Arkansas BlueCross BlueShield
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PROVIDERS' NEWS

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2021 Open enrollment – Please use Availity

The 2021 Open Enrollment period begins October 4 and will continue through December 15. The enrollment of many new members and renewal of current members will produce extremely high call volumes, which are expected to remain elevated through January 31, 2022.

Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the Availity website for verifying eligibility, benefits and claims status. Availity displays information to assist providers when scheduling appointments, checking eligibility and identifying benefits.

Arkansas Blue Cross is planning and staffing to answer these higher call volumes, but please be aware that they can spike and exceed our ability to answer every call. Availity uses the same information available to our customer service representatives and can save you valuable time.

AHIN/Availity functions

Provider applications, clinic applications, recredentialing and provider data updates will remain on AHIN.

As has been communicated previously, the provider community should continue using AHIN for functionality that has not been transferred to Availity.

The following functions will not be active in Availity until at least 2nd quarter 2022:

- Adding new provider applications to an existing clinic.
- Adding or terminating a provider from an existing clinic or group.
- Recredentialing for all professional providers.
- Updating provider data.

You will need to maintain your AHIN access and continue to complete the needed provider enrollment, updates and recredentialing on AHIN until full transition of these functions have been made to Availity. The alternative to AHIN is a manual paper process, which will take longer to administer.

In addition, communication to providers about their recredentialing needs and status will come from AHIN until this function is moved to Availity.

The Health Information Network section on the Arkansas Blue Cross website is a helpful resource which lists current Availity and AHIN access as well as how to register for Availity and AHIN. https://www.arkansasbluecross.com/providers/resource-center/health-information-network.

Annual compliance training

The federal annual compliance training through the Centers for Medicare and Medicaid has changed. The Medicare Part C and D compliance training is no longer required, but a training link will be available for providers to view on the Availity payer space. Providers are not required to attest. Contact Regulatory Compliance at regulatorycompliance@arkbluecross.com with any questions.

BlueAdvantage appeal reminder

A designated appeal form signed by the member from the provider is required when submitting an appeal on behalf of a BlueAdvantage member. The form can be found on our website https://www.blueadvantagearkansas.com/members/forms. For any additional information, please contact our customer service department at 1-888-872-2531.

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Consolidated Appropriations Act (CAA) update

The **Consolidated Appropriations Act (CAA)** contains many requirements that have implications for health insurers, health plans, healthcare providers and consumers. We fully anticipate being able to meet our obligation to comply with any of the applicable effective dates of the law's provisions.

Arkansas Blue Cross is analyzing and relying on the legislation's text to guide our preliminary assessments, planning and compliance activities. We continue to closely monitor for additional regulations from the Department of Health & Human Services (HHS) related to the requirements put forth under the CAA so that we will be prepared to comply on the effective dates put out under the forthcoming rules' release(s).

As **background**, below are **general explanations** of some of the items included in the CAA that may impact healthcare providers in some way:

- **Price comparison tools** – This rule is similar to the 2020 Transparency Rule which applied to certain providers/facilities. The CAA requires group health plans and health insurance issuers to provide price comparison tools. It requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.
- The Tool must be available for 500 covered items and services by ***January 1, 2023***, and for all covered items and services ***by January 1, 2024***.
- In order to align the enforcement date of the CAA Price Comparison Tool with the enforcement date of the Transparency in Coverage Tool, ***enforcement of [the CAA price comparison tool] requirement will be deferred . . . until January 1, 2023*.**

  Effective: January 1, 2023

- **Advance Explanation of Benefits (EOB)** – CAA requires group health plans and health insurance issuers to provide an advance explanation of benefits (EOB) for scheduled services. Requires individual and group health plans to provide a detailed estimate prior to services that are scheduled at least three days in advance. ***Estimates will be based on mandated notice from providers*** or members and must be created in three business days or less.

- **Effective for providers and facilities:** Enforcement of the Advanced EOB requirement deferred pending a rulemaking process.
    - Surprise billing – CAA establishes requirements to protect patients from surprise medical bills received from out-of-network hospitals, freestanding emergency facilities, out-of-network providers at in-network facilities, and out-of-network air ambulance carriers. Provides for patients to be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain nonemergency situations in which patients do not have the ability to choose an in-network provider. This does not apply where the member chooses to receive services from an out-of-network provider.
    - Out-of-network providers and facilities who have provided emergency services or out-of-network providers offering services in an in-network facility where the member would not have the opportunity to know in advance that services would be provided by an out-of-network provider will have requirements to provide notice and receive consent to allow for balance billing.
    - Providers and facilities are encouraged to work with their legal representatives to *ensure that they will be in compliance with this new law and its requirements.*

  Effective for plan years: beginning on or after January 1, 2022

- **Air ambulance** – As a part of the Surprise Billing protections, members who unknowingly receive services from out-of-network (OON) air ambulance providers are protected from out-of-network (OON) cost-sharing and balance billing.
    - Contains requirements for air ambulance providers and plans to both report and submit to the Tri-Agencies a number of metrics on air ambulance services within 90 days of the end of a plan year.

