PROVIDERS' NEWS

September 2018

A publication for participating providers and their office staffs

Patient-Centered Medical Home Program: Open Enrollment

October 1, 2018 begins open enrollment for the 2019 Patient-Centered Medical Home (PCMH) program year. The PCMH is a method to deliver and organize healthcare with the goal of improving the patient's experience of care, improving the health of populations and reducing or controlling the cost of healthcare.

The PCMH model allows the primary care physician and the patient to be in the center of the healthcare system, to know what is going on and help the patient be in control of their health. In addition to improving the healthcare experience for patients, the PCMH model's goal is to increase the provider and care team satisfaction.

If you're interested in learning more about PCMH or you would like instructions on enrolling, please visit arkansasbluecross.com or email primarycare@arkbluecross.com.

TABLE OF CONTENTS

2018 Open Enrollment: Please use AHIN

2018 Open Enrollment periods will begin on October 1, 2018, and runs through December 15, 2018. Due to the anticipated enrollment of many new members and current member renewals, we are expecting extremely high call volumes through January 31, 2019. Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the Advanced Health Information Network (AHIN) website for verifying eligibility, benefits and claims status. AHIN displays information on benefits to assist providers when scheduling appointments, checking eligibility and identifying benefits. Arkansas Blue Cross is planning and staffing to answer a higher call volume, but call volumes can spike and exceed our ability to answer every call. AHIN uses the same information available to our customer service representatives and can save you valuable time.

AHIN Corner

In an effort to inform users of changes affecting functionality, a post will be placed on the AHIN Home Page the week of the change enabling users to view the new functionality and receive instructions. Updates to AHIN are made as frequently as monthly. Users are advised to closely monitor the Provider News section on AHIN for updates.

Recently, AHIN added VBCI to the navigation menu. VBCI eLearning is now in a more convenient location under VBCI on the navigation menu as well as under the graduation cap icon. As we approach the last quarter of 2018, several more changes are on the horizon. Additional changes will allow providers to receive and respond to all medical record requests through a new menu option. HEDIS Quality Gaps and Diagnosis Compliance previously located under Document Transfer will be located under the new Record Request menu option; allowing providers the convenience of responding to record requests in one location. Primary Care requests will remain under Document Transfer located within the Portal menu option. Also coming to AHIN is provider re-credentialing as well as the ability to update provider data. Claim Entry screen defaults will be added to increase provider efficiency. The following fields on the AHIN Claim Entry screen will be set to default:

Field	Default
Prv Sig on File	Y: Yes
Pat Auth Assign	Y: Yes
Release of Info Cd	Y: Yes Prov Signed Statement Perm Rel/Med Bill Data Rel-Clm
Prv Accepts Assign	A: Assigned
Serv Date	Blank: will no longer default to current date

AHIN offers a variety of training opportunities. Electronic learning allows users the ability to remain in their office and utilize a small portion of the day to stay up to date on changes that may affect their workflow.

We encourage providers to utilize the self-service tools found within AHIN. Please see the AHIN training calendar under "Provider News" on the AHIN Home Page or email ahinuniversity@ahin.net to schedule a time to receive training on any functionality within AHIN; or contact AHIN Customer Support at 501.378.2336 for assistance.

Central Arkansas Region Network Development Representative Changes

Arkansas Blue Cross and Blue Shield Provider Network Operations would like to welcome Network Development Representatives (NDRs) Tina Baggett and Jennifer Shelton. They will replace long-time NDRs Pat Fournier (Tina Baggett) and Jan Hodges (Jennifer Shelton) in the central Arkansas region. Tina and Jennifer transferred from other positions within Arkansas Blue Cross in May, which allowed time to work alongside Pat and Jan for a smooth transition before their retirement at the close of 2018.

Tina began a career with Arkansas Blue Cross in 1991. She has held various positions throughout Arkansas Blue Cross and its family of companies including claims, benefit configuration, membership, etc. under our self-funded, fully-insured and Exchange products for both individuals and groups and brings a diversity of experience to the team.


Tina Baggett

Jennifer, a Registered Dietician, transferred from a position as a Practice Transformation Coach for value-based programs in our Primary Care department and has been with the company since 2015. She has been working with many primary care offices and has made presentations at our annual Spring provider workshops. Her clinical background offers a valuable outlook from the provider's perspective.


Jennifer Shelton

Tina and Jennifer's current responsibilities include serving as liaison between the health plan and the provider community, conducting required site visits, contracting with and educating healthcare providers on new or changing programs administered within the enterprise, payment transformation strategies, helping providers resolve complex claims issues, conducting provider workshops and providing in-service training for new providers.

Jan and Pat will be officially retired from Arkansas Blue Cross as of December 31, 2018. Their roles in building and sustaining relationships with our providers have been essential to network development success. Arkansas Blue Cross hopes you will join us in wishing them well as they begin this new journey in life.

Xerostomia and Dental Health

About 30% of Americans suffer from xerostomia or dry mouth. Many things can cause dry mouth, such as fear, snoring, mouth-breathing from a cold, autoimmune disorders or even mental illness as a result of stress and anxiety. The most common cause of xerostomia is medication[1]. Hundreds of medications can cause xerostomia including diuretics, antidepressants and antihistamines. Medications prescribed by providers known to cause Xerostomia should be prescribed with a saliva stimulant. Pilocarpine (Salagen) and cevimeline (Evoxac) are commonly prescribed to increase saliva production, but there are several other options available without a prescription including Aquoral, Biotene mouthwash and Mouth Kote[2].

Dental complications are prevalent in people who suffer from xerostomia because saliva serves several purposes in addition to keeping the mouth wet. The average individual produces about three pints of saliva per day, made up of electrolytes, enzymes and proteins. Enzymes break down some starches into dextrin and maltose and begin fat breakdown to start digestion, while calcium and phosphate in saliva helps to restore tooth enamel. Chronic dry mouth significantly increases the risk of oral infection and caries, as well as changes in speech patterns and dietary preferences, which can cause vitamin deficiencies. Chewing and swallowing can become difficult when saliva production is reduced by 50 percent.

When prescribing medications known to cause dry mouth, providers should inform patients of oral complications which can occur and prescribe additional medication to reduce the effects of xerostomia by increasing the flow of saliva. Advise patients to visit their dentist and discuss any changes in oral care routines that should be made to reduce the risk of infection and caries.

Please Note: This article is intended solely for informational purposes. Nothing herein is intended as or should be construed to be an endorsement of Arkansas Blue Cross and Blue Shield or its family of companies of any medication, treatment regimen or medical practice.

[1] https://www.pharmacytimes.com/publications/issue/2011/november2011/drug-induced-dry-mouth
[2] https://www.drugs.com/condition/xerostomia.html

Medical Record Requirements

Collecting and validating legitimate medical records is fundamental when it comes to audit reviews and program effectiveness. Proper medical record documentation is crucial, as it ensures complete, consistent and accurate information about a patient encounter. For medical record effectiveness, it is mandatory to include all of the proper elements as required under CMS guidelines before completing a patient's file.

Arkansas Blue Cross and Blue Shield and its family of companies are continuously involved in requesting and submitting medical records for audit review. Once a medical record is received and examined, it is determined as to whether the record is legitimate and meets the network agreements requirements. According to the provider network agreements, medical records "shall contain the information required by state and federal laws and regulations, including requirements of the Medicaid and Medicare programs" and "provider agrees that the applicable payer or its designated representative may deny any claim lacking appropriate documentation of the provision of services."

According to CMS regulation 482.24(c)(1), "all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided." If it appears your portion of the medical record does not meet these required elements, then it will not meet the Networks requirements. If your medical record is determined to be illegible or is missing certain criteria then please refer to your office notes, transcription, or provide a copy of your typed notes in order to confirm the services provided when submitting a medical record. All initial and follow-up medical record documentation will need to include the following required elements:

- Reason for visit, medical history, test results, treatments and findings.
- Diagnosis and assessment including progress notes.
- Plan of care with legible date and signature of the observer.
- Documentation supporting the claim information (i.e. rendering provider matches).
- Level of care and service provided.
- Medical record must be complete, timed, dated, signed and authenticated.
- Physician credentials must be identified with a signature.

Resources:

1. "Medicare Program Integrity Manual," Chapter 3, Section 3.3.2.4 - Signature Requirements http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf.
2. "Medicare Learning Network." Complying with Medical Record Documentation Requirements. ICN 909160 April 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf.
3. "Medicaid Program Integrity Education." Your Medical Documentation Matters. Presentation. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html.

Coverage Policy Manual Updates

Since April 2018, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The table highlights these additions and updates. To view entire policies, access the coverage policies located on our website at arkansasbluecross.com.

