. In the event that [the network] identifies any deficiencies in the terms of a collaborating practice agreement or supervisory agreement, [the network] may decline to admit or to continue participation of any Extender in the [network], or may condition admission or continued participation upon revisions to the terms of any such agreement. In addition, [the network] shall be entitled to review the actual practice activities, oversight and monitoring methods or practices, physical proximity between any Extender and their collaborating or supervising physician, and other conditions of the relationship to verify that the written terms of the collaborating or supervisory agreement are, in fact, being fulfilled by both parties to the agreement, and that adequate procedures, protocols and protections are in place to ensure proper oversight of the activities of the Extenders. Should [the network] or its representatives identify any breach or violation of the terms of the collaborating or supervising agreement, or should failure to honor the terms of such agreements come to the attention of [the network], the network participation of the applicable Extender shall be subject to immediate termination for failure to meet network credentialing standards."

Additional license and certification requirements:
The heading for this standard is revised to refer to "Additional license and certification requirements for Registered Dieticians and Pharmacists" and the wording of this standard is revised to read:
"The following practitioners are required to maintain the following licensure status or professional certification in addition to basic licensure:

- Registered Dieticians performing diabetic education must be a registered category I professional member of the American Diabetes Association.
- Pharmacists must possess the additional license certification for the authority to administer medications / immunizations which requires the following:

    1. Successfully completion of a Pharmacy Board-approved course of study, examination and certification related to immunization;
    2. Obtain and maintain current certification in cardiopulmonary resuscitation (CPR) or basic cardiac life support (BCLS);

Successfully complete one (1) hour of CE related to immunization every year."

II. Deleted Standard:

The following standard is deleted entirely:

Collaborating and Supervisory Physician specialty match requirements for APRNs and PAs

NOTE: For a complete copy of the Networks' Credentialing Standards for all eligible disciplines, see the published versions as revised, posted to the websites of Arkansas Blue Cross Blue Shield, USAble Corporation and Health Advantage under the heading "Network Participation Guidelines and Listing Changes".

Updates to the network credentialing standards – DEA certificate standard

Effective October 1, 2016, the network credentialing standards applicable to all individual network participants and applicants for the Preferred Payment Plan, Medi-Pak® Advantage PFFS, Medi-Pak® Advantage LPPO, Medi-Pak® Advantage HMO, Arkansas' FirstSource® PPO, True Blue PPO, and Health Advantage HMO Networks will be updated in section C, Drug Enforcement Agency (DEA) to effect the following significant changes in the DEA certificate standard:

- Recognition that primary care physicians (PCPs), and advanced practice registered nurses and physicians assistants who collaborate with PCPs, but who do not prescribe or intend to prescribe controlled substances no longer have to obtain a DEA certificate as a condition of network credentialing and participation.
- Clarification that any practitioner who does prescribe or intends to prescribe controlled substances must maintain a DEA certificate in good standing as a condition of network credentialing and participation.
- A new requirement that practitioners who hold a DEA certificate must enroll in the Arkansas Prescription Monitoring Program (AR PMP).
- New provisions detailing the ineligibility period applicable to any practitioner whose DEA certificate is subject to a disciplinary action.

Special Note on the Prescription Monitoring Program procedures and extended compliance deadline:
Registration for the Prescription Monitoring Program is free and takes about five minutes. The registration page can be found at: arkansaspmp.com/practitioner-/-pharmacist/.

Current participating providers will have until April 1, 2017, to complete enrollment in the AR PMP in order to be in compliance with the network credentialing standards. Non-compliance with the revised DEA Certificate Standard could prompt the networks to take additional action, up to and including network termination.
The following is revised language for the DEA Certificate Standard, effective October 1, 2016:

DEA and Arkansas Prescription Monitoring Program
All practitioners are responsible for complying with all applicable state and federal laws and regulations related to the prescribing and administration of medications. This includes a network requirement (consistent with applicable law) that applicants or current network participants who prescribe or intend to prescribe controlled medications must hold an active Drug Enforcement Agency certificate in good standing. In addition, applicants and current network participating practitioners who hold an active DEA certificate must be registered with the Arkansas Prescription Monitoring Program as a condition of network participation.
A practitioner whose DEA certificate is subject to any action (as hereinafter defined) shall lose eligibility to participate in the networks for the longer of (a) 365 days or (b) the date that the networks determine, in their

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sole discretion, that the conditions leading to any action have been appropriately alleviated or redressed by the practitioner and any applicable disciplinary board oversight or monitoring program.