  Effective for plan years: starting January 1, 2022

- **Provider directories** – CAA impacts:
    - ***Requires providers to update directory information*** and provide refunds to enrollees if OON costs are inappropriately applied (in certain circumstances).
    - Requires group health plans and issuers offering group and individual health plans ***to establish a verification process to confirm directory information at least every 90 days***. Accordingly, it is very important that healthcare providers respond in a timely manner to health plans who inquire about their provider information – and attest to the information's accuracy – to avoid possible

termination from the health plan's provider networks due to noncompliance with the requirements of the law

  - If a member provides documentation that they received incorrect information, they are only responsible for in-network cost-sharing.
  - Major point of provisions are data accuracy and data currency that offer members up-to-date and correct provider-related data.

  Effective for plan years: starting January 1, 2022

- **Mental health parity** – CAA requires group health plans and health insurance issuers offering individual or group coverage to perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTL) when applicable to mental health/substance use disorder benefits.

  Effective: February 10, 2021

- Changes to ID Cards – Requires group and individual health plans to identify on insurance cards the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum, and a phone number and website address for consumer assistance information.

  Effective: Compliance enforcement deferred to January 1, 2023.

While Arkansas Blue Cross and Blue Shield strives to be helpful, we do not provide legal or regulatory advice or services to third parties. If providers have questions about whether or how a law or regulation applies to them, they should consult with their own legal counsel. We can provide background information and offer our business perspective where we believe it would be helpful – but not legal, regulatory or compliance advice.

We very much appreciate the quality care you provide to the people who count on us for their health coverage. As final rules and guidelines become available, we will be sharing more details about process changes that may affect you and that are required to implement the law's requirements.

Cardiac and Coronary Artery Computed Tomography and Fractional Flow Reserve measurement

Coverage policy 2005010, Cardiac and Coronary Artery Computed Tomography, CT Derived Fractional Flow Reserve and CT Coronary Calcium Scoring, describes criteria for coverage of these procedures. **There have been no changes since the current policy took effect February 14, 2021.**

This article provides a reminder of two points:

1) Prior approval through AIM is required for coronary CT angiography (CCTA). If FFR is needed after the CCTA has been obtained, prior approval for the FFR should be obtained through AIM separately. Claims for either CCTA or FFR received without PA from AIM will be denied. (This does not apply to members of plans that do not utilize AIM for prior authorization).

2) For certain indications outlined in the policy, approval of CCTA requires that the facility have the capability to perform FFR if needed.

For specific details, please see coverage policy 2005010.

Coverage Policy manual updates

Since June 2021, Arkansas Blue Cross has added or updated several policies in its Coverage Policy manual. The table below highlights these additions and updates. If you want to view entire policies, you can access the coverage policies located on our website at arkansasbluecross.com.

Policy ID	Policy Name
1997014	Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions
1998156	PET or PET/CT for Non-Small Cell Lung Cancer
2000001	PET or PET/CT for Colorectal Cancer
2000002	PET or PET/CT for Non-Hodgkin's Lymphoma
2000003	PET or PET/CT for Melanoma
2000023	PET or PET/CT for Head and Neck Malignant Disease

