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

PROVIDERS' NEWS

March 2019

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TABLE OF CONTENTS

2019 Spring Provider Workshops

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

Central Region

Little Rock
Wyndham Riverfront
2 Riverfront Place
Wednesday, May 22
(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
Thursday, May 23
(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
Wednesday, May 29

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 9

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

South Central Region

Hot Springs
National Park Comm College
- Martin Eisele Auditorium
101 College Dr
Tuesday, May 14

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 7

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

Southwest Region

El Dorado
El Dorado Conference Ctr
311 South West Ave
Wednesday, May 1

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 2

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

West Central Region

Fort Smith
Mercy Hospital
- Sicard Education Ctr
7301 Rogers Ave
Wednesday, May 8

Morning session:
Registration 12:30 – 1:00 p.m.
Workshop 1:00 – 4:00 p.m.

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

El Dorado: https://surveymonkey.com/r/NHZ8TQQ
Fort Smith: https://www.surveymonkey.com/r/755WBRB
Hot Springs: https://www.surveymonkey.com/r/22Z6LH5
Jonesboro: https://www.surveymonkey.com/r/79NMXC6
Little Rock: https://www.surveymonkey.com/r/5MXHCYC
Mtn. Home: https://www.surveymonkey.com/r/98TFNGX
Pine Bluff: https://www.surveymonkey.com/r/LG297K5
Springdale: https://www.surveymonkey.com/r/98YDXNB
Texarkana: https://www.surveymonkey.com/r/NFFHZWF

AHIN Pre-Service Review/Prior Approval

AHIN allows providers the ability to obtain prior approval electronically, as an alternative to contacting customer service at Arkansas Blue Cross and Blue Shield. Obtaining prior approval through AHIN is as simple as entering the member's information, requesting physician, attending physician, admission, and facility information then selecting "Request Approval." The "Pre-Service Review (In State or Out of State)" option is accessible from the AHIN home page under the members' section or from the member benefits page when verifying the applicable service type on AHIN.

Providers are encouraged to utilize the self-service tools found within AHIN. For additional assistance in utilizing these tools, 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 the prior approval process.

EFT Enrollment Requires AHIN

The following is a true story, and the results have required Arkansas Blue Cross and Blue Shield to mandate revisions involving the electronic funds transfer processes.

Arkansas Blue Cross received its official EFT form through e-mail from a large respected Arkansas medical practice. This is a normal occurrence. The request was to change the bank and account numbers being used by the practice. **This form even included the signature of the clinic's CEO!**

Arkansas Blue Cross processed the request, sent a copy of the executed form back to the medical practice using the email address we had received, and also sent a paper copy to the medical practice.

From start to finish about a week passed, when the clinic's CEO called Arkansas Blue Cross and said the requested EFT changes **had not come from his organization**! Arkansas Blue Cross immediately notified the financial institutions involved as well as our cybersecurity office. In a week's time about $72,000.00 had been sent to the fake account (which was in a very well-known national bank). Law enforcement agencies are also involved but have not given much hope that the money will ever be recovered.

It is suspected that a phishing email had been sent at some point to the medical practice, and someone had opened it and clicked on the link. As a result, their system was infiltrated and hacked. **Please educate your staff about phishing e-mail.**

Arkansas Blue Cross will now require that all EFT processes, both initial set-up and change requests, come through AHIN. Our AHIN platform has much better security processes than e-

mail and paper. Arkansas Blue Cross realizes that some providers may not have AHIN. We ask that you please sign up as we believe we have to take these protective measures in this day and time of cybercrimes.

iRhythm Technologies is in Network

iRhythm became an in network provider October 1, 2018 in all commercial provider networks.

iRhythm provides continuous electrocardiographic recording services, such as those covered under codes 0297T, 93226, and 93229.

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

Ancillary Code Editing – ClaimsXten (CXT)

Arkansas Blue Cross and Blue Shield updated some of the editing with ClaimsXten in December 2018. As a part of this editing, an additional edit will be implemented for claims effective May 1, 2019.

The additional editing that will be implemented is for the ancillary services surrounding a non-covered service. Certain procedures are deemed to be non-covered based upon their medical and/or payment policies. When procedures related to those non-covered services are submitted, they should be denied as non-covered, as well.

This editing will look at the following five types of ancillary services: anesthesia, assistant surgeon, pre op testing, pathology or radiology. If no other payable major surgical service was performed on the same date of service, the ancillary services will also be denied.
Example:
A provider submits procedure 15820 (Blepharoplasty), which is considered a non-covered procedure for Arkansas Blue Cross on 08/01/2019. The anesthesiologist bills procedure 00103 (Anesthesia for reconstructive procedures of eyelid ((i.e., blepharoplasty, ptosis surgery)). Due to the 15820 being a non-covered procedure, the 00103 procedure will also be denied.

Code	Description
15820	Blepharoplasty, lower eyelid;
00103	Anesthesia for reconstructive procedures of eyelid (i.e., blepharoplasty, ptosis surgery)

Arkansas Blue Cross has always performed this type of review, and this edit will allow us to do so in a much more consistent and efficient way.

Long Acting Reversible Contraception

Effective April 01, 2019, Arkansas Blue Cross and Blue Shield and Health Advantage coverage payment policy will provide for reimbursement separately (outside of global fee) for the insertion of long acting reversible contraception (LARC) at the patient's request prior to patient's discharge home. LARC will be reimbursed under the PPACA preventive services (e.g. 100%). This change in coverage payment policy, applies to all fully-insured plans, all exchange plans, and all self-insured groups administered by Arkansas Blue Cross and Health Advantage. This will promote intrapartum placement of reversible contraception on the part of both the provider and the facility to reduce unplanned pregnancy and improve spacing between pregnancies, improving both maternal and fetal outcomes as advocated by the March of Dimes.

The following CPT codes will be allowed for payment outside the facility DRG and/or provider global:

CPT CODE	Description
58300	Professional Code for Intrauterine Device Insertion
J7296	Levonorgestrel-releasing Intrauterine Contraceptive System (Kyleena and Makena)
J7297	Levonorgestrel-releasing Intrauterine Contraceptive System (Liletta)
J7298	Levonorgestrel-releasing Intrauterine Contraceptive System (Mirena)
J7300	Intrauterine Copper Contraceptive
J7301	Levonorgestrel-releasing Intrauterine Contraceptive System (Skyla)
J7307	Etonogestrel Implant System

New Applied Behavior Analysis (ABA) Codes

Effective January 1, 2019, the American Medical Association replaced the temporary category III codes used by ABA (Applied Behavior Analyst) treatment services with new permanent Category I codes. Eight Category I codes (97151-97158) will replace most of the Category III codes. Two modified codes remain in Category III (0362T and 0373T, for extreme behavior). All codes are now in 15-minute increments, where the old codes ranged from untimed to 60 minutes each. The ABA Code Crosswalk is summarized in the table below.