Policy ID#	Policy Name
1997229	Cardiac Event Recorder, External Loop or Continuous Recorder
2001032	Closure Devices for Atrial or Ventricular Septal Defects (ASD, VSD) or Patent Foramen Ovale (PFO), Percutaneous
2003046	Laser Treatment of Congenital Port Wine Stain Hemangiomas and Burn Scars
2004018	Intravenous Lidocaine or Ketamine for the Outpatient Management of Chronic Pain
2004026	MR Guided Ultrasound Ablation - Uterine Fibroids and Other Tumors
2005003	Genetic Test: Cytochrome p450 Genotype Guided Treatment Strategy
2006032	Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)
2007015	Genetic Test: Genotype-Guided Warfarin Dosing
2009015	Golimumab
2009019	Sleep Apnea, Testing
2010017	Aqueous Shunts and Devices for Glaucoma
2011008	Left Atrial Appendage, Closure Device, Percutaneous
2011026	Preventive Services For Non-Grandfathered (PPACA) Plans: Type 2 Diabetes Mellitus Screening For Adults
2011061	Genetic Test: Melanoma, V600 Mutation Testing to Predict Response to BRAF Inhibitor Targeted Therapy
2011066	Preventive Services For Non-Grandfathered (PPACA) Plans: Overview
2011066	Preventive Services For Non-Grandfathered (PPACA) Plans: Overview
2012002	Transcatheter Pulmonary Valve Implantation
2012003	Genetic Test: Molecular Markers in Fine Needle Aspirates of the Thyroid
2012043	Genetic Test: Rett Syndrome
2012054	Measurement of Serum Antibodies to Infliximab, Adalimumab, Vedolizumab, and Ustekinumab
2012055	Preventive Services For Non-Grandfathered (PPACA) Plans: Prevention Of Falls In Community-Dwelling Older Adults
2013015	Treatment of Varicose Veins/Venous Insufficiency
2013018	Genetic Test: Lactase Insufficiency
2013028	Tumor-Treating Fields Therapy
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment
2013046	Genetic Test: Testing for the Diagnosis and Management of Mental Health Conditions
2014019	Patient-Specific Instrumentation (eg Cutting Guides) for Joint Arthroplasty

(Continued on page 7)

Coverage Policy Manual Updates (Continued from page 6)

Policy ID#	Policy Name
2015008	Genetic Test: Miscellaneous Genetic and Molecular Diagnostic Tests
2015024	Prostatic Urethral Lift (UroLift System)
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab) (Durvalumab)
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab) (Durvalumab)
2016008	Thermal Ablation of Peripheral Nerves to Treat Pain Associated with Plantar Fasciitis or Knee Osteoarthritis
2016012	Daratumumab (Darzalex)
2017001	Alpha-1 Proteinase Inhibitor Therapy
2017008	Brentuximab (Adcetris™)
2017009	Denosumab (XGEVA™ and Prolia™)
2017016	Ramucirumab (Cyramza™)
2017020	Pemetrexed (Alimta)
2017024	Panitumumab (Vectibix™)
2017037	Direct Acting Antiviral Medications for Treatment of Chronic Hepatitis C
2018002	Chemodenervation, Botulinum Toxins
2018014	Pharmacy: Lutetium Lu 177 Dotatate (Lutathera®)
2018015	Genetic Test: Gene Expression Profiling for Cutaneous Melanoma
2018015	Genetic Test: Gene Expression Profiling for Cutaneous Melanoma
2018016	"Pilot Policy: Stereotactic Body Radiotherapy (SBRT) for the Treatment of Prostate Cancer Within Clinical Trial NRG-GU005 Pilot Policy for the use of SBRT in the treatment of Prostate Cancer within an Established Clinical Trial NRG-GU005"
2018018	Three Dimensional Printed Orthopedic Implants
2018019	Use of Laser Therapy or Radiofrequency Therapy for the Treatment of Vaginal Atrophy or Vaginal Relaxation Syndrome
2018020	Surgical Treatments for Lymphedema Secondary to Breast Cancer Treatment

Hysteroscopic Placement of Micro-Inserts in the Fallopian Tubes as a Form of Permanent Sterilization

On July 20, 2018, Bayer announced discontinuing sales of the Essure permanent birth control implant in the United States at the end of 2018. Effective immediately, Arkansas Blue Cross and Blue Shield and its family of companies will no longer cover this implant. Coverage Policy #2003020, Hysteroscopic Placement of Micro-Inserts in the Fallopian Tubes as a Form of Permanent Sterilization, has been revised to reflect the non-coverage of this device.

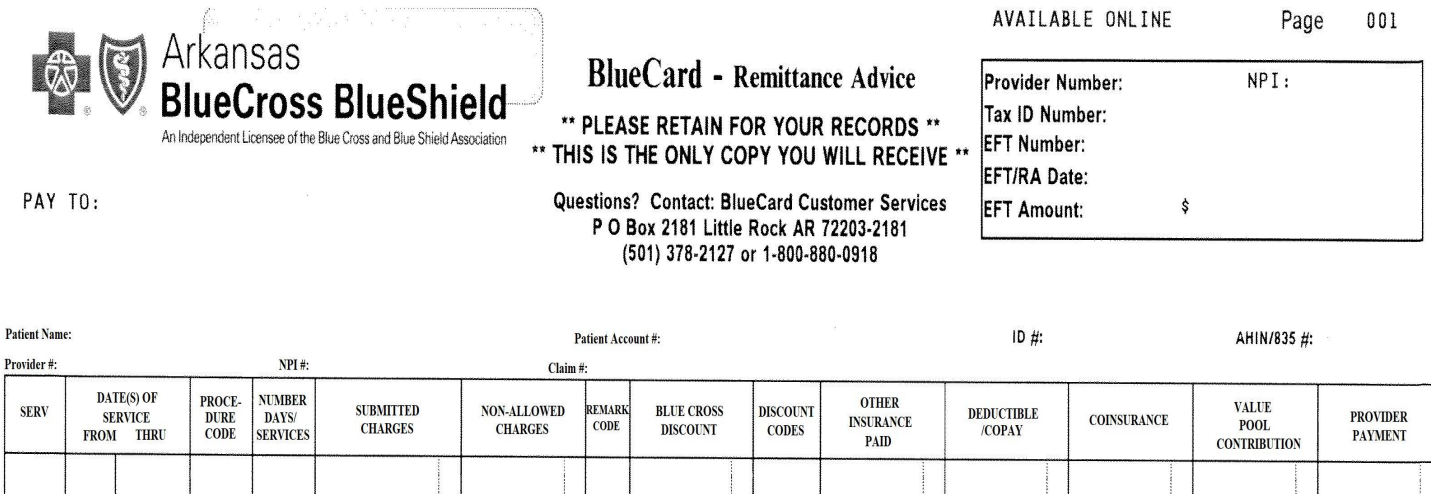
BlueCard Remittance Advice (RA) Enhancement

RA enhancements in preparation for the Value-Based Compensation Initiative

Arkansas Blue Cross and Blue Shield and its family of companies will implement changes to the BlueCard Remittance Advice (RA) in preparation for the Value-Based Compensation Initiative with Release 18.5, which will be installed on **October 14, 2018**. In addition to an updated RA format consistent with other Arkansas Blue Cross lines of business, the BlueCard Remittance Advice (RA) will now contain a column for the value pool contribution amount. All information currently available on the BlueCard RA will be available on the enhanced BlueCard RA; the only new component is the column for the value pool contribution amount.

This new RA column will not contain any values until the value pool contributions begin. Value pool contributions will begin after the end of a 12-month "shadow" reporting period that is intended to give providers information about their performance. The 12-month shadow reporting period will be "triggered" by the date in which shadow reports are first released and available to all participating providers.

Arkansas Blue Cross is implementing the Value-Based Compensation Initiative (VBCI) as part of our ongoing efforts to contribute to the improvement of the quality, affordability and sustainability of healthcare. This effort partially transitions from volume-based (fee-for-service) reimbursement to a compensation approach that is aimed at incentivizing value-based care and eliminating waste and inefficiencies from the healthcare delivery system.



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

AVAILABLE ONLINE Page 001

BlueCard - Remittance Advice

** PLEASE RETAIN FOR YOUR RECORDS **
** THIS IS THE ONLY COPY YOU WILL RECEIVE **

Questions? Contact: BlueCard Customer Services
P O Box 2181 Little Rock AR 72203-2181
(501) 378-2127 or 1-800-880-0918

PAY TO:

Provider Number: NPI:
Tax ID Number:
EFT Number:
EFT/RA Date:
EFT Amount: $

Patient Name: Patient Account #: ID #: AHIN/835 #:
Provider #: NPI #: Claim #:

SERV	DATE(S) OF SERVICE FROM THRU	PROCE-DURE CODE	NUMBER DAYS/ SERVICES	SUBMITTED CHARGES	NON-ALLOWED CHARGES	REMARK CODE	BLUE CROSS DISCOUNT	DISCOUNT CODES	OTHER INSURANCE PAID	DEDUCTIBLE /COPAY	COINSURANCE	VALUE POOL CONTRIBUTION	PROVIDER PAYMENT

New CARC Code on the 835 transaction

Claim Adjustment Reason Code (CARC) **104** will be used on the 835 transaction to identify the VBCI value pool contribution amounts. The code won't be utilized until the value pool contributions begin following the end of a 12-month "shadow" reporting period. However, Arkansas Blue Cross wants to ensure that providers have ample time to make any system changes to accommodate the new code.