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Policy ID	Policy Name
2001030	PET or PET/CT for Esophageal or Esophagogastric Junction (EGJ) Cancer
2001035	PET or PET/CT for Prostate Cancer
2001036	PET or PET/CT for Breast Cancer
2001037	PET or PET/CT for Ovarian Cancer
2001038	PET or PET/CT for Pancreatic Cancer
2001039	PET or PET/CT for Neuroendocrine Tumors
2001040	PET or PET/CT for Testicular Germ Cell Cancer
2002015	PET or PET/CT for Carcinoma of Unknown Primary (CUP)
2004024	PET or PET/CT for Thyroid Cancer
2004026	MR Guided Ultrasound Ablation - Uterine Fibroids and Other Tumors
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)
2005007	PET or PET/CT for Cervical Cancer
2005008	PET or PET/CT for Mesothelioma
2005033	PET or PET/CT for Primary Central Nervous System Cancer (Malignant Brain and Spinal Cord Tumors)
2008012	Radiation Therapy, Proton Beam or Helium Ion Irradiation
2008025	Stem Cell Growth Factor, Romiplostim (Nplate)
2008031	Rilonacept (Arcalyst)
2009013	Testing for Drugs of Abuse or Drugs at Risk of Abuse Including Controlled Substances
2009037	Genetic Test: JAK2 and MPL Mutation Testing for Myeloproliferative Disorders
2011010	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: SERUM LIPIDS SCREENING AND STATIN USE FOR THE PRIMARY PREVENTION OF CARDIOVASCULAR DISEASE
2011061	Genetic Test: Melanoma and Glioma, Testing to Predict Response to Targeted Therapy
2011066	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: OVERVIEW
2011069	PET or PET/CT for Anal Carcinoma
2011074	PET or PET/CT for Gastric Cancer
2012002	Transcatheter Pulmonary Valve Implantation
2012005	Genetic Test: Molecular Testing of Tumors for Genomic Profiling as a Therapeutic Guide
2012022	PET or PET/CT for Urological Cancers
2012024	PET or PET/CT for Thymoma/Thymic Carcinoma
2012027	PET Scan for Multiple Myeloma, Plasmacytoma
2012046	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: WELL-CHILD VISITS, NEWBORN, INFANT, CHILDREN, ADOLESCENTS & AGES 18-21
2012047	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: CARDIOMETABOLIC RISKS OF OBESITY IN CHILDREN AND ADOLESCENTS, COUNSELING
2012058	PET or PET/CT for Small Cell Lung Cancer
2013002	PET or PET/CT for Hodgkin's Lymphoma
2013006	Prostate, Saturation Biopsy
2013008	PET or PET/CT for Soft Tissue Sarcoma, including Gastrointestinal Stromal Tumor (GIST)
2014008	Infertility Services
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients With Non-Small-Cell Lung Cancer
2015003	Patient-Actuated Mechanical Devices (Range of Motion & Stretching Devices)
2015008	Genetic Test: Miscellaneous Genetic and Molecular Diagnostic Tests
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015016	Focal Treatments for Prostate Cancer

Policy ID	Policy Name
2016003	Omalizumab (Xolair)
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Nivolumab) (Durvalumab) (Cemiplimab)
2016011	PCSK9 INHIBITORS (Evolocumab) (Alirocumab)
2016012	Daratumumab (Darzalex) / Daratumumab and Hyaluronidase-fihi (DARZALEX FASPRO)
2016017	Radium Ra 223 dichloride for Symptomatic Osseous Metastatic Prostate Cancer (Xofigo®; Ra 223)
2016022	PET or PET/CT for Uterine Cancer
2016023	Treatments for Duchenne Muscular Dystrophy
2017016	Ramucirumab (Cyramza™)
2017024	Panitumumab (Vectibix™)
2017031	Dupilumab
2018011	PET or PET/CT for Penile, Vaginal, and Vulvar Cancer
2018012	PET or PET/CT for Bone Cancer
2018014	Lutetium Lu 177 Dotatate (Lutathera®)
2020012	Tagraxofusp-erzs (Elzonris)
2020015	Fam-trastuzumab deruxtecan-nxki (Enhertu®)
2020016	Inebilizumab-cdon (Uplizna™)
2020018	Digital Health Therapies for Substance Abuse
2020020	Sacituzumab govitecan-hziy (Trodelvy™)
2020023	Bimatoprost (Durysta™)
2020029	Covid-19 Monoclonal Antibody Therapy
2021004	PET or PET/CT for Cancer Surveillance and Other Oncologic Applications
2021017	Naxitamab-gqgk (Danyelza)
2021019	Obinutuzumab (Gazyva)
2021022	Trabectedin (Yondelis)
2021025	Margetuximab-cmkb (MARGENZA)
2021026	Melphalan Flufenamide (Pepaxto)
2021027	Evinacumab-dgnb (Evkeeza)
2021028	Ustekinumab (Stelara)
2021029	Percutaneous Arteriovenous Fistula (pAVF)
2021030	Allograft Injection for Degenerative Disc Disease
2021032	Lumasiran (Oxlumo)
2021033	Belimumab (Benlysta)
2021035	Sodium Iodide I 131 Oncologic Therapy

Licensed Marriage and Family Therapists (LMFT) may join our networks

Effective October 1, 2021, Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation will add LMFTs to its list of contracted providers for the following provider networks: Preferred Payment Plan, Health Advantage HMO and True Blue PPO.