For unit and frequency limits, please refer to policies for Arkansas Blue Cross, Blue Advantage National Accounts, and Walmart.

NEW Category I Code Effective 1/01/2019	Category III Code Used prior to 1/01/2019
97151-Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	**0359T**-Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report. (1 hour/2 hours)
97152-Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes. *Behavior identification-supporting assessment will require rationale and only face-to-face time by one provider/line therapist is reimbursable.	
0362T- Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment customized to the patient's behavior.	**0362T**-Exposure behavior follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face to face with the patient.
0362T- Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	**0363T**-Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure).

NEW Category I Code Effective 1/01/2019	Category III Code Used prior to 1/01/2019
97153-Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	**0364T**-Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time.
97153-Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	**0365T**-Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure).
97154-Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	**0366T**-Group behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time.
97154-Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes.	**0367T-**Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure).
97155-Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	**0368T**-Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time.
97155-Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	**0369T**-Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure).
97156-Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.	**0370T**-Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) (30 min).

NEW Category I Code Effective 1/01/2019	Category III Code Used prior to 1/01/2019
97157-Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.	**0371T**-Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present). (30 min).
97158-Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes.	**0372T**-Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients. (30 min).
0373T-Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment customized to the patient's behavior.	**0373T**-Exposure adaptive behavior treatment with protocol modification, requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient.
0373T-Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment customized to the patient's behavior.	**0374T**-Exposure adaptive behavior treatment with protocol modification, requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)

Coverage Policy Manual Updates

Since February 2019, 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
1997195	Sleep Apnea and Other Pulmonary Diseases, Ventilation Support and Respiratory Assist Devices
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1998034	Cytoreduction Surgery with Hyperthermic Intraperitoneal Chemotherapy
1998038	Allergy Immunotherapy
1998051	Genetic Test: BRCA1 or BRCA2 Mutations
1998099	Electrical Stimulation, Deep Brain (e.g. Parkinsonism, Dystonia, Multiple Sclerosis, Post-Traumatic Dyskinesia)
1998109	Adoptive Immunotherapy
1998118	Surgery for Morbid Obesity
1998119	Viscosupplementation for the Treatment of Osteoarthritis of the Hip, Knee, and All Other Joints
1998151	Arthroereisis for Pes Planus (Flat Feet) (Subtalar stabilization)
1998153	Cardiac Event Recorder, Insertable Loop Recorder
1998161	Infliximab
2000023	PET or PET/CT for Head and Neck Malignant Disease
2001009	Glucose Monitoring, Continuous
2001028	Magnetic Resonance Imaging (MRI), Breast
2003015	Intensity Modulated Radiation Therapy (IMRT)
2004017	Genetic Test: Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
2004029	Genetic Test: Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients With Breast Cancer (Oncotype DX®, EndoPredict, the Breast Cancer Index and Prosigna, Mammaprint and BluePrint)
2004039	Genetic Test: HFE Hemochromatosis
2004046	Genetic Test: FMR 1 Mutations Including Fragile X Syndrome
2004057	Laboratory Tests for Heart and Kidney Transplant Rejection
2006016	Rituximab (Rituxan), Off-label Use
2008002	Transanal Endoscopic Microsurgery (TEMS/TAMIS)
2008010	Certified Nurse Practitioners
2008012	Radiation Therapy, Proton Beam or Helium Ion Irradiation, other than Prostate
2008013	Certified Nurse Midwives
2008014	Physician Assistants
2008015	Clinical Nurse Specialist
2009013	Testing for Drugs of Abuse or Drugs at Risk of Abuse Including Controlled Substances
2009015	Golimumab (Simponi® and Simponi Aria®)
2010011	Myoelectric Prosthetic and Orthotic Components for the Upper Limb
2010017	Aqueous Shunts and Devices for Glaucoma
2010020	Plugs for Anal Fistula Repair
2010028	Sipuleucel-T (Provenge) for the Treatment of Prostate Cancer

Policy ID	Policy Name
2010041	Hemodynamic Monitoring of Heart Failure, Management in the Outpatient Setting
2011016	Preventive Services For Non-Grandfathered (PPACA) Plans: BRCA Testing; Genetic Counseling And Evaluation
2011021	Preventive Services For Non-Grandfathered (PPACA) Plans: Cervical Cancer And Human Papillomavirus (HPV) Screening
2011043	Preventive Services For Non-Grandfathered (PPACA) Plans: Depression Screening, Adults
2011045	Preventive Services For Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening
2011053	Autism Spectrum Disorder, Applied Behavioral Analysis
2011066	Preventive Services For Non-Grandfathered (PPACA) Plans: Overview
2012003	Genetic Test: Molecular Markers in Fine Needle Aspirates of the Thyroid
2012005	Genetic Test: Molecular Testing of Tumors for Genomic Profiling as a Therapeutic Guide
2012009	Skin and Soft Tissue Substitutes, Bio-Engineered Products
2012012	Genetic Test: Uveal Melanoma, Gene Expression Profile To Predict Risk Of Metastasis
2012025	Biomarkers for Liver Disease
2012029	Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease (apolipoprotein B) (apolipoprotein A-1) (HDL subclass) (LDL subclass) (apolipoprotein E) (Lipoprotein A)
2012046	Preventive Services For Non-Grandfathered (PPACA) Plans: Well-Child Visits, Newborn, Infant, Children, Adolescents & Ages 18-21
2012050	Dopamine Transporter Imaging with Single Photon Emission Computed Tomography (DAT-SPECT)
2012068	Genetic Test: Preconception or Prenatal Testing as a Carrier Screen
2013003	Stem Cell Growth Factors, Erythropoiesis-Stimulating Agents (ESAs), Darbepoetin, Epoetin, Peginesatide
2013015	Treatment of Varicose Veins/Venous Insufficiency
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients With Non-Small-Cell Lung Cancer
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015016	Focal Treatments for Prostate Cancer
2015036	Preventive Services For Non-Grandfathered (PPACA) Plans: Prevention And Treatment Of Preeclampsia In Pregnant Women
2016003	Omalizumab (Xolair)
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab) (Durvalumab)
2016007	Noninvasive Imaging Technologies to Detect Liver Fibrosis or Cirrhosis (Elastography)
2016016	Atezolizumab (Tecentriq®)
2017001	Alpha-1 Proteinase Inhibitor Therapy