CARC	104	Managed care withholding

Please contact your Network Development Representative with any questions.

Value-Based Compensation Initiative

In the June 2018 *Providers' News*, ABCBS provided an update on the timeline for implementation of the Value-Based Compensation Initiative (VBCI). It was also communicated that ongoing meetings and communications with physicians, physician groups and other stakeholders would continue prior to and throughout the 12-month shadow reporting period in order to obtain feedback important to continued improvements to the program.

Since the June *Providers' News* article, meetings with providers and stakeholders have continued, and ABCBS has continued to make modifications to VBCI based upon feedback that has been received. Since June, ABCBS has been working with RowdMap to make modifications to measures within the RowdMap platform, taking into account feedback from stakeholders. ABCBS has also been working to make modifications to AHIN to prepare for release of shadow reports.

As a reminder, value pool contributions will begin after the end of a 12-month shadow reporting period that is "triggered" by the release of shadow reports in AHIN. The shadow reporting period will be used to educate providers on information about their performance in VBCI relative to their peers. In the June 2018 *Providers' News*, it was communicated that the anticipated release of the shadow reports was July 20, 2018. As a result of modifications that have continued based upon stakeholder feedback, shadow reports were not released in July.

We remain committed to making changes to the program based upon provider feedback and making sure the program fairly aligns incentives to include a value-based compensation component prior to release of the reports – accuracy before speed. Therefore, we have continued to make modifications in preparation for release of the shadow reports. Our current expectation is to release shadow reports no later than the end of this calendar year.

When the shadow reports are released, we expect participating providers to receive access to a full year of information showing:

1. How they are performing relative to their peers – i.e., what is their current value score?
2. Where are their opportunities for improvement that would allow them to improve their value score?
3. What would their value pool contribution have been had VBCI been active for the period?
4. What would their value pool distribution have been had VBCI been active for the period?

Assuming shadow reports are released in December 2018, the "trigger date" will be the first day of the next month, which will be January 1, 2019. The 12-month shadow reporting period will then end on December 31, 2019, and value pool contributions will begin on January 1, 2020. During the shadow reporting period, reports will be released quarterly on AHIN.

The first release of "live" value scores and related value pool distributions would follow 30 days after the end of the calendar-year quarter in which value pool contributions begin. Subsequent release of value scores and value pool distributions will be made on the same schedule (30 days after the close of each calendar-year quarter).

Meetings and communications with physicians, physician groups and other stakeholders will continue prior to and throughout the shadow reporting period in order to obtain feedback that may be used to further modify and improve the program prior to implementation – and beyond.

We will continue to include updates in *Providers' News* and AHIN on the status of the release of shadow reports. Questions regarding VBCI can be emailed to VBCI@arkbluecross.com.

Provider Network Agreements and VBCI

Hospitals and physicians are reminded that in 2020 the Value-Based Compensation Initiative (VBCI) will become part of the normal reimbursement methodology for the commercial networks sponsored Arkansas Blue Cross and Blue Shield (Arkansas Blue Cross), Health Advantage and USAble Corporation. With that in mind, this is considered an official notice and amendment to all Arkansas Blue Cross provider agreements, that the VBCI Program shall be included in each Agreements' definition of "Allowance" "Allowances" or "Fee Schedules," as well as becoming part of the Compensation Subject to Health Plan Terms and Payer Policies section in each Agreement.

On sensitive VBCI information requiring additional security, AHIN will be the source of communication with providers. However, details of the VBCI Program will be outlined in the provider manual at www.arkansasbluecross.com and communicated through *Providers' News*.

Federally Required Compliance Requirements

Arkansas Blue Cross and Blue Shield and its family of companies are required by the Centers for Medicare and Medicaid Services (CMS)[1], as well as the federal government, state government and other regulators, to ensure that certain individuals and entities with whom we do business[2] (including healthcare-related professionals and organizations) complete **general compliance training** and **fraud, waste and abuse training** on an annual basis[2] in addition to meeting certain federal and state compliance requirements.

What requirements must be met?

1. **Training**: General compliance training and Fraud, Waste and Abuse (FWA) training (where applicable), should be completed annually by **all persons** who have contact (indirect or direct) with beneficiaries of Medicare Advantage (MA) and members covered by the Affordable Care Act (ACA). This includes staff in all billing, reception, lab and clinical areas.

General compliance training is required for all persons who meet the criteria above, but certain individuals and entities who participate in the Medicare program are deemed to have met the **FWA** component by virtue of

[1] Arkansas Blue Cross and Blue Shield must maintain an annual compliance training program because we are a:

- *Contractor with the federal Centers for Medicare & Medicaid Services (CMS)*
- *Qualified Health Plan (QHP) through the U.S. Department of Health and Human Services (HHS) through the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act).*

[2] Entities that must complete annual compliance training (including fraud, waste and abuse training) include:

- *First-tier, downstream and related entities (FDRs).*
- *Delegated entities (DEs).*

According to the Federal Register Notice CMS-4124-FC and 45 C.F.R. Subpart D §156.340, providers are considered first-tier and/or delegated entities because there is a direct contract for Medicare/Affordable Care Act Services between Arkansas Blue Cross and each provider.

(Continued on page 11)

satisfying Medicare's annual certification requirements. This includes entities and/or individuals who are:

- Participating healthcare providers in the federal Medicare program (Parts A and/or B).
- Accredited, Medicare-approved suppliers of durable medical equipment, prosthetics, orthotics and supplies.

When should training be completed?

The General Compliance Training and/or Fraud, Waste and Abuse (FWA) training must occur within 90 days of initial hiring and annually thereafter. The annual training may be completed at any time during a traditional calendar year. Training must be documented. All documentation is subject to random audit by Arkansas Blue Cross or the federal government.

In the event that your organization does not provide annual compliance training, Arkansas Blue Cross has made compliance training available on our website at www.arkbluecross.com/providers under 'Resource Center' and selecting the *Required Annual Compliance Information* link. The compliance is also available on AHIN, under Providers News.

Additionally, on or after October 12, the AHIN User Administrator (AUA) will receive notification, via AHIN, when the compliance attestation is available. The AUA should attest that all compliance related requirements have been met by the provider for the plan year. The attestation should be completed by December 31.

NOTE: *CMS will be removing the compliance training from the Medicare Learning Network (MLN) website in anticipation of regulation changes for the 2019 plan year. However, if you have already completed the web-based compliance training on the MLN for the 2018 plan year, you are compliant with the requirements for 2018.*

2. **Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), and the U.S. General Services (GSA) System for Award Management (SAM), formerly the Excluded Parties List System (EPLS) , Exclusion Checks**

   These lists for individuals or entities excluded by any Federally-funded health care program for participating in or receiving health care reimbursement or payment[3] should be reviewed prior to hiring or contracting and monthly thereafter. Upon discovery of an excluded individual, immediate disclosure must be provided to Arkansas Blue Cross.

[3] *https://exclusions.oig.hhs.gov/OIG; https://sam.gov*

Cardionet is in Network

CardioNet became an in network provider March 27, 2018. This includes all commercial provider networks and Medi-Pak® Advantage. Previously, specific in network providers for the types of services offered by CardioNet have not been available.

CardioNet provides monitoring and is covered under codes 93225, 93226, 93229, 92370, 93271, 93293-TC, 0296T and 0297T. More information on Cardionet is available at https://www.cardionet.com/.

Please remember that all provider agreements require the use of in network providers in order for a member to receive in network benefits.

The Drug Cost Resource Tool for Primary Care

The Drug Cost Resource Tool within the Care Management Portal on AHIN for primary care providers (with aligned members) assists with understanding the cost of covered drugs for the 10 therapeutic classes. If primary care providers (with aligned members) do not currently have access, they may contact their site AHIN User Administrator (AUA) or AHIN Customer Support at 501-378-2336 or 855-822-2446

This tool is produced and mailed quarterly and based on the most recent quarter of Arkansas Blue Cross claims data. Strengths and quantities of each drug are included in the calculated average cost. However, this is not the absolute cost of a particular drug, but the relative cost when compared to a 30-day supply or fill in these 10 drug classes.

The main objective of the Drug Cost Resource Tool is to help prescribers choose the most cost effective drug for the condition they are treating for the patient without compromising quality. Most of the time, generic medications are the most cost effective, but at times, there are generic medications that are very expensive as well, this tool allows providers to see this.