These therapists will follow the same credentialing standards and terms and conditions that are required for Licensed Professional Counselors. Provider agreements and enrollment forms should be available mid-September. To begin the enrollment process or to find out more information, please contact your respective regional office's Network Development Representative or email providernetwork@arkbluecross.com.

Multiple surgical procedures

For Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators and Health Advantage

Professional CMS 1500 claims and Outpatient Hospital and ASC UB04 claims

When two or more surgical procedures are performed on the same date of service by the same professional provider, the following pricing methodology is used:

- Primary procedure: Eligible at 100% of the applicable fee schedule or billed amount, whichever is less.
- Secondary and subsequent procedures: Eligible at 50% of the applicable fee schedule or billed amount, whichever is less.

Multiple procedures should be submitted on one (1) claim.

In addition, when billing multiple surgical procedures, enough charges should be billed on all surgical procedures to equal the expected allowance for each service. This will reduce the length of time to process the claim as well as ensure proper payment for each procedure. When fewer charges are billed for the surgical code, there is a risk that if the billed charges are lower than the allowance, only billed charges will be allowed.

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Network changes

USAble Corporation, a wholly owned subsidiary of USAble Mutual Insurance Company, d/b/a Arkansas Blue Cross and Blue Shield, no longer has commercial business using three provider networks and accordingly has closed those provider networks.

As such, the provider community may have noticed the networks being removed or terminated via AHIN. One network, the JB Hunt Employer Network, is no longer needed as JB Hunt will be using the True Blue PPO network statewide. The other two networks, USAble PPO and USAble Mutual Connect PPO, no longer have business attached to them and have become inactive.

Network participation guidelines – update

Notice of material amendment

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

Effective August 1, 2021, the network 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 Blue Medicare Advantage PFFS network, Blue Medicare LPPO network, Health Advantage Medicare Advantage HMO network, Blue Medicare HMO, USAble Corporation Arkansas' FirstSource® PPO network, USAble Corporation True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been revised.

The detailed revised credentialing standards may be found at https://www.arkansasbluecross.com/providers/resource-center/network-participation-guidelines

Summary of sections with changes:

- Action on DEA certification or Bureau of Narcotics certificate.
- Collaborating/supervising physicians of mid-level practitioners.
- License restrictions.
- Criminal investigations, charges or convictions.

Terms and conditions of provider participation updates for all networks sponsored by Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Corporation

Effective August 1, 2021, the Network Terms and Conditions of participation for all eligible disciplines and applicants for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan network, Arkansas Blue Cross and Blue Shield Blue Medicare Advantage PFFS network, Blue Medicare LPPO network, Health Advantage Medicare Advantage HMO network, Blue Medicare HMO, USAble Corporation Arkansas' FirstSource® PPO network, USAble Corporation True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been revised.

The detailed revised credentialing standards may be found at https://www.arkansasbluecross.com/providers/resource-center/network-participation-guidelines

Summary of sections with changes:

- Member health and safety.
- Ineligibility time frames for breach of provider agreements.
- Ineligibility time frames for breach of utilization review, claims and coding policies and medical coverage.
- Submitting false or misleading claims.
- False or misleading information on credentialing and network applications.
- Clarifying network quality standards.
- Issues that result in automatic ineligibility of applicants.

New credit balance reconciliation and recovery service is coming

Later this year, Arkansas Blue Cross and Blue Shield and its subsidiaries will begin rolling out a new credit balance reconciliation and recovery service. The service is designed to assist our provider partners in researching and resolving outstanding credit balances and to reduce the administrative burden on facility staff. Through this initiative, Arkansas Blue Cross will provide access to a range of vendor-based solutions including an innovative software platform and skilled professional services to aid in credit balance resolution specific to members.

These services support the provider's administrative team by managing credit balances on the facility's books while resolving potential overpayments in real time with Arkansas Blue Cross and allowing more efficient use of valuable resources.

Watch for more information as we prepare to launch these innovative services.

Primary Care programs

Open enrollment begins October 8, 2021

Arkansas Blue Cross and Blue Shield will offer two Primary Care programs in 2022: Patient-Centered Medical Home and Primary Care First. Network providers and practices can elect to participate in either program. Open enrollment begins October 8 and closes October 22.