Policy ID	Policy Name
2017002	Pilot Policy: Telemedicine for Applied Behavioral Analysis in the Treatment of Autism Spectrum Disorder
2017003	Ziv-aflibercept (Zaltrap)
2017004	Asfotase alfa (Strensiq®)
2017006	Bevacizumab (Avastin™) for Oncologic Indications
2017008	Brentuximab (Adcetris™)
2017009	Denosumab (XGEVA™ and Prolia™)
2017011	Nusinersen (Spinraza) for the Treatment of Spinal Muscular Atrophy
2017014	Olaratumab (LARTRUVO™)
2017015	Avelumab (Bavencio™)
2017017	Pilot Policy: Total Arthroplasty-Hip (THA) or Knee (TKA)
2017022	Cerliponase Alfa (Brineura™)
2017026	Edaravone
2017029	Immobilized lipase cartridge for enteral feedings (Relizorb)
2017030	Guselkumab
2017032	Synthetic Cartilage Implant for Joint Pain
2017034	Inotuzumab Ozogamicin (Besponsa™)
2017035	Gemtuzumab Ozogamicin (Mylotarg™)
2018000	Leadless Cardiac Pacemakers
2018002	Chemodenervation, Botulinum Toxins
2018003	Copanlisib (Aliqopa)
2018005	Triamcinolone Acetonide Extended Release (Zilretta)
2018009	Benralizumab (Fasenra)
2018013	Lab Test: Fecal Calprotectin Testing
2018014	Pharmacy: Lutetium Lu 177 Dotatate (Lutathera®)
2018021	Gene Therapy for Inherited Retinal Dystrophy-Voretigene (Luxturna)
2018024	Burosumab-twza (Crysvita®)
2018025	Mucopolysaccharidoses Agents
2018026	Lab Test: Hepsin Biomarker Testing
2018027	Pegloticase (Krystexxa®)
2018028	Absorbable Nasal Implant for Treatment of Nasal Valve Collapse
2018029	Continuous Local Anesthetic Infusion Pumps (Disposable Pain Pumps)
2018030	Site of Care or Site of Service Review

Exchange Metallic Individual Medical Policies – Home Health

Home health benefits require prior authorization with a limit of 50 home health visits per service year. The provider can call 800-558-3865, fax a completed request to 501-378-6647, or use the Pre-Service Review Screen located in AHIN to submit the request to review for prior approval. Prior approval requests must be submitted within 48 hours of the beginning of the treatment plan and must include a copy of the order from the MD with medical necessity for home health. If Arkansas Blue Cross and Blue Shield is closed for a holiday or weekend, the prior approval request timeframe is extended until the end of the second business day. Home Health is only allowed in place of service 12. When using CPT 99600, it must be billed with modifier TE or TD.

"Never Events" Policy Reminders

"Never Events" are adverse events or errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. Identifying and addressing adverse medical events and "Never Events" has gained more attention throughout the healthcare industry. Industry drivers include the following:

- The National Quality Forum (NQF) has identified a list of 28 "Never Events" that is gaining interest from various constituencies focused on health-care quality, including health plan organizations, employers and state hospital organizations.
- Since October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) no longer pays the extra cost of treating the 12 Hospital Acquired Conditions (HACs) that occur while the patient is in the hospital.
- CMS requires that most hospitals use a Present on Admission (POA) indicator on claims to indicate if the patient's specific condition was present when the patient was admitted to the hospital or if it was acquired during the inpatient stay (e.g., infection
- or ulcers). In addition, CMS requires all Medicare Advantage plans to report "Never Events" and claims with the POA indicator.
- The National Business Group on Health, which represents 300 large employers, supports the reporting of medical errors and continues to apply pressure to all payers for solutions.

As of October 1, 2008, Medicare defined HACs are considered "Never Events" as they relate to this policy. HACs include:

- Pressure ulcers, Stages III and IV,
- Catheter-associated urinary tract infections,
- Vascular catheter-associated infection,
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG),
- Air embolism,

- Blood incompatibility,
- Foreign object retained after surgery,
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock),
- Surgical-site infections following certain orthopedic procedures,
- Surgical-site infections following bariatric surgery for obesity,
- Manifestations of poor glycemic control, and
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

In addition, "Never Events" include:

- Surgery performed on a wrong body part,
- Surgery performed on a wrong patient, and
- Wrong surgical procedure performed.

The Arkansas Blue Cross "Never Event" policy, effective since January 1, 2010, states:

- All acute care hospitals participating in the Arkansas Blue Cross, USAble Corporation and Health Advantage provider networks must populate the POA indicator on all acute care inpatient hospital claims for all "Never Events," as applicable. Valid POA values include:
  - Y =Yes
  - N = No
  - U = Unknown/No information in the record
  - W = clinically undetermined
  - 1 = exempt from reporting on 837 claim
  - Blank = exempt from reporting on paper claim
- This policy applies to all acute care hospitals including critical access hospitals and specialty hospitals.
- All participating acute care inpatient hospitals will not receive or retain reimbursement for inpatient services related to "Never Events."
- All participating acute care inpatient hospitals will not bill members (hold harmless) for any inpatient services related to "Never Events."

All HACs should be billed normally using the correct diagnosis codes and will be accommodated through POA indicators. All appropriate E codes should be billed for "Never Events." All inpatient hospital claims will be passed through the Arkansas Blue Cross internal DRG grouper. Hospitals will NOT receive a higher reimbursement rate due to "Never Events" and members will not be responsible for higher deductible, copayments or coinsurance amounts resulting from "Never Events."

Arkansas Blue Cross, Health Advantage and PPO Arkansas will not reimburse hospitals, ambulatory surgery centers or other outpatient settings for surgery performed on a wrong body part, surgery performed on a wrong patient or the wrong surgical procedure performed. This includes all services related to these "Never Events."

- All services provided in the operating room or applicable surgical setting when the error occurs are considered related. These services will not be reimbursed nor will members be liable for their charges.
- All providers in the operating room or applicable surgical setting when the error occurs, who could bill individually for their services, are not eligible for payment nor will members be liable for their charges.
- All related services provided during the same hospitalization or outpatient setting in which the error occurred will not be reimbursed nor will members be liable for their charges.
- Providers should note that related services do not include performance of the correct procedure.

"Never Events" discovered through any and all avenues such as post pay audits and customer service calls are subject to this policy.

Billing Instructions for "Never Events"

For all inpatient discharges, hospitals shall separate a hospital stay into two claims where a "Never Event" surgical error is reported and a covered service is also being reported:

1. One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and
2. The other claim with the noncovered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
3. Both the covered and noncovered claim shall have a matching "statement covers" period.

The noncovered TOB 110 must indicate in Form Locator (FL) 80 (Remarks) or on the 837i at Loop 2300, Billing Note NTE01=ADD, NTE02, one of the applicable erroneous surgery(s) two-digit codes (entered exactly as specified below):

1. For a wrong surgery on patient enter MX;
2. For a surgery on a wrong body enter MY;
3. For a surgery on wrong patient enter MZ.