The color-coding, which is a recent improvement, readily identifies each drug's cost and coverage considerations:

- Green – means the drug is a cost-effective generic, with no coverage concerns.
- Yellow – indicates that the medicine may have some coverage concerns. This usually means that "step therapy" (which is code for "try the generic first") may be required for the drug to be covered.
- Red – is a flag that the drug is a very-high-cost option that may not be covered at all or may require step therapy or prior approval.

A prescriber can simply glance at it and make an informed choice. Among other things, it depicts the sometimes huge pricing disparity between generic and brand-name medications.

The drug cost resource tool was developed to be shared with Collaborative Health Initiatives (CHIs) working with Arkansas Blue Cross. For providers participating in CPC+, PCMH or Arkansas Blue Cross Collaborative, the drug cost resource tool is available electronically through the AHIN portal: https://secure.ahin-net.com/ahin/Session/logon. After logging into AHIN, click on the Portal tab. Under tools, select "Arkansas Blue Cross Blue Shield." Once the Care Management Portal has been accessed, there will be a link for the Drug Cost Resource Tool in the "Resources" section.

Proton Pump Deprescribing Algorithm and Tool

This tool was developed to assist prescribers in helping patients who may not require long term therapy taper off PPIs. Often, prescribers or patients try to discontinue medications abruptly. Abrupt withdrawal of a PPI can lead to rebound reflux. The patient may feel like his/her symptoms have come back, so he or she continues taking the medication. In reality, the patient should have been tapered off the PPI and managed on an over the counter product for a short period of time.

The resource also provides an algorithm for how to discontinue PPIs successfully. It also contains tables that provide cost of a 30-day supply for a typical dose, potential adverse events associated with long term use and the appropriate duration for approved indications. Many patients are started on PPIs and remain on them for many years unnecessarily.

The Drug Cost Resource and Proton Pump Inhibitor (PPI) Deprescribing Algorithm have been included on the next four pages.

Drug Cost Resource

Based on claims data from:
JANUARY - MARCH 2018

Listed by Average Cost of a 30 Day Supply Except Where Noted*

- Most of the time, generic medications are the most cost-effective choices to treat most conditions and should always be evaluated as first choice over brand medications.
- This is a guide for prescribers to differentiate the relative average cost of a 30-day supply or fill of generic and brand drugs within a therapeutic drug class.
- All strengths and quantities are included in the calculated average cost - this is not the absolute cost.
- The cost of some generic medications is hyper-inflated, as shown by this tool.
- Most therapeutic categories require generic step therapy before the higher cost brand is covered.
- Brand drugs are printed in UPPERCASE.

Most Cost-effective Drugs in Class
Proceed with Caution; May Require Prior Approval or Step Therapy
Very High Cost; May be Excluded or Require Prior Approval or Step Therapy

*Antibiotics**	
Sulfamethoxazole-Trimethoprim DS	$3
Levofloxacin	$4
Ciprofloxacin HCL	$5
Amoxicillin	$6
Penicillin VK	$7
Metronidazol	$8
Azithromycin	$8
Cephalexin	$8
Clindamycin HCL	$10
Cefadroxil	$10
Trimethoprim	$11
Amoxicillin K Clavulanate	$18
Ampicillin	$18
Doxycycline Monohydrate	$22
Sulfamethoxazole-Trimethoprim	$25
Sulfatrim PD	$27
Doxycycline Hyclate	$34
Dicloxacillin	$35
Cefprozil	$41
Cefdinir	$41
Minocycline	$44
Cefuroxime	$47
Cefaclor	$52
Clarithromycin	$59
Tinidazole	$60
Dapsone	$76
Cefpodoxime	$79
Cefpodoxime Proxetil	$85
Moxifloxacin	$97
Clindamycin	$112
Amoxicillin K Clavulanate ER	$124
Erythrocin	$158
MOXATAG (amoxicillin)	$160
Demeclocycline	$179
Tetracycline	$292
SUPRAX (cefixime)	$300
AUGMENTIN (Amoxicillin K Clavulanate)	$341
Cefixime	$353
Ceftibuten	$370
ERY-TAB (erythromycin delayed release)	$409
Erythromycin	$482
Linezolid	$524
Vancomycin	$641
E.E.S. 400 (erythromycin ethylsuccinate	$658
TARGADOX (doxycycline hyclate tab)	$690
ACTICLATE (doxycycline hyclate tab)	$939
Erythromycin Ethylsuccinate	$949
Atovaquone	$1,022
SOLODYN (minocycline ext-tab)	$1,218
ALINIA (nitazoxanide)	$1,560
XIFAXAN (rifaximin)	$1,951

Diabetes - Oral Medications	
Glipizide	$3
Metformin	$3
Metformin ER	$5
Glimepiride	$8
Glyburide/Metformin	$10
Glyburide	$10
Glipizide ER	$13
Glipizide XL	$15
Pioglitazone	$23
Acarbose	$35
Glipizide/Metformin	$44
Nateglinide	$70
Repaglinide	$74
Pioglitazone/Metformin	$130
Alogliptin	$176
INVOKAMET XR (canagliflozin ER)	$316
ONGLYZA (saxagliptin)	$386
JENTADUETO (linagliptin/metformin)	$397
JANUMET XR (sitagliptin/metformin)	$403
Pioglitazone/Glimepiride	$410
TRADJENTA (linagliptin)	$411
JANUMET (sitagliptin/metformin)	$417
KOMBIGLYZ XR (saxagliptin/metformin)	$425
JANUVIA (sitagliptin)	$427
INVOKAMET (canagliflozin/metformin)	$443
XIGDUO XR (dapagliflozin/metformin)	$452
SYNJARDY (empagliflozin/metformin)	$459
JARDIANCE (empagliflozin)	$461
FARXIGA (dapagliflozin)	$462
INVOKANA (canagliflozin)	$465
FORTAMET/GLUMETZA ER (metformin ER)	$488
GLYXAMBI (empagliflozin/linagliptin)	$518

ADHD	
FOCALIN (Dexmethylphenidate)	$39
RITALIN (Methylphenidate)	$40
Metadate	$61
Guanfacine	$67
Amphetamine/Dextroamphetamine	$75
METHYLIN (Methylphenidate)	$115
Dexmethylphenidate	$129
Dextroamphetamine	$134
Armodafinil	$141
Methylphenidate	$149
Atomoxetine	$153
APTENSIO XR (Methylphenidate)	$213
ZENZEDI	$231
Modafinil	$244
MYDAYIS (Amphet/Dextroamphet)	$273
FOCALIN XR (Dexmethylphenidate)	$288
VYVANSE (Lisdexamfetamine)	$298
QUILLIVANT (Methylphenidate)	$308
ADDERALL XR (Amphet/Dextro)	$329
DAYTRANA (Methylphenidate)	$330
ADDERALL (Amphetamine/Dextro)	$334
CONCERTA (Methylphenidate)	$366
QUILLICHEW (Methylphenidate)	$369
RITALIN LA (Methylphenidate)	$478
STRATTERA (Atomexetine HCL)	$514
PROCENTRA (Dextroamphet solution)	$514
NUVIGIL (Armodafinil)	$656
Methamphetamine	$782
PROVIGIL (Modafinil)	$2,825

Diabetes - Injectables (Est. Avg. cost per vial/box)	
Rapid Acting	
NOVOLOG 10ml vial	$242
APIDRA 10 ml vial	$260
HUMALOG 100U 10ml vial	$274
NOVOLOG 15ml Pen	$466
APIDRA 15ml Pen	$503
HUMALOG KWIKPEN 200U/ml 6ml	$424
HUMALOG KWIKPEN 100U/ml 15 ml	$528
Short (R) and Intermediate (N)	
NOVOLIN N 10ml vial	$113
HUMULIN N 10ml vial	$148
NOVOLIN R 10ml vial	$115
HUMULIN R 10ml vial	$148
HUMULIN R U500 20ml vial	$1,298
Long Acting	
LEVEMIR 10ml vial	$245
LANTUS 10ml Vial	$258
BASAGLAR 15ml Pen	$288
LEVEMIR 15ml Pen	$365
LANTUS 15ml Pen	$383
TRESIBA 100U/ml 15 ml	$403
TRESIBA 200U/ml 9ml Pen	$482
TOUJEO 300U/ml 4.5ml Pen	$353
Pre-Mixed	
NOVOLIN 70/30 Mix 10ml Vial	$123
HUMULIN 70/30 Mix 10ml Vial	$148
HUMULIN 70/30 Mix 15ml Pen	$468
NOVOLOG 70/30 Mix 10ml Vial	$257
HUMALOG 50/50 Mix 10mL vial	$285
HUMALOG 75/25 Mix 10ml Vial	$284
NOVOLOG 70/30 Mix 15ml Pen	$473
HUMALOG 75/25 Mix 15ml Pen	$529
HUMALOG 50/50 Mix 15mL pen	$533
Incretin Mimetics	
VICTOZA 2 Pens	$484
VICTOZA 3 Pens	$724
BYETTA 10 mcg 1 pen	$684
TRULICITY 0.75mg, 4 pens	$608
TRULICITY 1.5mg Pens, 4 pens	$608
OZEMPIC pen	$634
TANZEUM30mg, 4 pens	$516
TANZEUM 50mg, 4 pens	$522
BYDUREON 2 mg 4 pens	$639
Incretin + Long Acting Insulin	
SOLIQUA (insulin glargine + lixisen)	$583
XULTOPHY (insulin degludec and lirag)	$953
Amylin Analog	
SYMLIN 60 pen 2pk	$742
SYMLIN 120 pen 2pk	$926