Eligible Specialties:

- Family medicine
- General practice
- Geriatric medicine
- Internal medicine
- Pediatric medicine
- Primary Care nurse practitioners
- Primary Care physician assistants
- Primary Care clinical nurse specialists

Eligible Networks:

- Arkansas Blue Cross Blue Shield PPP
- Health Advantage HMO
- Arkansas' First Source PPO or True Blue PPO

Primary Care First (PCF)

Primary Care First aims to improve quality, improve patient experience of care and reduce expenditures by increasing access to advanced primary care services. PCF practices will deliver patient-centered, comprehensive and continuous care. The specific approaches to care delivery will be determined by practice priorities.

PCF rewards participants with additional revenue for taking on limited risk based on easily understood, actionable outcomes. PCF is an advanced payment model along the path to value. Practices may participate in the Arkansas Blue Cross and Blue Shield PCF program even if they are not participating with CMMI's PCF model. Pediatricians are also eligible to participate in the 2022 PCF program.

Care management fees

Practices participating in PCF will receive per-member-per-month (PMPM) care management fees to support practice redesign and care coordination efforts. These fees are non-visit based monthly payments to support staffing and training demands of transforming a practice. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses, lower PMPM for patients with lower risk.

Professional population-based payments

Clinics receive monthly professional population-based payments to allow flexibility in caring for patients, in exchange for reduced fee-for-service allowed amounts on Evaluation and Management codes instead of discounted payments. Professional Population-Based Payments are risk adjusted.

Performance-based adjustments (PBA)

Arkansas Blue Cross will pay performance-based adjustments (PBA) to practices to encourage and reward quality metric performance. Practices will have the opportunity to earn a PBA on their commercial members for performance on Utilization measures as well as Clinical Quality measures.

The 2022 Utilization PBA will be calculated quarterly and applied to care management fees the second quarter following the performance period. Meeting at least one utilization target will result in an increase in care management fees. Meeting additional targets will increase the PBA. Poor performance will result in a decrease in care management fees.

Clinical quality measures will continue to be calculated and paid annually. There will be 8 quality metrics for the general track and 8 quality metrics for the pediatric track. Clinics must meet a minimum number of metrics to earn a PBA. Meeting additional metrics will increase the PBA.

This is a voluntary program. There are no penalties for providers who choose not to participate. For more information on the Arkansas Blue Cross and Blue Shield 2022 PCF program, contact us at primarycare@arkbluecross.com.

Notice of material amendment

For providers who are currently participating in this PCF program, the following changes to the PCF program will be effective January 1, 2022:

- Practices may participate in Arkansas Blue Cross and Blue Shield PCF program even if they are not participating in CMMI's PCF model.
- Pediatricians are eligible to participate in the 2022 PCF program.
- Plan payments will no longer be discounted on E&M codes.
- Fee for service allowed amounts will be reduced on E&M codes.
- In 2022, there will be 8 quality metrics for the general track and eight quality metrics for the pediatric track.

Patient-Centered Medical Home (PCMH)

A Patient-Centered Medical Home (PCMH) is a care team that manages the overall health and coordinates the care of a patient. The PCMH program is designed to assist primary care providers (PCPs) in transitioning to become PCMH practices through guidance and support, while rewarding them for high-quality, coordinated, and efficient care.

Care management fees

Practices participating in PCMH will receive per-member-per-month (PMPM) care management fees to support practice redesign and care coordination efforts. These fees are non-visit based monthly payments to support staffing and training demands of transforming a practice. Care management fees are risk-adjusted, with higher PMPM for patients with more severe illnesses, lower PMPM for patients with lower risk.

Performance based adjustments (PBA)

For 2022, Performance Based Incentive Payments (PBIP) will change to align with PCF. Arkansas Blue Cross will pay performance-based adjustments (PBA) to practices to encourage and reward quality metric performance. Practices will have the opportunity to earn a PBA on their commercial members for performance on Utilization measures as well as Clinical Quality measures.

The 2022 Utilization PBA will be calculated quarterly and applied to care management fees the second quarter following the performance period. Meeting at least one utilization target will result in an increase in care management fees. Meeting additional targets will increase the PBA. Poor performance will NOT result in a decrease in care management fees.

Clinical quality measures will continue to be calculated and paid annually. There will be 8 quality metrics for the general track and 8 quality metrics for the pediatric track. Clinics must meet a minimum number of metrics to earn a PBA. Meeting additional metrics will increase the PBA.

This is a voluntary program. There are no penalties for providers who choose not to participate. For more information on the Arkansas Blue Cross and Blue Shield 2022 PCMH program, contact us at primarycare@arkbluecross.com.