For hospital outpatient, ambulatory surgical centers, practitioners and all TOBs, providers should append the following applicable HCPCS modifiers to all lines related to the surgical error:

1. PA: Surgery wrong body part
2. PB: Surgery wrong patient
3. PC: Wrong surgery on patient

Credentialing Standards Updates for all Networks Sponsored by Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation

Effective January 1, 2019 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® network, True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been revised as indicated below:

I. Revised Standards:

The following standards have been revised and re-stated.

DEA and Arkansas Prescription Monitoring Program:

The wording of this standard is revised to read:

"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 and Bureau of Narcotics ("BON") certificate (in applicable states) 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 or Bureau of Narcotics certificate (in applicable states) is subject to any Action (as hereinafter defined) shall lose eligibility to participate in the network for the longer of (a) 365 days or (b) the date that the network determines, in its 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 or BON certificate, including but not limited to any arrangement whereby the practitioner agrees to a surrender, restriction, limitation, suspension or revocation of the DEA or BON certificate, or any arrangement whereby practitioner's use of the DEA or BON 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 or BON certificate may be utilized to legally

prescribe medications, or the length of time that the DEA or BON certificate may be utilized without further review or approval from any government agency or disciplinary board or program.

Any practitioner whose DEA or BON certificate is subject to any Action must give written notice of the same to the network 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 network recognizes one exception under which a practitioner who has been subject to an Action may, in the judgment of the network, remain eligible for network participation and not be excluded from the network 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 network 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 network's members, as determined in the network's sole discretion."

Collaborating and Supervisory Physician Agreements Required for APRNs, PAs and certain other practitioners:

The wording of this standard is revised to read:

"Certified Nurse Practitioners (CNPs), Certified Nurse Midwifes (CNMs), Clinical Nurse Specialists (CNSs) and Physician Assistants (PAs), collectively referred to as Extender, must hold a certificate of prescriptive authority and 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 Arkansas Blue Cross 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., Arkansas Blue Cross 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 Arkansas Blue Cross, 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 or relationship. Arkansas Blue Cross 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 Arkansas Blue Cross identifies any deficiencies in the terms of a collaborating practice agreement or supervisory agreement, Arkansas Blue Cross may decline to admit or to continue participation of any Extender in the Arkansas Blue Cross networks, or may condition admission or continued participation upon revisions to the terms of any such agreement. In addition, Arkansas Blue Cross 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 Arkansas Blue Cross 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 Arkansas Blue Cross, the network participation of the applicable Extender shall be subject to immediate termination for failure to meet network credentialing standards."

Board Certification/Residency Training (Applies to MD's and DO's):

The wording of this standard is revised to read:

"Recognized certifying Boards for MDs and DOs are the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). Board Certification is preferred but not required. Physicians who have completed an ABMS or AOA approved residency/fellowship are not considered to have an issue which requires presentation to the Credentialing Committee. However, Physicians who request a specialty and have not completed an ABMS or AOA approved residency/fellowship for that specialty are considered to have an issue and must be reviewed by the Credentialing Committee with details regarding their education, CME, work history and hospital privileges. The Credentialing Committee may, in its sole discretion, recommend approval or denial of credentials and, if approved, the specialty. Physicians who are determined by the Credentialing Committee not to meet standards for a requested specialty may be denied participation or may be restricted in participation. Physicians who are in the process of residency/fellowship training for a specialty are not eligible to be admitted to the networks as specialists until successful completion of such residency/fellowship, but, after completion of their second year in such residency/fellowship program, may apply for provisional admission to the networks as General Practitioners, pending completion of the

residency/fellowship for the requested specialty, subject to the following conditions: (a) admission as a General Practitioner shall be at the discretion of the Credentialing Committee; and (b) the applying physician must, at the time of application, have successfully completed two years in the applicable specialty residency program, and be in good standing with such residency program; and (c) the applying physician must agree in writing to limit her/his network practice during such pre-residency/fellowship completion period to performing only such services/treatments as a non-specialist, General Practitioner would perform, i.e., the applying physician must agree not to perform or bill for any specialty services to network members during such pre-residency/fellowship completion period; and (d) the applying physician must agree to restrict the location of his/her practice during the pre-residency/fellowship completion period to the emergency department of a network-participating hospital or to an urgent care clinic approved by [the network sponsoring company].

Medical Specialty Prior Approval Medications Update

On April 1, 2018, Arkansas Blue Cross and Blue Shield and its family of companies enacted prior approval for payment of specialty medications used in treating rare, complex conditions that may go through the medical benefit. Since then, medications have been added to the initial list as products come to market. The following is the current list of medications that require prior approval through medical benefit. ASE/PSE and Medicare are not included in this prior approval (PA) program. Also indicated, is when medication is required to be processed through Pharmacy Benefit.

An additional list of medications has been provided. This list contains medications that are either new to market or soon to be available. These medications will require prior approval, although policy may not be available yet. Any new medication used to treat a rare disease should be considered to require prior approval.

Medications currently requiring prior approval:

(1) Nusinersen (Spinraza) – Spinal muscular atrophy
(2) Cerliponase alfa (Brineura) – Late infantile neuronal ceroid lipofuscinosis type 2 (CLN2 or Batten disease)
(3) Eculizumab (Soliris) – Paroxysmal nocturnal hemoglobinuria (PNH), atypical (complement mediated) hemolytic uremic syndrome (aHUS), and refractory generalized AchR positive myasthenia gravis
(4) Alemtuzumab (Lemtrada) – refractory relapsing remitting multiple sclerosis
(5) Asfotase alfa (Strensiq) – Perinatal/infantile or juvenile-onset hypophosphatasia **
(6) Metreleptin (Myalept) – Congenital or acquired complete generalized lipodystrophy (GL) with leptin deficiency **
(7) Omalizumab (Xolair) – Moderate to severe persistent asthma and chronic idiopathic urticaria