For purposes of this standard, "action" means any voluntary or involuntary surrender, restriction, limitation, suspension or revocation of a DEA certificate, including but not limited to any arrangement whereby the practitioner agrees to a surrender, restriction, limitation, suspension or revocation of the DEA certificate, or any arrangement whereby practitioner's use of the DEA certificate is limited or restricted (voluntarily or involuntarily) in terms of the scope or classifications of medications that may be prescribed, the location(s) or conditions under which the DEA certificate may be utilized to legally prescribe medications, or the length of time that the DEA certificate may be utilized without further review or approval from any government agency or disciplinary board or program.

Any practitioner whose DEA certificate is subject to any action must give written notice of the same to the networks not later than three business days following the action, and failure to promptly provide such notice shall, in itself, constitute separate grounds upon which network participation may be denied or terminated.

The preceding notwithstanding, the networks recognize one exception under which a practitioner who has been subject to an action may, in the judgment of the networks, remain eligible for network participation and not be excluded from the networks as provided in subpart (b), above: if the practitioner is actively enrolled in and fully compliant with all terms of a practitioner health/rehabilitation program that is officially sanctioned and overseen by the practitioner's applicable disciplinary board or agency and such practitioner is (i) otherwise in good standing with the practitioner's applicable disciplinary board or agency; and (ii) otherwise in good standing with all regulatory authorities and state and federal agencies and programs, including but not limited to Medicaid and Medicare; and (iii) otherwise in good standing with the networks and in compliance with all other terms and conditions of the practitioner's network participation agreement and network terms and conditions; and (iv) practicing with competence and quality and in a manner that does not pose a risk of harm to the networks' members, as determined in the networks' sole discretion.

Arkansas Blue Cross and Blue Shield is closed April 14, 2017 for Good Friday

Please note that some of our offices will be open on April 14, 2017, due to service level agreements including the State of Arkansas (Arkansas State and Public School Employees).

End of the ABCBS Section

FEP national drug code policy

Providers are required to supply the 11-digit national drug code (NDC) when billing for injections and other drug items on all claim submissions. Many NDCs are displayed on drug packaging in a 10-digit or 9-digit format and must be converted to meet billing requirements. NDCs have a three segment configuration (NDC: 12345-1023-12).

NDC Number Section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package strength

If you encounter NDCs with fewer than 11-digits, convert the NDC to an 11-digit number. An additional "0" is added to the appropriate segment to create a 5-4-2 configuration. The example below demonstrates the placement of the additional "0" by bolding the correct segment.

Label Configuration	Add Leading Zero, Remove Hyphens
4-4-2 (**xxxx**-xxx-xx)	**0xxxx**xxxxxx
5-**3**-2 (xxxxx-**xxx**-xx)	xxxxx**0xxx**xx
5-4-**1** (xxxxx-xxxxx-**x**)	xxxxxxxxx**0x**

Missing digit corrections

If the NDC appears as...	Then the NDC...	It is submitted as...
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	01234123401
NDC 12345-1234-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345012312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	12345123401

For example: the drug Rosuvastatin Calcium 20mg (generic for Crestor) has an NDC package code of 52959-629-30. For proper billing, the submission would be 52959062930.

FEP sleep study prior approval

FEP requires providers to obtain prior approval for sleep studies performed in a provider's office, sleep center, clinic, outpatient center, hospital, skilled nursing facility, residential treatment center and any other location that is not the member's home.