Notice of material amendment

For providers who are currently participating in this program, the following changes to the PCMH program will be effective January 1, 2022:

- Performance-Based Incentive Payments will change to Performance-Based Adjustments with utilization PBA being applied to monthly care management fees.
- In 2022, there will be 8 quality metrics for the general track and eight quality metrics for the pediatric track.

Prior authorization of CPT 21089

Effective September 15, 2021, CPT Code 21089, "Unlisted maxillofacial prosthetic procedure", will require Prior Authorization. This is an unspecified code and will require submission of a full description of the service being billed. CPT 21089 can be used to describe services addressed in the member benefit certificate of coverage and will require submission of a full description of the service being billed.

Medical specialty medications prior approval 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 table below is the current list of medications that require prior approval through the member's medical benefit. It is also indicated when a medication is required to be processed through the pharmacy benefit. Any new medication used to treat a rare disease should be considered to require prior approval. **ASE/PSE and Medicare are not included in this article but have their own prior approval programs.**

Drug	Indication	Benefit
Adakveo	Sickle cell disease	Medical
(crizanlizumab-tcma)		
Aldurazyme	MPS I	Medical
(laronidase)	Hurler syndrome	
Arcalyst	CAPS	Medical
(rilonacept)	DIRA	
	Recurrent pericarditis	
Benlysta	Systemic lupus erythematosus	Medical
(belimumab)	Lupus nephritis	
Berinert	Hereditary angioedema	Medical
(c1 esterase, inhib, human)		
Breyanzi	Large B-cell lymphoma	Medical
(lisocabtagene maraleucel)		
Brineura	CLN2 disease	Medical
(ceroliponase alfa)		
Cablivi	Thrombocytic thrombocytopenia	Medical & Pharmacy
(caplacizumab-yhdp)		
Cinqair	Severe asthma	Medical
(reslizumab)		

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Cinryze	Hereditary angioedema	Medical
(c1 Esterase, inhib, human)		
Crysvita	Hypophosphatemia	Medical & Pharmacy
(burosumab – twza)	Tumor induced 18steomalacia	
Duopa	Parkinson’s	Medical
(levodopa-carpidopa intestinal gel)		
Durysta	Open-angle glaucoma	Medical
(bimatoprost)	Ocular hypertension	
Elaprase	MPS II	Medical
(idursulfase)	Hunter syndrome	
Elzonris	BPDCN	Medical
(tagraxifusp-erzs)		
Enspryng	NMOSD	Medical & Pharmacy
(satralizumab-mwge)		
Evenity	Severe Osteoporosis	Medical
(romosozumab-aqqg)		
Evkeeza	Homozygous familial hypercholesterolemia	Medical
(evinacumab-dgnb)		
Fabrazyme	Fabry disease	Medical
(agalsidase beta)		
Fasenra	Mod to severe asthma	Medical & Pharmacy
(benralizumab)		
Firazyr	Hereditary angioedema	Pharmacy
(icatabant acetate)		
Gamifant	Hemophagocytic lymphohistiocytosis	Medical
(emapalumab-lzsg)		
Givlaari	Acute hepatic porphyria	Medical
(givosiran)		

Haegarda	Hereditary angioedema	Pharmacy
(c1 esterase, inhib, human)		
Ilaris	Periodic fever syndrome	Medical & Pharmacy
(canakinumab)	Still's disease	
Kalbitor	Hereditary angioedema	Medical & Pharmacy
(ecallantide)		
Krystexxa	Gout	Medical
(pegloticase)		
Kymriah	Cancers	Medical
(tisagenlecleucel)		*Reviewed by Transplant Coordinator
Lemtrada	Multiple Sclerosis	Medical
(alemtuzumab)		
Lumizyme	Pompe Disease	Medical
(alglucosidase alfa)		
Lutathera	Neuroendocrine tumors	Medical
(lutetium Lu 177 Dotatate)		
Mepsevii	MPS VII	Medical
(vestronidase-Alfa)	Sly syndrome	
Myalept	Lipodystrophy	Pharmacy
(metreleptin)		
Nagalzyme	MPS VI	Medical
(galsulfase)	Maroteaux-Lamy syndrome	
Nucala	Mod to severe asthma	Medical & Pharmacy
(mepolizumab)	Hypereosinophilic syndrome	
Oxlumo	Primary hyperoxaluria	Medical
(lumasiran)		
Reblozyl	Beta thalassemia	Medical
(luspatercept)	Myelodysplastic syndrome	
Ruconest	Hereditary angioedema	Medical
(c1 esterase, inhib, recombinant)		