(8) Mepolizumab (Nucala) – Severe persistent asthma with an eosinophilic phenotype in patients 12 years of age or older
(9) C1 esterase inhibitor, human (Haegarda) – Routine angioedema prophylaxis in patients with hereditary angioedema **
(10) C1 esterase inhibitor, recombinant (Ruconest) – Treatment of acute attacks of hereditary angioedema
(11) C1 esterase inhibitor, human (Berinert) – Treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema
(12) C1 esterase inhibitor, human (Cinryze) – Routine angioedema prophylaxis in patients with hereditary angioedema
(13) Ecallantide (Kalbitor) – Treatment of acute attacks of hereditary angioedema **
(14) Icatibant (Firazyr) -- Treatment of acute attacks of hereditary angioedema**
(15) Benralizumab (Fasenra) – Add-on maintenance treatment of severe asthma of eosinophilic phenotype
(16) Reslizumab (Cinqair) – Add-on maintenance treatment of severe asthma of eosinophilic phenotype
(17) Lutetium Lu 177 (Lutathera) -- Treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumor (NET), including foregut, midgut, and hindgut neuroendocrine tumors
(18) Axicabtagene ciloleucel (Yescarta) – Treatment of relapsed or refractory large B-cell lymphoma (e.g., diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high-grade B-cell lymphoma, and DLBCL (arising from follicular lymphoma) following 2 or more lines of systemic therapy ***
(19) Tisagenlecleucel (Kymriah) – Treatment of B-cell precursor acute lymphocytic leukemia that is refractory or in second or later relapse ***
(20) Levodopa-carbidopa intestinal gel (Duopa) – Treatment of select Parkinson's disease patients
(21) Burosumab-twza (Crysvita) – Treatment of X-linked hypophosphatemia **
(22) Laronidase (Aldurazyme) -- Treatment of the Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for treatment of the Scheie form of MPS I (moderate to severe symptoms only)
(23) Idursulfase (Elaprase) -- Treatment of mucopolysaccharidosis II (Hunter syndrome)
(24) Elosulfase alfa (Vimizim) -- Treatment of mucopolysaccharidosis IVA (Morquio A syndrome)
(25) Galsulfase (Naglazyme) -- Treatment of mucopolysaccharidosis VI (Maroteaux-Lamy syndrome)
(26) Vestronidase-alfa (Mepsevii) -- Treatment of mucopolysaccharidosis VII (Sly syndrome)
(27) Pegloticase (Krystexxa) -- Treatment of chronic gout in patients' refractory to conventional therapy (treatment-failure gout)

*** claims are processed through Pharmacy Benefit*
****claims are reviewed through Transplant Benefit*

New medications requiring prior approval:

1. Patisiran (Onpattro)

2. Inotersen (Tegsedi)
3. Elapegademase (Revcovi)
4. Emapalumab-izsg (Gamifant)
5. Ravulizumab-cwyz (Ultomiris)
6. Landelumab-flyo (Takzyro)

For more information on how to submit a request for prior approval of one of these medications, please call the appropriate Customer Service phone number on the back of the member ID card.

Customer Service will direct callers to the prior approval form specific to the member's group. Blue Advantage members can find the form at the following link: http://www.blueadvantagearkansas.com/providers/forms.aspx. For all other members, the appropriate prior approval form can be found at the following link: http://www.arkansasbluecross.com/providers/AuthServices.aspx.

These forms and any additional documentation will be faxed to 501-378-7051 for Blue Advantage members. For all other members, the appropriate fax number is 501-378-6647.

2019 Radiology Authorization Program Update

Arkansas Blue Cross and Blue Shield and its family of companies is dedicated to meeting the evolving needs of our members. With consumers looking for tools to guide better healthcare decision making, we are pleased to announce an updated radiology authorization program that supports these goals.

Diagnostic imaging is one of the most important clinical tools available. At an average cost per test of $500 to $700 for Medicare members and $600 to $900 for commercial health plan members, the costs of inappropriate imaging are staggering. Arkansas Blue Cross is committed to a comprehensive imaging management program designed to:

- Improving the clinical appropriateness of imaging services through the application of evidence-based guidelines in an efficient and effective review process.
- Maximizing a health plan's network value through a wide range of solutions including provider assessment tools, cost and quality transparency and reporting.
- Engaging consumers in understanding the range of choices they have in selecting among imaging providers and increasing their ability to make informed decisions.

Effective January 1, 2019, Arkansas Blue Cross will require prospective clinical case review (prior authorization) for outpatient, non-emergent imaging for Arkansas Blue Cross, Blue Advantage Administrators of Arkansas, Federal Employee Program Blue Focus, Health Advantage, and Medi-Pak® Advantage members. The following procedures are included in the program:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET and PET-CT)
- Nuclear cardiology:
    - Myocardial perfusion imaging (MPI)
    - Blood pool imaging
    - MUGA
    - First pass ventriculography
    - Infarct imaging

The prior authorization requirement applies to Arkansas Blue Cross, Blue Advantage Administrators of Arkansas, Federal Employee Program Blue Focus, Health Advantage, and Medi-Pak® Advantage members. The requirement does not apply to the Federal Employee Program's Standard and Basic Option members.

Providers should contact AIM Specialty Health® (AIM) to obtain an order number before scheduling or performing any elective outpatient imaging service.

Services performed in conjunction with emergency room services, inpatient hospitalization, or urgent-care facilities are excluded. **IF APPLICABLE --- *Both ordering physicians (those referring the member for imaging) and servicing providers (those free-standing or hospitals that perform imaging) may submit requests. We recommend that servicing providers confirm an order number has been issued before rendering services.***

To submit your request, you may contact AIM Specialty Health® (AIM) online via their ***Provider****Portal*℠ at **www.aimspecialtyhealth.com/goweb** (select Arkansas Blue Cross from drop-down menu) or toll-free at 866-688-1449, Monday – Friday 7:00 a.m. – 7:00 p.m. Central Time.

Radiology Solution Frequently Asked Questions

Prospective case review will be handled by AIM Specialty Health® (AIM). This document provides responses to the most frequently asked questions.

1. What is AIM Specialty Health (AIM)?

AIM Specialty Health® (AIM) is a specialty benefits management company that promotes appropriate, safe, and affordable health care services. We deliver value through clinical appropriateness review, provider collaboration, and member engagement services through our work with 50+ health plans serving over 48 million members. We focus on today's most complex and costly tests and treatments in radiology, cardiology, medical and radiation oncology, specialty pharmacy, sleep medicine, genetic testing, musculoskeletal, and other emerging clinical areas.

Arkansas Blue Cross updated the Radiology Authorization Program to promote the most appropriate use of imaging services provided to Blue Advantage Administrators of Arkansas, Federal Employee Program Blue Focus, Health Advantage, and Medi-Pak® Advantage members.

2. Why is Arkansas Blue Cross focusing on diagnostic imaging?

Diagnostic imaging is one of the most important clinical tools available to physicians and patients. However, a growing number of studies have shown that a high proportion of the studies that are performed are not clinically appropriate. At an average cost per test of $500 to $700 for Medicare members and $600 to $900 for commercial health plan members, the costs of inappropriate imaging are staggering. Cardiovascular imaging, in particular, represents 29% of all imaging workload and at least a third of the several billion medical imaging examinations performed worldwide. Yet, several studies have indicated that up to 15% of cardiac imaging exams are inappropriate based on Appropriate Use Criteria (AUC), issued by the American College of Cardiology (ACC). Similarly, a recent study in the Journal of the American Medical Association shows that 22.5% patients who have received implantable cardioverter-defibrillator (ICDs) may not have met ACC guidelines.