*** Average Cost per Fill.**
Generics are the most clinically and cost effective options but if not appropriate then Preferred Brands are the best alternative

Drug Cost Resource

Based on claims data from
JANUARY - MARCH 2018

Listed by Average Cost of a 30 Day Supply Except Where Noted*

- Most of the time, generic medications are the most cost-effective choices to treat most conditions and should always be evaluated as first choice over brand medications.
- This is a guide for prescribers to differentiate the relative average cost of a 30-day supply or fill of generic and brand drugs within a therapeutic drug class.
- All strengths and quantities are included in the calculated average cost - this is not the absolute cost.
- The cost of some generic medications is hyper-inflated, as shown by this tool.
- Most therapeutic categories require generic step therapy before the higher cost brand is covered.
- Brand drugs are printed in UPPERCASE.

Most Cost-effective Drugs in Class
Proceed with Caution; May Require Prior Approval or Step Therapy
Very High Cost; May be Excluded or Require Prior Approval or Step Therapy

Renin/Angiotensin Aldosterone System

Lisinopril	$2
Lisinopril HCTZ	$2
Benazepril	$4
Ramipril	$5
Losartan Potassium	$6
Enalapril Maleate HCTZ	$8
Fosinopril	$8
Losartan HCTZ	$8
Quinapril	$8
Trandolapril	$10
Enalapril	$15
Irbesartan	$15
Valsartan HCTZ	$17
Amlodipine Besylate-Benazepril	$20
Perindopril	$23
Valsartan	$23
Qnapril HCTZ	$25
Irbesartan HCTZ	$27
Moexipril	$37
Fosinopril Sodium HCTZ	$38
Benazepril HCTZ	$40
Telmisartan	$41
Olmesartan Medoxomil	$44
Olmesartan Medoxomil HCT	$46
Amlodipine Besylate Valsartan	$48
Captopril	$55
Candesartan	$66
Candesartan Cilexetil HCTZ	$80
Telmisartan HCTZ	$87
Telmisartan Amlodipine	$97
Olmesartan Medoximil Amlodipine	$102
Amlodipine Besylate Olmesartan	$103
Amlodipine Valsartan Hctz	$109
Trandolapril Verapamil	$134
HYZAAR (Losartan HCTZ)	$140
EDARBI (azilsartan)	$185
TEKTURNA-HCT (aliskiren/hctz)	$198
TEKTURNA (aliskiren)	$210
Captopril HCTZ	$221
BENICAR-HCT (olmesartan/hctz)	$244
ALTACE (ramipril)	$248
TRIBENZOR (olmesartan/amlodipine/hctz)	$282
AZOR (olmesartan/amlodipine)	$289

Proton Pump Inhibitors

Omeprazole	$5
Pantoprazole	$6
Lansoprazole	$18
Rabeprazole	$37
Esomeprazole Magnesium	$90
DEXILANT (dexlansoprazole)	$283
NEXIUM (esomeprazole magnesium)	$304
PRILOSEC (omeprazole)	$419
PREVACID (lansoprazole)	$429
ACIPHEX (rabeprazole)	$527
PROTONIX (pantoprazole)	$536

*Topical Steroids**

Hydrocort Ace W/ Pramoxine	$91
PROCTOFOAM (hydrocort & pramoxine)	$156
ANALPRAM-HC (hydrocort & pramoxine)	$208
PROCORT (hydrocortisone & pramoxine)	$275
Calcipotrien	$1,034
ENSTILAR (calcipotriene/betamethasone)	$1,185
TACLONEX (calcipotriene/betamethasone)	$1,252
Very High Potency	
Augmented Betamethasone Dipropionate	$71
Clobetasol Emollient Cream	$93
Halobetasol	$137
Desoximetasone	$161
Clobetasol Propionate Emulsion	$322
Fluocinonide	$343
TOPICORT (desoximetasone)	$552
CORDRAN 80X3 (flurandrenolide)	$638
Diflorasone	$1,180
High Potency	
Betamethasone Valerate	$42
Betamethasone Dipropionate	$65
Fluocinonide Emulsified Base	$66
Fluocinolone Acetonide	$105
Clobetasol Propionate	$222
Clocortolone	$365
HALOG (halcinonide)	$638
Medium Potency	
Triamcinolone	$11
Mometasone	$24
Fluticasone	$29
Hydrocorticone Butyrate	$73
Hydrocortisone Valerate	$134
HC Butyrate Hydrophilic	$423
Low Potency	
Hydrocortisone	$8
Alclometasone	$47
Desonide	$137
CAPEX (fluocinolone acetonide)	$378
DESONATE (desonide)	$570

*Triptans**

Rizatriptan	$21
Sumatriptan Succinate	$35
Naratriptan	$68
IMITREX NASAL SPRAY (sumatriptan)	$80
Zolmitriptan	$110
Eletriptan	$161
Almotriptan	$236
MAXALT-MLT (rizatriptan)	$332
Sumatriptan	$350
Frovatriptan	$353
ZOMIG (zolmitriptan)	$470
RELPAX (eletriptan)	$480
Sumatriptan-Naproxen	$527
IMITREX (sumatriptan)	$688
ONZETRA XSAIL (sumatriptan)	$689
TREXIMET (sumatriptan & naproxen)	$850
ZEMBRACE SYMTOUCH (sumatriptan)	$1,099

Antidepressants - SSRI/SSNRI

Citalopram	$2
Sertraline	$4
Escitalopram	$6
Paroxetine	$7
Fluoxetine	$9
Venlafaxine	$14
Bupropion SR	$16
Bupropion XL	$23
Duloxetine	$25
Bupropion HCL	$25
Fluvoxamine	$70
Dexvenlafaxine Succinate ER	$89
Paroxetine ER	$110
Paroxetine Mesylate	$149
BRISDELLE (paroxetine)	$190
PAXIL CR (paroxetine CR)	$196
Fluoxetine 60mg	$229
Dexvenlafaxine ER	$245
Fluoxetine PMDD	$253
PAXIL (paroxetine)	$256
VIIBRYD (vilazodone)	$256
CYMBALTA (duloxetine)	$303
LEXAPRO (escitalopram)	$341
FETZIMA (levomilnacipran)	$362
KHEDEZLA (dexvenlafaxine)	$366
TRINTELLIX (vortioxetine)	$392
PEXEVA (paroxetine)	$393
PRISTIQ (desvenlafaxine)	$421
ZOLOFT (sertraline)	$426
FORFIVO XL (bupropion)	$429
SARAFEM (fluoxetine)	$600
WELLBUTRIN SR (buproprion SR)	$650
PROZAC (fluoxetine)	$729
EFFEXOR XR (venlafaxine XR)	$825
WELLBUTRIN (buproprion)	$1,632

Beta Blockers

Metoprol Tartrate	$2
Atenolol	$4
Bisoprolol HCTZ	$5
Carvedilol	$5
Sotalol HCL	$13
Acebutolol	$14
Metoprolol Succinate	$15
Bisoprolol Fumarate	$17
Metoprolol ER	$17
Atenolol & Chlorthalidone	$18
Sotalol AF	$18
Propranolol	$26
Labetalol	$26
Betaxolol	$28
Metoprolol HCTZ	$33
TOPROL XL (metoprolol ER)	$37
Pindolol	$58
Nadolol	$66
Metoprolol	$94
Timolol Maleate	$97
BYSTOLIC (nebivolol)	$136
Carvedilol Phosphate Cap ER	$231
COREG CR (carvedilol CR)	$304
INNOPRAN XL (propranolol)	$759
HEMANGEOL (propranolol)	$819

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

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

*** Average Cost per Fill**
Generics are the most clinically and cost effective options
but if not appropriate then Preferred Brands are the best alternative

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

Proton Pump Inhibitors (PPIs)

Cost of available PPIs and H2RAs			
Cost Rating	**Drug**	**Average 30 day cost for all strengths and quantities**	**Typical Dose**
H2RAs			
	Famotidine	**$5.70***	20-40 mg BID
	Ranitidine	**$9.40***	150 mg BID
	Cimetidine	**$11.20***	200-400 mg BID
	Nizatidine	**$60***	150 mg BID
PPIs			
	Omeprazole	**$8**	20-40 mg qd
	Pantoprazole	**$8**	40 mg qd
	Lansoprazole	**$33**	15-30 mg qd
	Rabeprazole	**$66**	20 mg qd
	Esomeprazole Magnesium	**$175**	20-40 mg qd
	DEXILANT (dexlansoprazole)	**$269**	30-60 mg qd
	NEXIUM (esomeprazole)	**$337**	20-40 mg qd
	PREVACID (lansoprazole)	**$378**	15-30 mg qd
	PROTONIX (pantoprazole)	**$394**	40 mg qd
	PRILOSEC (omeprazole)	**$411**	20-40 mg qd
	ACIPHEX (rabeprazole)	**$544**	20 mg qd
	Omeprazole/Na Bicarbonate	**$2,259**	20-40g qd

* Wholesale acquisition cost (WAC) for 30 days treatment with lowest usual oral dose.