Soliris	PNH	Medical
(eculizumab)	aHUS	
	Myasthenia Gravis	
	NMOSD	
Spinraza	Spinal muscle atrophy	Medical
(nusinersen)		
Spravato	Treatment resistant depression	Pharmacy
(esketamine)	Major depressive disorder with suicidality	
Stelara	Crohn's disease	Medical & Pharmacy
(ustekinumab)	Plaque psoriasis	
	Psoriatic arthritis	
	Ulcerative colitis	
Strensiq	Hypophosphatasia	Pharmacy
(asfotase alfa)		
Takhzyro	Hereditary angioedema	Pharmacy
(lanadelumab)		
Tecartus	Mantle cell lymphoma	Medical
(brexucabtagene autoleucel)		
Tepezza	Thyroid eye disease	Medical
(teprotumumab)		
Ultomiris	PNH	Medical
(ravulizumab-cwyz)		
Uplizna	Neuromyelitis optica spectrum disorder	Medical
(inebilizumab)		
Vimizim	MPS IV	Medical
(elosulfase alfa)	Morquio A	
Yescarta	Cancers	Medical
(axicabtagene ciloleucel)		*Reviewed by Transplant Coordinator
Xolair	Mod to severe asthma	Medical & Pharmacy
(omalizumab)	Urticaria	

Zolgensma	Spinal muscle atrophy	Medical
(onasmnogene abeparvovec-XIOI)		
Zulresso	Postpartum depression	Medical
(brexanolone)		

For more information on how to submit a request for prior approval of one of these medications, 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. BlueAdvantage members can find the form at the following link: https://www.blueadvantagearkansas.com/providers/forms.aspx.

For all other members, the appropriate prior approval form can be found at the following link: https://www.arkansasbluecross.com/providers/resource-center/provider-forms.

These forms and any additional documentation should be faxed to 501-210-7051 for BlueAdvantage members. For all other members, the appropriate fax number is 501-378-6647.

Metallic formulary changes effective October 1, 2021

On Exchange, Off Exchange, Arkansas Works, Arkansas Blue Cross and Blue Shield small group, Health Advantage small group and USAble Mutual small group members use the metallic formulary.

Drugs no longer covered

Drug Name	Formulary Alternatives
AZOPT SUS 1% OP	Use generic form of the drug
BIMATOPRO LM SOL 0.03% OP	USE LUMIGAN SOLUTION, latanoprost solution, travoprost drops, ZIOPTAN DROPS
BIMATOPROST SOL 0.03%	USE LUMIGAN SOLUTION, latanoprost solution, travoprost drops, ZIOPTAN DROPS

DOXYCYCL HYC TAB 100MG DR	USE doxycycline hyclate tablet 75mg, 150mg DR, doxycycline monohydrate capsule 50mg, 100mg, doxycycline monohydrate tablet 50mg, 75mg, 150mg, Avidoxy tablet 100mg, doxycycline suspension 25mg/5mL, doxycycline hyclate capsule 50mg, 100mg, doxycycline hyclate tablet 100mg, VIBRAMYCIN SYRUP 50MG/ML
EXELDERM SOL 1%	Use generic form of the drug
GLUCAGON INJ EMERGNCY	Use generic form of the drug
HYSINGLA ER TAB 100 MG	Use generic form of the drug
HYSINGLA ER TAB 20 MG	Use generic form of the drug
HYSINGLA ER TAB 30 MG	Use generic form of the drug
HYSINGLA ER TAB 40 MG	Use generic form of the drug
HYSINGLA ER TAB 60 MG	Use generic form of the drug
METHYLPHENID TAB 18MG ER	USE methylphenidate tablet 18 mg, 27 mg, 36 mg, 54 mg ER (osmotic release), methylphenidate capsule 20 mg, 30 mg, 40 mg ER, methylphenidate capsule 60 mg LA
METHYLPHENID TAB 27MG ER	USE methylphenidate tablet 18 mg, 27 mg, 36 mg, 54 mg ER (osmotic release), methylphenidate capsule 20 mg, 30 mg, 40 mg ER, methylphenidate capsule 60 mg LA
METHYLPHENID TAB 36MG ER	USE methylphenidate tablet 18 mg, 27 mg, 36 mg, 54 mg ER (osmotic release), methylphenidate capsule 20 mg, 30 mg, 40 mg ER, methylphenidate capsule 60 mg LA
METHYLPHENID TAB 54MG ER	USE methylphenidate tablet 18 mg, 27 mg, 36 mg, 54 mg ER (osmotic release), methylphenidate capsule 20 mg, 30 mg, 40 mg ER, methylphenidate capsule 60 mg LA
THEO-24 CAP 100MG ER	USE theophylline ext-rel tablets 400 mg, 600 mg
THEO-24 CAP 200MG ER	USE theophylline ext-rel tablets 400 mg, 600 mg
THEO-24 CAP 300MG ER	USE theophylline ext-rel tablets 400 mg, 600 mg

Standard formulary changes effective October 1, 2021

Arkansas Blue Cross and Blue Shield large groups, Health Advantage large groups, and Blue Advantage plans that have selected our prescription drug benefits use the standard formulary.