3. When will this program begin?

Beginning December 17, 2018, AIM's call center and Web site, ***Provider****Portal*$_{SM}$, are available for submission of order requests for imaging services occurring on or after January 1, 2019**.**

4. How does a physician office staff member obtain an order number from AIM and request clinical appropriateness review?

There are two ways providers can contact AIM to request review and obtain an order number:

Online

- Get fast, convenient online service via the AIM ***Provider****Portal*$_{SM}$ (registration required). ***Provider****Portal* is available twenty-four hours a day, seven days a week. Go to www.providerportal.com to begin. Select Arkansas Blue Cross from drop-down menu.

By phone

- Call AIM Specialty Health toll-free at: 866-688-1449
- Hours: Monday – Friday 7:00 am – 7:00 pm CT

5. How does the Radiology Authorization Program work?

Ordering physicians' offices submit order requests through ***Provider****Portal* – AIM's interactive Internet application - or through the AIM Call Center. Web users or callers will be guided through an interview where member and ordering physician information, diagnosis, symptoms, exam type, and treatment/clinical history will be requested.

If the information provided meets AIM's clinical criteria and is consistent with the Arkansas Blue Cross medical policy, the web user/caller will then be guided to select an imaging provider where the imaging study will be performed, and an order number will be issued.

If all criteria are not met or additional information or review is needed, the case is forwarded to a Registered Nurse (RN) who uses additional clinical experience and knowledge to evaluate the request against clinical guidelines. The nurse reviewer has the authority to issue order numbers in the event that he or she is able to ensure that the request is consistent with AIM's clinical criteria and Arkansas Blue Cross medical policy.

If an order number still cannot be issued by the nurse reviewer, they contact the ordering physician to schedule a peer-to-peer discussion with an AIM Physician Reviewer (MD). The Physician Reviewer can approve the case based on a review of information collected or through their discussion with the ordering physician.

In the event that the AIM Physician Reviewer cannot approve the case based on the information previously collected, is unable to reach the ordering physician to discuss the case, or is unable to approve the case based on the information supplied by the ordering physician during the peer-to-peer discussion, the Physician Reviewer will issue a denial for the request.

6. What does the AIM order number look like?
AIM's order numbers are nine (9) numeric digits.

7. How long is an order number valid?
An order number issued by AIM is valid for sixty (60) days.

8. Can AIM handle multiple requests per call?
Yes, imaging requests for multiple members can be made on the same call.

9. Does AIM need to know when the procedure is scheduled?
No, although the order number should be issued ***prior to scheduling*** the study. Retrospective reviews may be completed within 2 business days of the date of service.

10. Which members are included in the Radiology Authorization Program?
The Radiology Authorization Program includes all Arkansas Blue Cross, Blue Advantage Administrators of Arkansas, Federal Employee Program Blue Focus, Health Advantage, and Medi-Pak® Advantage enrolled members. Please contact the customer service number on the back of the member's insurance card if you need additional information regarding products covered under the program.

11. Which members are not included in the Radiology Authorization Program?
The Radiology Authorization Program does not include the following members:

- Federal Employee Program Basic and Standard Option

12. Will members be able to contact AIM?
Members should contact Arkansas Blue Cross directly if they have any questions.

13. What information will AIM require in order to evaluate an imaging request?

Please refer to the checklist below to ensure you have all the necessary information prior to submitting a request to AIM:

- Member's identification number, name, date of birth, and health plan
- Ordering provider information
- Imaging provider information
- Imaging exam(s) being requested (body part, right, left or bilateral)
- Patient diagnosis (suspected or confirmed)
- Clinical symptoms/indications (intensity/duration)

For most situations, the above will suffice. For complex cases, more information may be necessary, including:

- Results of past treatment history (previous tests, duration of previous therapy, relevant clinical medical history

14. How can I determine whether an order number has been obtained for a member?

Servicing providers will be able to contact AIM to determine whether an order number has been obtained for a member covered under the programs.

15. What happens if a member is approved for a specific procedure (for example: CT of the abdomen) and during the course of this procedure, the radiologist or rendering provider feels that an additional procedure requiring precertification (for example: CT of the pelvis) is also needed?

The radiologist or rendering provider should proceed with the additional procedure. If this occurs, he/she should inform the member's ordering provider that an additional test was performed on the same day. AIM must be contacted for an order number for the additional procedure no later than two (2) business days after the services were rendered. The pertinent clinical information supporting the additional procedure must be available at the time AIM is contacted.

16. If AIM denies prior authorization of an imaging exam, is there an option to appeal the decision?

Yes, you may appeal through normal appeal procedures, as directed in the denial letter. If AIM makes the decision to deny the request at the end of your conversation, the ordering physician should appeal directly to Arkansas Blue Cross. (Arkansas Blue Cross and its family of companies retains the responsibility for grievances and appeals.)

17. If a service is already authorized by AIM and needs to be rescheduled beyond the original 60-day authorization period, do I need a new order number?

If the date of the service is extended beyond the original 60 days, a new authorization must be requested through AIM.

18. If the authorization is done via the telephone or via the Provider Portal**, is a letter sent to the provider whether the authorization was approved or denied?**

Yes, approval or denial letters will be sent to ordering providers requesting precertification of high-tech radiology imaging services.

19. Who develops the clinical criteria for the program?

AIM's Clinical Appropriateness Guidelines are updated at least once a year and are reviewed by:

- An independent physician review board, including cardiologists, orthopedic surgeons, radiologists, neurologists, and neurosurgeons
- Clinical subject matter experts including subspecialists and leading academic experts
- Client medical directors
- Local imaging advisory council (representing local physician communities)
- Physician review panels

In addition, AIM's guidelines are submitted as part of AIM's accreditation process to the National Committee for Quality Assurance (NCQA) and the American Accreditation Health Care Commission (URAC).

20. What methods and resources are used to develop the guidelines?

Development of AIM's Clinical Appropriateness Guidelines involves integration of medical information from multiple sources to support the reproducible use of high quality and state-of-the-art diagnostic imaging services. The process for criteria development is based on technology assessment, peer-reviewed medical literature, including clinical outcomes research, and consensus opinion in medical practice.