Appropriate Indications for PPIs	
Short Term (≤ 8 weeks of use)	• GERD – Initial 8-week course. • Gastric/duodenal ulcers – Typically 4- to 8-week course • H. pylori – Usually 10-14 days in duration • Stress Ulcer Prophylaxis in Hospitalized ICU Patients
Long Term (> 8 weeks of use)	• Refractory GERD – Only in non-responders after 2-3 mo. • Erosive Esophagitis – Consider maintenance PPI if continued symptoms after 8-week trial of PPI. • Zollinger-Ellison Syndrome • NSAID – Induced Ulcers – Only if risk factors for GI bleeding. • Chronic Anticoagulation After a GI Bleed • Barrett's Esophagus

Comparative Effectiveness

According to the 2013 American College of Gastroenterology guidelines for the treatment of GERD, "**there is no clinically significant difference in efficacy for symptom relief between available proton pump inhibitors based off published literature.**"[1,2]

Potential Adverse Events from Long Term PPI Use		

Drug – Drug Interactions	• PPIs inhibit CYP2C19 in varying degrees
	  • Still controversy on significance of DDI with clopidogrel. Clopidogrel package insert says to **avoid concomitant use with omeprazole or esomeprazole**.
	  • Systematic reviews and meta analyses have shown increased CV events in patients taking PPIs and clopidogrel concomitantly, while others have shown no increase in CV events.[3,4,5,6]
	  • No interaction with clopidogrel and H2RAs	

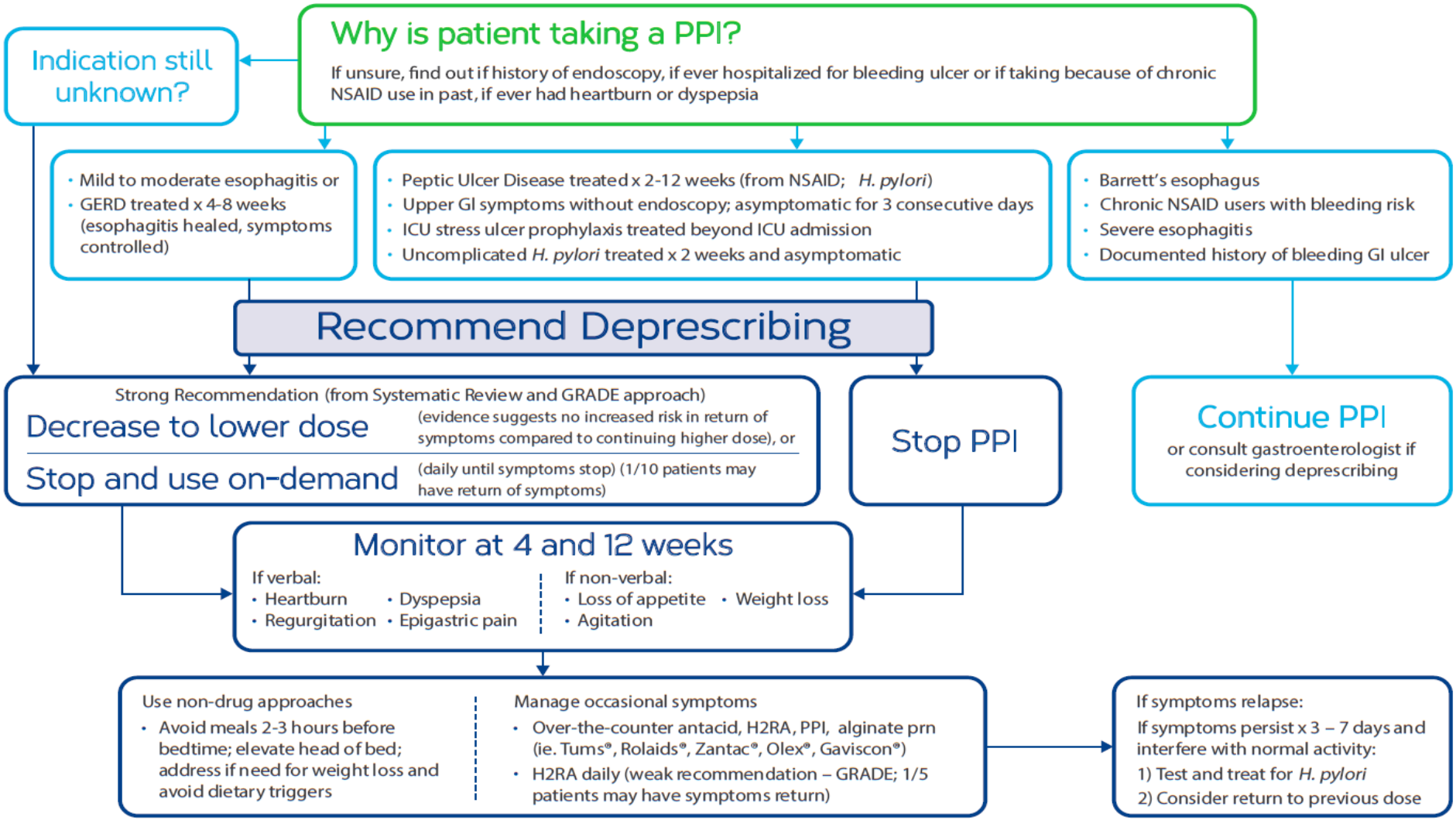
Vitamin Deficiencies[6]	Calcium	Vitamin B12
	Iron	Magnesium
Association with Infection[6]	**Hospital Acquired Pneumonia** – One additional HAP case for every 111 non-ICU patients treated with a PPI for at least three days.	
	Community Acquired Pneumonia – Weak correlation between PPI use and CAP. One extra case of CAP for every 226 patients treated with a PPI for five months.	
	***Clostridium difficile* infection** – For every 533 hospitalized patients receiving a daily PPI, at least one will develop *C. diff*. 42% increased risk of recurrent infection within 90 days in patients being treated for C. difficile while taking a PPI.	
Fracture Risk[6]	• PPI use is associated with a 25% increase in overall fracture risk and 47% increase in spinal fractures in postmenopausal women. High dose and long-term treatment increase risk. • Data suggest that PPIs don't increase risk of osteoporosis in most patients, except if there is at least one other risk factor for hip fracture.	

This tool is designed as a reference and resource for prescribers; it is in no way intended to supersede the prescriber's clinical judgement for an individual patient. The relative drug cost in each therapeutic class is provided to assist prescribers in making cost-effective decisions.

Proton Pump Inhibitor (PPI) Deprescribing Algorithm

April 2018

Farrell, Barbara, et al. "Deprescribing proton pump inhibitors: Evidence-based clinical practice guideline."
Canadian Family Physician 63.5 (2017): 354-364.



Ref Previous Page:

1. Katz, Philip O., Lauren B. Gerson, and Marcelo F. Vela. "Guidelines for the diagnosis and management of gastroesophageal reflux disease." The American journal of gastroenterology 108.3 (2013): 308.
2. Gralnek, Ian M., et al. "Esomeprazole versus other proton pump inhibitors in erosive esophagitis: a meta-analysis of randomized clinical trials." *Clinical Gastroenterology and Hepatology* 4.12 (2006): 1452-1458.
3. Clopidogrel package insert accessed 2/13/18
4. Siller-Matula, Jolanta M., Et Al. "Effect Of Proton Pump Inhibitors On Clinical Outcome In Patients Treated With Clopidogrel: A Systematic Review And Meta-Analysis." *Journal of Thrombosis and Haemostasis* 8.12 (2010): 2624-2641.
5. Sherwood, Matthew W., Et Al. "Individual Proton Pump Inhibitors and Outcomes in Patients with Coronary Artery Disease on Dual Antiplatelet Therapy: A Systematic Review." *Journal of The American Heart Association* 4.11 (2015): E002245.
6. *PL Detail-Document, Proton Pump Inhibitors: Appropriate Use and Safety Concerns. Pharmacist's Letter/Prescriber's Letter. April 2016*

Zoll Life Vest is in Network

Zoll Life Vest became an in network provider in May. This includes all commercial networks and Medi-Pak® Advantage. Previously, the Zoll Life Vest could be approved through a special process but will now be treated as any other in network provider.