End of the FEP Section

CMS enforcement of Medi-Pak® Advantage provider directory accuracy

The Centers for Medicare and Medicaid Services (CMS) recently issued regulatory guidance on the accuracy of online and printed provider directories. Medicare Advantage Organizations (MAOs) like Arkansas Blue Cross and Blue Shield will undergo directory audits to ensure accuracy of provider and demographic information. CMS representatives will also randomly call and ask the provider's office staff questions to validate the information in directories. If deficiencies are found, the MAO will receive a warning letter to take corrective action. If the deficiencies are not corrected, the MAO will be subject to fines. The new regulatory oversight makes provider data accuracy a high priority. Provider staff will be asked to verify the following data elements:

1. The provider name given by office staff matches what is printed in the directory.
2. Physicians and practitioners do practice at the location specified in the directory.
3. If providers are accepting new patients.
4. If provider's practicing specialty matches what is listed in the directory.
5. Clinic name, phone number and address accuracy, including suite number if applicable.

Arkansas Blue Cross requests your compliance by submitting changes of the above elements as they occur. Online directories are updated within three business days upon receipt of change of data. Printed directories are updated every 30 days. Validation of provider directory information accuracy is crucial to meeting the needs of our members and your patients.

Provider Network Operations is reviewing provider data on a semiannual basis and mailing the profile on file to providers to validate, correct, sign, date and return. Changes or corrections to data can also be submitted by using the Provider Change of Data Form found at arkansasbluecross.com/providers/forms.aspx.

Mail or **fax** the completed form or submit the changes on office letterhead to:

Provider Enrollment
Attn: Provider Network Operations
PO BOX 2181
Little Rock, AR 72203
Fax: 501-378-2465

AHIN is developing an "information update screen" that should go live mid-summer 2017 where providers will be able to electronically update information such as their status of accepting new patients, joining or terminating from an existing clinic, and their hours of service. Reminders will be published in subsequent editions of Providers' News and on AHIN.

Guidelines for treating patients with rheumatoid arthritis

Disease-modifying anti-rheumatic drug (DMARD) therapy for rheumatoid arthritis, or RA, is a HEDIS® measure* used in determining Medicare star ratings. It assesses patients 18 years and older who were diagnosed with RA and who filled at least one ambulatory prescription for a DMARD in the measurement year.

Why DMARD therapy?
Several major studies have documented the dramatic benefits of aggressive early treatment, which is essential in helping prevent long-term damage and disability from RA. DMARD therapy increases the quality of life more effectively than other treatment strategies.

According to the American College of Rheumatology, patients with a confirmed RA diagnosis should be treated with a DMARD regardless of severity or how long they have had RA unless contraindicated.

Although patients with RA may be stabilized with an anti-inflammatory or steroidal medication, such as prednisone, DMARD therapy is the only treatment that helps prevent further erosion and damage to joints. Anti-inflammatory or steroidal medication does not.

Keep in mind that all patients on DMARD therapy treatment should be monitored at least four times a year by their managing provider for follow-up visits. Follow-up visits are highly encouraged to monitor the disease, effectiveness of DMARD therapy and adverse events with DMARD treatment.

Referral to a rheumatologist is *highly recommended* for patients to confirm and treat the disease.

- Suspected and early onset of RA may resemble other forms of inflammatory arthritis.
- Patients with RA, when appropriately treated, can experience reduction of disease progression, joint damage, long-term disability, elimination for surgery, lower disease activity and improved chances of disease remission.
- When treating a new patient who indicates they had or have RA, the diagnosis should be confirmed through appropriate testing.

To find a rheumatologist in your area, check the Arkansas Blue Cross and Blue Shield "Find a Doctor" directory.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Ensuring accurate diagnosis and coding
Ensure claims submitted are consistent with appropriate diagnosis coding guidelines. Confirm a diagnosis of RA (versus osteoarthritis or joint pain) before entering a diagnosis of RA on claims.

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Members' claims for RA are sometimes coded inaccurately when they have joint pain or other signs and symptoms that must be addressed. A claim for RA shouldn't be submitted unless the diagnosis is confirmed.

Please note that ICD-10 coding guidelines state the following:

- Don't code diagnoses using such terms as probable, suspected, questionable, rule out, working diagnosis or similar terms indicating uncertainty. Code conditions to the highest degree of specificity for the encounter, including symptoms, signs, abnormal test results or other reason for the visit.
- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis hasn't been established, i.e., confirmed by the provider.