AIM adheres to the Institute of Medicine's (IOM's) best practice standards for the development of trustworthy guidelines including a rigorous primary evidence review and a comprehensive evaluation of existing national and specialty society guidelines including:

- American College of Cardiology (ACC) Appropriateness Criteria
- American Heart Association (AHA)
- American Institute of Ultrasound in Medicine (AIUM)
- American College of Radiology (ACR) Appropriateness Criteria
- Provider Led Entities (PLE's)
- American Cancer Society
- American Academy of Neurology (AAN)
- American Academy of Pediatrics (AAP)
- Society of Interventional Radiology (SIR)
- Society of Nuclear Medicine (SNM)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare and Medicaid Services (CMS)
- National Guideline Clearinghouse

21. How can I receive a copy of the clinical criteria used by AIM?
AIM Clinical Appropriateness Guidelines are available on the homepage of their website at www.aimspecialtyhealth.com.

For more information, go to www.aimspecialtyhealth.com/nextgen/Resources.html for resources to help your practice get started with the Radiology Authorization Program. This special website helps you learn more and access helpful information and tools such as order entry checklists, clinical guidelines, and more. You may call 1-877-642-0722 to speak to an AIM Specialty Health representative. We value your participation and look forward to working with you.

PLEASE NOTE, just because prior authorization is obtained it does not mean coverage is guaranteed or even available for the particular member or service involved. Coverage is always subject to the specific terms and conditions of the member's health plan or policy, which must be met when the claim is received and reviewed. Such terms and conditions may include but are not limited to specific benefit limits or caps in some cases, out-of-network limitations, eligibility requirements such as the timely payment of premiums, and specific health plan or policy exclusions. See the Pre-Certification" section of your participating provider agreement.

It is the responsibility of the physician ordering the imaging examination to contact AIM for prior authorization. The rendering participating facility should not schedule procedures without prior authorization. Procedures performed that have not been properly authorized will not be reimbursed and the member cannot be balanced billed. If the patient calls to schedule a procedure that requires prior authorization and the patient does not have the authorization number, patient should be directed back to referring physician who ordered the examination.

New Identification Cards for Some Dental & Vision Members

Arkansas Blue Cross and Blue Shield dental and vision members will receive new ID cards, with potential new member ID numbers, for coverage beginning June 2019 as part of an improvement to our internal systems. There are no benefit changes associated with this system update. Some members will retain the same ID number; some will change.

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?
In June, 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.

Federal Employee Program

I. Electronic Replacement/Corrected and Voided Claim Submissions

Electronic claims submitted through the ANSI 837P (Professional) and the 837I (Institutional) electronic claims transactions contain claim frequency codes which indicate to the claim system that the claim is an adjustment or a void to a previously paid claim.

Professional and Institutional claims submitted with a replacement or void frequency code must be billed with the original claim that needs to be adjusted or voided. The new submitted claim will be rejected back to the provider if the original claim is not valid, not finalized, denied, already voided or the date of service is in a different year. Corrections to a claim that was denied or voided must be filed as a new claim with appropriate documentation if past timely filing.

Professional Providers:

Professional Claim Frequency Codes			
AHIN Frequency Code	**Description**	**When to Use**	**Action to be taken**
1	Original claim	Use when submitting a new claim. Corrections to a denied or voided claim would be considered a new claim.	Claim is processed as a brand new claim.
7	Replacement/Corrected claim	Use when submitting a correction to a paid claim. Meaning charges were allowed even if the charges were applied to the deductible or co-insurance/copayment.	The original claim will be adjusted and replaced with the new submitted charges.
8	Voided claim	Use to eliminate a previously submitted claim.	The original claim will be voided.

Examples:

Replacement/Corrected claims (Frequency code 7)

1. The original claim was submitted with 99212, 88003 and 76100. 76100 should have been billed as 76101. The replacement claim should be submitted with all procedures 99212, 88003 and 76101, frequency code 7 and the original claim number.
2. If a service was omitted from the original claim, the replacement claim should be submitted with all previously submitted charge lines, the additional service line, frequency code 7 and the original claim number.
3. The original claim was submitted with 99213, 81000 and 71020. In this case 81000 was billed in error. A replacement claim should be submitted with the 99213 and 71020, frequency code 7 and the original claim number. This indicates 81000 was removed.

Voided claims (Frequency code 8)

1. The original claim was billed in error. A new claim would need to be submitted exactly how the original claim was previously billed with a frequency code 8, and the original claim number. The original claim will be voided. No further action is needed.

Institutional providers:

The frequency code on institutional claims is the third digit of the type of bill (TOB).

Institutional Claim Frequency Codes			
Frequency Code (TOB)	**Description**	**When to Use**	**Action to be taken**
XX5	Late Charge	Use when submitting additional charges for the same date(s) of service as a previous claim.	The original claim will be adjusted and the late charges will be added.
XX7	Replacement of Prior Claim	Use when submitting a correction to a paid claim. Meaning charges were allowed even if the charges were applied to the deductible or co-insurance/copayment.	The original claim will be adjusted and replaced with the new submitted charges.
XX8	Void/Cancel Prior Claim	Use to eliminate a previously submitted claim.	Original claim will be voided.

Examples:

Replacement/Corrected claims (Frequency code XX7)

1. The patient was inpatient for 3 days but the original claim was submitted with room and board charges for 4 days in error. The replacement claim should be submitted with all charges lines and the correct from and through date, correct number of days, frequency code XX7 and the original claim number.
2. If a service(s) was omitted from the original claim the replacement claim should be submitted with all previously submitted charge lines, the additional charge(s), frequency code 7 and the original claim number.

Voided claims (Frequency code XX8)

1. The original claim was billed in error. A new claim would need to be submitted exactly how the original claim was previously billed with type of bill XX8, and the original claim number. The original claim will be voided. No further action is needed.

II. FEP Advanced Benefit Determination, Precertification, and Prior Approval

Advanced benefit determination (ABD) review is an expanded customer service function for FEP. This allows a provider to contact Blue Cross of Idaho to request information pertaining to a non-urgent service, procedure or piece of durable medical equipment (DME) for which the contract does not require precertification or prior approval, prior to performing or providing the non-urgent service, procedure or DME.

The services eligible for advance benefit determination review are:

- High dollar surgical procedures
- High dollar durable medical equipment
- Any other high dollar outpatient procedures

Advanced Benefit Determinations can be faxed to 501-210-7042.

Prior approval is the process of determining the medical necessity of elective services. Prior approval, please call or fax for prior approvals. Outpatient prior approvals can be submitted by using the prior approval form or by contacting FEP Customer Service at 800-482-6655 or 501-378-2531 (Monday-Friday 8:00 a.m.-5:00 p.m.) and following the prompts for the prior approval department.