For commercial plans, the coverage policy for the Life Vest (Policy 1997018, Cardioverter Defibrillator; Implantable, Subcutaneous, and Wearable Cardioverter Defibrillator) has been recently revised. As long as the member's medical conditions meet the policy coverage criteria, prior approval for initial use of the vest is not required. Depending on the member's condition, initial use may be covered up to 4 consecutive months. However, any extended use of the vest past the initial approved length of use will require a formal request to Arkansas Blue Cross and its family of companies. Zoll will know the process of obtaining the benefit extension, so physicians should work through them.

The Medi-Pak® Advantage plans remained governed by CMS coverage criteria and processes.

Testing for Drugs of Abuse or Drugs at Risk of Abuse

Arkansas Blue Cross and Blue Shield has a coverage policy for Testing for Drugs of Abuse or Drugs at Risk of Abuse, including Controlled Substances (Policy #2009013). This coverage policy requires a precedent screening (presumptive) test for each specific drug or drug class prior to confirmatory (definitive) drug testing.

Note: Urine drug testing is expected to be performed by in-network providers. Referral to out-of-network providers – including labs – constitutes a breach of the network participation agreement except where referral is unavoidable due to an emergency or if a covered service is not available in-network. For a list of current in network laboratory service providers, visit the Arkansas Blue Cross website at arkansasbluecross.com.

Effective January 01, 2019 services performed for urine testing for drugs of abuse or drugs at risk of abuse should be submitted according to the following guidelines:

Screening (Presumptive) Testing

- Three CPT codes are available for Drug Screening (Presumptive Testing). These codes include 80305, 80306, 80307. Please note that per Coverage Policy #2009013, Services billed using CPT 80307 do not meet member benefit certificate primary coverage criteria and are not covered.
- Only one presumptive code (80305 or 80306) may be billed per day.
- There is a limit of a maximum of one unit of procedure codes 80305 and 80306 per date of service.
- There is a limit of 24 screening services per year (combined total of 80305 and 80306).

Confirmatory (Definitive) Testing

- Confirmatory (Definitive) Testing should

(Continued on page 18)

Testing for Drugs of Abuse or Drugs at Risk of Abuse (Continued from page 17)

be billed using the HCPCS codes G0480-G0482 and G0659 as appropriate
- Please note that per Coverage Policy #2009013 Services billed using HCPCS G0483 do not meet member benefit certificate primary coverage criteria and are not covered.
- Only one of the five definitive codes (G0480, G0481, G0482, G0483, G0659) may be billed per day.
- There is a limit of a maximum of one unit of procedure code G0480-G0483 and/or G0659 per date of service.
- There is a limit of 24 confirmatory services per year (combined total of G0480-G0482 and/or G0659)
- Confirmatory (Definitive) drug testing performed on saliva, hair, sweat or nails is not covered.

For definitive testing, the selection of the correct definitive G code to bill is based on two factors:

1. The use or absence of specific (1) calibration controls, (2) quality controls, and (3) internal standards. (CMS, 2017)
2. The number of drug classes documented as tested.
   - The available drug classes are specified by CMS.
   - The AMA CPT Manual may be consulted for examples of individual drugs within each drug class.

Report a code from range G0480 – G0483 if the drug testing method utilized "stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength)" and "method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift)" (CMS, 2017)
G0659 must be reported if the definitive drug testing method was performed:
- Without method or drug-specific calibration,
- Without matrix-matched quality control material, or
- Without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen.

Specimen validity testing is not eligible to be separately billed under any procedure codes (e.g. 81000, 81001, 81002, 81003, 81005, 81099, 82570, 83986, or any other code). This is because for all codes in range 80305 – 80307 & G0480 – G0483, G0659, the code description indicates that this testing is included if it was performed.

CPT codes 80320-80377 are not accepted for processing claims. These services should be reported with G0480-G0483, G0659.

Please see the complete coverage policy for details on coverage criteria for testing of drugs of abuse. The complete Coverage Policy #2009013 can be accessed on the Arkansas Blue Cross website under the "Coverage Policy" page under the "Doctors and Hospitals" tab (www.arkansasbluecross.com/members/other_links/coverage_policy.aspx).

Federal Employee Program Maternity Claims

Effective January 1, 2019, Federal Employee Program will require facility providers for inpatient or outpatient maternity claims to submit an Occurrence code and date. Specific details will follow in the December 2018 issue of *Providers' News*.

Federal Employee Program Pharmacy Benefit Change

Beginning January 1, 2019, Blue Cross and Blue Shield Federal Employee Program (FEP) benefit procedures will change for the autoimmune infusion drug infliximab (brand names Remicade, Inflectra, and Renflexis). Members currently receiving the drug may be covered under either pharmacy or medical benefits. However, members who receive a first infusion on or after January 1, 2019 can only receive the drug under medical benefits. Members who receive it under pharmacy benefits prior to January 1, 2019 will continue receiving it under pharmacy benefits.

Access Only: Current PPO Groups

Group Name	PPO Network
Alternative Opportunities	True Blue Access Only
Arkansas Department of Corrections	True Blue Access Only
Arkansas Department of Youth Services	True Blue Access Only
Arkansas Sheet Metal Workers	True Blue Access Only
Arkansas State University Athletes	True Blue Access Only
Bryce Corporation	True Blue Access Only
Diocese of Little Rock	True Blue Access Only
Franklin Electric	First Source Access Only
United Food & Commercial Workers	True Blue Access Only

2017 Plan Year HHS ACA Risk Adjustment Data Validation (RADV)/Initial Validation Audit

The Centers for Medicare and Medicaid Services (CMS), requires all organizations participating in the Marketplace/Exchange to comply with the Affordable Care Act HHS COMMERCIAL RADV INITIAL VALIDATION AUDIT (IVA) program by submitting complete and accurate ICD-10 diagnostic data to CMS for beneficiaries enrolled in an individual and/or small group health plan.

To comply with program requirements, our partner CIOX has been conducting the retrieval of randomly selected patient charts on our behalf. If your office or facility has been contacted by CIOX, we are requesting your cooperation and prompt attention to fulfill these chart requests in a timely manner. This process began in June and relates to services provided during the 2017 calendar year. If you have any questions regarding any portion of this process, you may contact your Arkansas Blue Cross Network Development Representative at your respective regional office.

Thank you for your ongoing partnership to improve the health of your patients and our members in compliance with CMS-HHS guidelines/regulations.

AIM Clinical Appropriateness Guidelines for BlueAdvantage Members

For BlueAdvantage Administrators of Arkansas (BlueAdvantage) members, updates to AIM's Clinical Appropriateness Guidelines for radiation oncology and cardiac radiology programs will be effective for dates of service on and after January 28, 2019.

The following updates apply to BlueAdvantage members participating in AIM's Radiation Oncology program:

Breast cancer

- Removed age and tumor size criteria for accelerated whole breast irradiation (AWBI).

Head and neck cancer

- Added criteria to allow IMRT for head and neck lymphomas.
- Clarified no IMRT for stage I/II glottic cancer.

Lung cancer

- Added DVH parameter for cardiac V50.

Pancreatic cancer

- Added criteria for SBRT in treating locally advanced or recurrent disease without evidence of distant metastasis.

Prostate cancer

- Added discussion on hypofractionation and on brachytherapy.

Rectal cancer

- Modified criteria no longer limits treatment with IMRT for rectal adenocarcinoma.

Sarcoma

- Removed preoperative and joint sparing requirements for IMRT

The following updates apply to BlueAdvantage members participating in AIM's Cardiac Radiology program:

Cardiac MRI

- New criteria allows for annual study to quantify cardiac iron load in chronically ill patients with cardiomyopathy who require frequent blood transfusions (e.g., thalassemia).
- Removed allowance for annual LV function evaluation when echocardiography is suboptimal

Carotid duplex ultrasound

- Criteria removed for evaluation of syncope in patients with suspected extracranial arterial disease.
- New criteria added to address evaluation of TAVR (TAVI in patients with suspected or established extracranial arterial disease.

MPI, stress echocardiography, cardiac PET

- Criteria added to allow annual surveillance of coronary artery disease in patients with established CAD post-cardiac transplant . Clarified definition of established coronary artery disease when diagnosed by CCTA.
  - o more restrictive for patients diagnosed with coronary artery disease by prior coronary angiography, as FFR must be ≤0.8.
  - o more permissive for patients diagnosed with coronary artery disease by CCTA with FFR ≤0.8 (patients previously excluded)

Myocardial perfusion imaging (MPI), stress echocardiography, cardiac PET, and coronary CT angiography (CCTA)

- Clarifications address exercise-induced syncope and exercise-induced dizziness, lightheadedness or near syncope in symptomatic patients with suspected coronary artery disease.