Clinical criteria for RA

Joint pain or arthritis isn't always RA. The clinical criteria for RA are chronic inflammatory disorder for more than six weeks with four of the following symptoms:

- Affecting three or more joints
- Presence of swelling in joints, especially multiple joints
- Erosion showing on X-ray of joints
- Metacarpophalangeal, or MCP, and proximal interphalangeal, or PIP, joint involvement
- Morning stiffness lasting more than 45 minutes
- Positive test results for cyclic citrullinated peptide, or CCP, or rheumatology factor, or RF
- Rheumatoid nodules
- Symmetrical joint pain
- Elevated erythrocyte sedimentation rate, or ESR, with joint pain, swelling, fevers, rash or weakness
- Weakness, such as a new onset in difficulty rising from a chair, along with an elevated ESR and creatinine kinase
- New blue or white color changes in the fingers and toes, particularly with ulcers

DMARD Therapy			
5-Aminosalicylates	Sulfasalazine	Immunomodulators Cont.	Etanercept
Alkylating Agents	Cyclophosphamide		Golimumab
Aminoquinolines	Hydroxychlorquine		Infliximab
Antirheumatics	Auranofin		Rituximab
	Leflunomide		Tocilizumb
	Methotrexate	Immunosuppresive agents	Azathioprine
Immunomodulators	Abatacept		Cyclosporine
	Adalimumab		Mycophenolate
	Anakinra	Janus Kinase Inhibitor (JAK)	Tofacitinib
	Certolizumab		
	Certolizumab pegol	Tetracyclines	Minocycline

Requirements for Medicare outpatient observation notice

In compliance with the Centers for Medicare and Medicaid Services (CMS) Medicare Outpatient Observation Notice (MOON), Arkansas Blue Cross and Blue Shield requires all acute care and critical access hospitals to provide written notification and an oral explanation of the notification to patients receiving outpatient observation services for more than 24 hours. The notice must be delivered no later than 36 hours after observation services begin. For Medi-Pak® Advantage members, any observation stays require pre-authorization or pre-notification requirements.

The notice should explain the following using contemporary language:

- The patient is classified as outpatient, not an inpatient of the hospital
- The reason for receiving observation services
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage of services furnished by a skilled nursing facility
- Advise patients to contact his or her insurance plan with specific benefit questions

All acute care and critical access hospitals are required to start providing the notification to patients no later than March 8, 2017. The notice and accompanying instructions are available on our website at arkansasbluecross.com/providers/forms.aspx or on the CMS Beneficiary Notices Initiative page at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Reminder on billing qualified Medicare beneficiaries

Medicare providers are prohibited by federal law from billing qualified Medicare beneficiaries for Medicare coinsurance, copayments, or coinsurance. Providers should accept Medicare and Medicaid payments received for billed services as payment in full. Dual-eligible members classified as qualified Medicare beneficiaries (QMBs) are covered under this rule. QMBs have Medi-Pak® Advantage as primary coverage and Medicaid as secondary coverage. Payments are considered accepted in full even if the provider does not accept Medicaid.

Providers are subject to sanctions if you bill a QMB patient for amounts not paid by Arkansas Blue Cross and Blue Shield and Medicaid.

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

End of the Medi-Pak® Advantage Section

ActiveHealth now providing precertification for ASE/PSE member medical services

Effective 03/01/17, Arkansas Public School and State Employees precertification for medical services will go through ActiveHealth, instead of American Health Holdings. The contact information will remain the same (877-815-1017, options 2, 1, 2, 1). Drugs will continue to be Prior Authorized (PA) through EBRx and the PA drug list will be updated as changes occur. The following services require precertification:

Medical Services
ABA Therapy
Residential Treatment
Intensive Outpatient Treatment
Partial Hospital /Day Treatment
Skilled Nursing Facility
Cognitive Rehabilitation
Occupational Therapy
Home Health Services
Inpatient Rehabilitation
Physical Therapy
Speech Therapy
Enteral Feeds
Long Term Acute Care Hospital (LTACH)
Intensity-Modulated Radiation Therapy (IMRT)
In Patient Admissions

Durable Medical Equipment
Spinal Cord Stimulators (implantation and device)
Continuous Glucose Monitoring Devices
Defibrillator Vests
Power Mobility Devices
Wound Vac