Precertification is the process by which- prior to your inpatient admission-we evaluate the medical necessity of your proposed stay, the procedure (s)/service (s) to be performed, the number of days required to treat your condition, and any applicable benefit criteria. Unless we are misled the information given to us, we will not change our decision on medical necessity.

Precertification inpatient prior approvals can only be submitted by contacting FEP Customer Service staff (Monday-Friday 8:00 a.m.-5:00 p.m.) at 800-482-6655 or 501-378-2531 and following the prompts for inpatient admissions.

III. FEP High Tech Diagnostic Imaging

Effective April 1, 2019, FEP Blue Focus will begin requiring prior approval for high tech diagnostic imaging using the vendor AIM Specialty Health® (AIM). A list of procedures can be found on page 16 of this newsletter. Providers should contact AIM Specialty Health® (AIM) to obtain an order number before scheduling or performing any elective outpatient imaging service.

Services performed in conjunction with emergency room services, inpatient hospitalization, or urgent-care facilities are excluded. IF APPLICABLE --- Both ordering physicians (those referring the member for imaging) and servicing providers (those free-standing or hospitals that perform imaging) may submit requests. We recommend that servicing providers confirm an order number has been issued before rendering services.

The FEP UM Guidelines will be finalized and put into effective for implementation on April 1, 2019. To submit your request, you may contact AIM Specialty Health® (AIM) online via their ***Provider****Portal*SM at **www.aimspecialtyhealth.com/goweb** (select Arkansas Blue Cross from drop-down menu) or toll-free at 866-688-1449, Monday – Friday 7:00 a.m. – 7:00 p.m. Central Time.

Medi-Pak® Advantage

I. Updated Medi-Pak® Advantage Forms

In January, Medi-Pak® Advantage updated their forms on the www.arkansasbluecross.com provider web page. Utilizing an incorrect form causes misroutes and delay in member services. Providers, please ensure that you are utilizing the correct forms when submitting requests for Medi-Pak® Advantage products. The list below highlights frequently misrouted documents:

- Claim Reconsideration Request
- Organization Determination/Prior Authorization Form
- Out of Network Exception Form
- Medical Records Routing Forms

II. Requirements for Outpatient Observation Care

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 oral an explanation of the notification to patients receiving outpatient observation services for more than 24 hours. For Medi-Pak® Advantage members, observation stays require any pre-authorization or pre-notification requirements.

The notice should explain the following using contemporary language:

- The patient is classified as outpatient
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage for services furnished by a skilled nursing facility
- Advise patients to contact his or her insurance plan with specific benefit questions

The notice and accompanying instructions are available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

III. 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.

HEDIS® News

I. Medical Record Reviews

Each year from February through May, Arkansas Blue Cross and Blue Shield manages Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews to help improve our member quality initiatives.
Inovalon and CIOX, our vendors, will conduct HEDIS reviews for Medi-Pak® Advantage (PFFS), Health Advantage Medi-Pak® Advantage (HMO) members, and Exchange members for the 2018 measurement year.

What are HEDIS Reviews?

Inovalon and CIOX looks for details that may not have been captured in claims data such as blood pressure readings, HbA1c lab results, colorectal cancer screenings and body mass index. This information helps us improve our member quality initiatives.
Inovalon or CIOX will contact you to schedule an appointment for a HEDIS review or request that you fax the necessary records. The HEDIS review also requires proof of service documentation for data collected from a medical record.

2019 Chart Review Schedule

Arkansas Blue Cross also conducts other medical record reviews throughout the year for different purposes as outlined in the schedule below. We greatly appreciate your assistance with these important reviews.

Type of Review	Dates	Reviewer
HEDIS Audit	February – May 2019	• Arkansas Blue Cross • CIOX • Advantasure • Inovalon
Medicare Advantage Risk Adjustment Data Validation (RADV) Audit	February – June 2019	• Advantasure • CIOX • Inovalon
Commercial Risk Adjustment Data Validation (RADV) Audit	June – October 2019	• Arkansas Blue Cross • CIOX • Inovalon
Medicare Advantage Retrospective Chart Review	February – December 2019	• CIOX
Stars	September – December 2019	• Arkansas Blue Cross • Advantasure • CIOX
Risk Adjustment Chart Review	January – December 2019	• Arkansas Blue Cross • CIOX
Exchange HEDIS Gaps	June – December 2019	• Arkansas Blue Cross • Advantasure • CIOX

II. New Advanced Illness and Frailty Exclusions for HEDIS® Star Measures

The National Committee for Quality Assurance (NCQA) now allows patients to be excluded from select Healthcare Effectiveness Data and Information Set (HEDIS®) star quality measures due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

You now may submit claims with advanced illness and frailty codes to exclude patients who meet the criteria from select measures. Using these codes also reduces medical record requests for HEDIS data-collection purposes.

For a description of the criteria and a convenient list with some of the appropriate HEDIS-approved billing codes, click here to view the "2019 HEDIS® Advanced Illness and Frailty Exclusions Guide."

III. Improve HEDIS® Scores Through Claims Coding

What are CPT® Category II and Z codes?

Current Procedural Terminology (CPT) Category II codes are performance measurement tracking codes. Z codes are health status diagnosis codes. Certain CPT II codes and Z codes facilitate data collection for HEDIS® measures. Used together, they can give you credit for

quality of care without the need for medical record review and can help close gaps for HEDIS measures.

CPT Category II codes describe clinical performance measures that usually are included in the evaluation and management process (such as A1c or blood pressure values). They are entered in the procedure code field, similar to CPT Category I codes.

Z codes are International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes that describe a patient's health status. By submitting a claim with the appropriate Z code to indicate a patient's body mass index, the need to submit the member's medical record to validate BMI documentation may be eliminated.

Click here to access a claims-coding tip sheet that lists CPT II and ICD-10 codes for HEDIS measures.

IV. HEDIS® Measures Outcomes Survey

Remember to discuss fall risk, urinary incontinence and physical activity with Medicare patients.

According to the National Committee for Quality Assurance (NCQA):

- Falls are the leading cause of death by injury in people age 65 and older; every year, 1 in 3 older adults falls.
- Urinary incontinence is significantly underreported and underdiagnosed.
- Any amount of physical activity reduces the risk of developing certain chronic conditions and increases quality of life.

Due to these serious health concerns, the Medicare Health Outcomes Survey (HOS) measures patient-reported outcomes for three Healthcare Effectiveness Data and Information Set (HEDIS®) Effectiveness of Care measures:

- Fall Risk Management
- Management of Urinary Incontinence in Older Adults
- Physical Activity in Older Adults

The survey, which runs from April to July, asks randomly selected Medicare Advantage members questions about how providers talk with them about these important topics.

Review the HOS Tip Sheet to learn more, including what questions are asked and how you can address care opportunities with patients.