(Continued on page 21)

AIM Clinical Appropriateness Guideline Enhancements (Continued from page 20)

Resting transthoracic echocardiography (TTE)

- New criteria for evaluation of ventricular function in patients who have undergone cardiac transplantation.

For questions related to these guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. A copy may also be downloaded at http://www.aimspecialtyhealth.com/.

Reminder on Billing Qualified Medicare Beneficiaries

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

QMBs who are enrolled in Medi-Pak® Advantage to administer their Medicare benefits would 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 billing 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.

Medi-Pak® Advantage HMO Moving High Tech Radiology to AIM

Effective September 1, 2018, Arkansas Blue Cross and Blue Shield's Medi-Pak® Advantage HMO will be moving the High Tech Radiology process to the AIM website. Providers will now go to the AIM ProviderPortal online at www.providerportal.com, or contact AIM by phone at 1-844-377-1276, to receive authorizations for HMO High Tech Radiology requests. Beginning August 27, 2018, the contact center and ProviderPortal will open for prior approval requests with dates of service rendered on or after the effective date of September 1, 2018.

If you are a new user to the AIM website, visit the web address, www.providerportal.com, select "Register" from the home page, and follow the on screen prompts to obtain access. Please note, the client name is Visiant. Once the information has been reviewed and validated by an AIM staff member, providers will receive an email with information to access the system.

Reduce Medical Record Requests Through Proper HEDIS® Claims Coding

Submitting claims with CPT® Category II and ICD-10 codes can help Arkansas Blue Cross and Blue Shield determine if certain HEDIS® measures are met without needing to review medical records. This lessens the administrative burden on office staff because it reduces the need for them to pull medical records for Arkansas Blue Cross' review. As a health plan we are required to submit HEDIS data for all Medi-Pak® Advantage plans, Marketplace plans inclusive of Arkansas Works, and the Federal Employee Program plans.

CPT II codes that support select HEDIS measures include:

HEDIS measure	CPT II code	Description
Medication reconciliation post discharge	1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Comprehensive diabetes care - eye exam (The patient's eye exam report must be included in your medical record)	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Comprehensive diabetes care - HbA1c control	3044F	Most recent HbA1c level < 7.0%
	3045F	Most recent HbA1c level 7.0-9.0%
	3046F	Most recent HbA1c level > 9.0%
Comprehensive diabetes care - medical attention for nephropathy	3066F	Documentation of treatment for nephropathy (includes visit to nephrologist, receiving dialysis, treatment for end stage renal disease, chronic renal failure, acute renal failure or renal insufficiency)
	4010F	Angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy prescribed or currently being taken

(Continued on page 23)

HEDIS measure	CPT II code	Description
Comprehensive diabetes care - blood pressure control and Controlling high blood pressure**	3074F	Most recent systolic blood pressure <130 mm Hg
	3075F	Most recent systolic blood pressure 130 – 139 mm Hg
	3077F	Most recent systolic blood pressure ≥ 140 mm Hg
	3078F	Most recent diastolic blood pressure <80 mm Hg
	3079F	Most recent diastolic blood pressure 80 - 89 mm Hg
	3080F	Most recent diastolic blood pressure ≥ 90 mm Hg

**The National Committee for Quality Assurance requires medical record review for the controlling high blood pressure measure. However, for the comprehensive diabetes care – blood pressure control measure, CPT Category II codes can be used to identify compliant members through claims data when the member's latest blood pressure reading is compliant (<140/90).

ICD-10 codes that support HEDIS exclusion criteria include:
Patients will not be identified for certain HEDIS measures when ICD-10 exclusion codes are submitted on a claim. These include:

HEDIS measure	ICD-10 code	Description
Breast cancer screening Patients who have bilateral or two unilateral mastectomies	Z90.13	Acquired absence of bilateral breasts and nipples
	Z90.12	Acquired absence of left breast and nipple
	Z90.11	Acquired absence of right breast and nipple
Colorectal cancer screening Patients who currently have or with a history of colorectal cancer (cancer of the small intestine doesn't count)	Z85.038	Personal history of other malignant neoplasm of large intestine
	Z85.048	Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus

ICD-10 codes that support the adult BMI assessment measure include:

HEDIS measure	ICD-10 code	Description
Adult BMI	Z68.1	BMI of 19.99 or less
	Z68.20	BMI 20.0-20.9
	Z68.21	BMI 21.0-21.9
	Z68.22	BMI 22.0-22.9

(Continued on page 24)

HEDIS measure	ICD-10 code	Description
Adult BMI	Z68.23	BMI 23.0-23.9
	Z68.24	BMI 24.0-24.9
	Z68.25	BMI 25.0-25.9
	Z68.26	BMI 26.0-26.9
	Z68.27	BMI 27.0-27.9
	Z68.28	BMI 28.0-28.9
	Z68.29	BMI 29.0-29.9
	Z68.30	BMI 30.0-30.9
	Z68.31	BMI 31.0-31.9
	Z68.32	BMI 32.0-32.9
	Z68.33	BMI 33.0-33.9
	Z68.34	BMI 34.0-34.9
	Z68.35	BMI 35.0-35.9
	Z68.36	BMI 36.0-36.9
	Z68.37	BMI 37.0-37.9
	Z68.38	BMI 38.0-38.9
	Z68.39	BMI 39.0-39.9
	Z68.41	BMI 40.0-44.9
	Z68.42	BMI 45.0-49.9
	Z68.43	BMI 50.0-59.9
	Z68.44	BMI 60.0-69.9
	Z68.45	BMI 70.0 or greater
Pediatric BMI < 20 years	**Z68.51**	**BMI < 5th percentile**
	Z68.52	**BMI 5th to < 85th percentile**
	Z68.53	**BMI 85th to < 95th percentile**
	Z68.54	**BMI ≥ 95th percentile**

Star Rating Measures Impacted by Statin Therapy

Three Medicare star rating measures, one Federal Employee Plan star measure and one Marketplace/Exchange star measure reflect the importance of statin therapy for patients with cardiovascular disease and/or diabetes.

The Centers for Disease Control and Prevention estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes. Additionally, almost two out of five people with diabetes who could benefit from statin

(Continued on page 25)

therapy to lower their risk of future heart attack, stroke and related death were not prescribed one, according to the Journal of the American College of Cardiology.

To support the importance of statin therapy, the Centers for Medicare & Medicaid Services and the Federal Employee Plan administrators include star measures aimed at the use of statin therapy. Please review the measures described below and consider prescribing statins for your patients diagnosed with atherosclerotic cardiovascular disease and/or diabetes.

Measure	Definition
Statin Therapy for Patients with Cardiovascular Disease (Part C)	This measure assesses the percentage of males ages 21-75 and females ages 40-75 who were identified as having clinical atherosclerotic cardiovascular disease and met the following criteria: • Received statin therapy: Patients were dispensed at least one high or moderate-intensity statin medication in the measurement year. • Statin adherence 80 percent: Patients remained on a high or moderate-intensity medication for at least 80 percent of the treatment period. When patients are not able to tolerate statin medications, patients are excluded from the Statin for Patients with Cardiovascular Disease measure. Please ensure your office visit claim includes one of the following ICD 10 codes: • G72.0 Drug induced myopathy • G72.9 Myopathy unspecified • M62.82 Rhabdomyolysis • M79.1 Myalgia with nomenclature According to the American College of Cardiology and the American Heart Association, statins of moderate or high intensity are recommended for adults with established clinical atherosclerotic cardiovascular disease. Many studies support the use of statins to reduce atherosclerotic cardiovascular disease events in primary or secondary prevention.
Statin Therapy for Patients with Diabetes (Part D)	This measure assesses the percentage of members ages 40-75 with diabetes who do not have clinical atherosclerotic cardiovascular disease and met the following criteria: • Received statin therapy: Patients were dispensed at least one statin medication of any intensity during the measurement year. • Statin adherence 80 percent: Patients remained on a statin medication of any intensity for at least 80 percent of the treatment period.
Medication Adherence for Cholesterol (Statins)	This measure assesses the percentage of people age 18 and older who were dispensed at least two fills of a statin medication and filled the medication for at least 80 percent of the treatment period.

Sources for this article include: American College of Cardiology, American Heart Association, Centers for Disease Control and Prevention and Journal of the American College of Cardiology.

PLEASE NOTE

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies.

Would you prefer to receive the newsletter via email?

Send your name, the affiliated provider's name and your email address to **providersnews@arkbluecross.com**

We're on the web!

arkansasbluecross.com
healthadvantage-hmo.com
blueadvantagearkansas.com
fepblue.org

PROVIDERS' NEWS STAFF

Providers' News is published quarterly for providers and their office staffs by Arkansas Blue Cross and Blue Shield
Editor: Suzette Weast • 501-378-2002 • FAX 501-378-2464 • ProvidersNews@arkbluecross.com

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 2181
Little Rock, AR 72203