Medical Procedures
Septoplasty
UPPP, (Uvulopalatopharyngoplasty)
Varicose Vein Treatment
Blepharoplasty and/or Brow Lift
Gynecomastia Reduction
Mammoplasty
Panniculectomy
Rhinoplasty
Scar Revision outside doctor's office
Gastric Pacemaker
Bariatric Surgery, revisions, reversals (takedown) that require surgical intervention

Radiology
Computerized Tomography (CT Scan)
Computerized Tomography – Angiography (CTA Scan)
Magnetic Resonance Imaging (MRI)
Magnetic Resonance Angiography (MRA)
Positron Emission Tomography (PET Scan)

ASE/PSE Cervical Cancer Screening Policy

The cervical cancer screening policy (Arkansas Blue Cross Blue Shield Policy 2011021) did not go into effect until January 1, 2017 for Arkansas Public School and State employees. Women ages 21-65 years are still eligible in 2017 for a pap test as a preventive screening. If patients have one in 2017, they will not be eligible again until three years from the date of the last screening.

End of the ASE/PSE Section

Reminders about HIPAA and HITECH that affect providers

As a Qualified Health Plan participating in the Federal Facilitated Marketplace (FFM) including the Multi State Plan Program (collectively known as the Exchange) this is Arkansas Blue Cross and Blue Shield's reminder to all network participating providers that they must be compliant with their applicable sections of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economics and Clinical Health (HITECH) in order to be in our provider networks. Arkansas Blue Cross wants to bring attention to all network participating providers that:

1. Providers must comply with applicable interoperability standards and demonstrated meaningful use of health information technology in accordance with the HITECH Act, and
2. Subcontractors, Large Providers, providers, vendors, and other entities required by HIPAA to maintain a notice of privacy practices, must post such notices prominently at the point where an Exchange enrollee enters the website or web portal of such subcontractors, large providers, providers, and/or vendors.

For more detailed information, please visit: http://www.hhs.gov/ocr/privacy/index.html

Arkansas Works out-of-pocket

As of January 1, 2017, some Arkansas Works members have a quarterly in network out-of-pocket maximum.

The 2017 in-network, out-of-pocket maximum is $60 per quarter. Quarters are designated as January-March, April-June, July-September and October-December.

The accumulators for the maximum are administered the same as if was an annual maximum. The quarterly accumulators are reset on the first day of each quarter.

Covered services for medical and pharmacy are included in the maximum. Due to the processing time for filing claims, providers collecting copayments or coinsurance may at times need to credit amounts back to their patients. The remittance advice will notify providers when the quarterly out-of-pocket max for in-network services has been met. The member's Personal Health Statements will notify the member.

Providers will see the table on the next page on AHIN. AHIN also reflects the same information on the status of the accumulators as what a Customer Service Representative would reference.

(Continued on page 31)

Member's Cost	In Network	Out of Network
Active Coverage		
Pre-Authorization	No	No
Co-Insurance		
	0% (Service Year)	50% (Service Year)
Limitations		
	3 Month (Service Year) QUARTERLY OUT OF POCKET.	None
Remaining	0 Month (Remaining) QUARTERLY OUT OF POCKET.	None
Co-Payment		
	$8.00 (Day) QUARTERLY OUT OF POCKET.	None
Deductible		
Individual	$0.00 (Service Year)	$6,000.00 (Service Year)
Remaining	$0.00	$6,000.00 (Remaining)
Family	$0.00	$0.00
Remaining	$0.00	$0.00
Out of Pocket		
Individual	$60.00 (Service Year)	$14,300.00 (Service Year)
Remaining	$56.00 (Remaining)	$14,300.00 (Remaining)
Family	$0.00	$0.00
Remaining	$0.00	$0.00
Informational Messages		
	QUARTERLY OUT OF POCKET. THIS CONTRACT HAS TROOP BENEFIT. WHEN OUT OF POCKET IS SATISFIED, DO NOT COLLECT COPAYS FOR MEDICAL OR PHARMACY SERVICES.	THIS CONTRACT HAS TROOP BENEFIT. WHEN OUT OF POCKET IS SATISFIED, DO NOT COLLECT COPAYS FOR MEDICAL OR PHARMACY SERVICES.

End of the Exchange Section

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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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