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Product/Drug Label Name	Change	Formulary Alternatives
AZOPT SUS 1% OP	Moving to Non-Preferred Tier (generic is available)	brinzolamide, dorzolamide
CALCIPOTRIEN AER 0.005%	Drug No Longer Covered	calcipotriene ointment, calcipotriene solution
CORDRAN 80X3 TAP 4MCG/CM	Drug No Longer Covered	clobetasol cream, clobetasol foam, clobetasol gel, clobetasol lotion, clobetasol ointment
DOXYCYCLINE HYCLATE TAB 100MG DR	Drug No Longer Covered	doxycycline hyclate 20 mg, doxycycline hyclate capsule, minocycline, tetracycline
DYMISTA SPR 137-50	Moving to Non-Preferred Tier (generic is available)	azelastine-fluticasone, flunisolide, fluticasone, mometasone
HALOG CRE 0.1%	Drug No Longer Covered	desoximetasone (except desoximetasone ointment 0.05%), fluocinonide (except fluocinonide cream 0.1%)
HALOG OIN 0.1%	Drug No Longer Covered	desoximetasone (except desoximetasone ointment 0.05%), fluocinonide (except fluocinonide cream 0.1%)
MELOXICAM CAP 10MG	Drug No Longer Covered	diclofenac sodium, ibuprofen, meloxicam tablet, naproxen (except naproxen CR or naproxen suspension)
MELOXICAM CAP 5MG	Drug No Longer Covered	diclofenac sodium, ibuprofen, meloxicam tablet, naproxen (except naproxen CR or naproxen suspension)
PAROXETINE TAB ER 37.5MG	Drug No Longer Covered	citalopram, escitalopram, fluoxetine (except fluoxetine tablet 60 mg, fluoxetine tablet [generics for SARAFEM]), paroxetine HCl, paroxetine HCl ext-rel), sertraline
TRUVADA TAB 200-300	Moving to Non-Preferred Tier (generic is available)	abacavir-lamivudine, emtricitabine-tenofovir disoproxil fumarate, CIMDUO, DESCOVY, TEMIXYS
ULTRAVATE LOT 0.05%	Drug No Longer Covered	clobetasol cream, clobetasol foam, clobetasol gel, clobetasol lotion, clobetasol ointment

Retraction: Arkansas School & State / Public School Employees and Arkansas State University System medical plan audits

The previously published article in the June (2021) *Providers' News* is now retracted for the Employee Benefits Division.

The Employee Benefits Division, which governs the benefit plans for Arkansas State and Arkansas Public School employees and is administered by Health Advantage, will not implement third party audits of medical claims conducted by US Beacon / 4C Health Solutions, Inc. ("USB/4C"). If the Employee Benefits Division implements audits of medical claims in the future, prior notice will be given in accordance with a formal contractual change notification.

The Arkansas State University System, whose employee benefit plan is administered by Blue Advantage Administrators of Arkansas, is pending implementation of third party audits of medical claims conducted by US Beacon / 4C Health Solutions, Inc. ("USB/4C"). If Arkansas State University System proceeds with third party audits of medical claims, a separate notification will be issued with implementation details and effective date in accordance with a formal contractual change notification.

FEP adding AIM effective March 1, 2022

Approval information for radiological services

Effective March 1, 2022, an outpatient diagnostic imaging program will be in place for Federal Employee Program members of Arkansas Blue Cross and Blue Shield.

Physicians are required to secure prior approval for the following outpatient procedures: CT scan, MRI/MRA, nuclear cardiology and PET scan.

Arkansas Blue Cross utilizes AIM Specialty Health — an independent company — to provide prior approval of health plan coverage services, and this will be the same program.

Medicare Advantage

Prior authorization updates

Notice of material amendment to the Arkansas Blue Medicare and Health Advantage Medicare Advantage HMO healthcare contracts

Updates for Medicare Advantage prior authorization list effective October 1, 2021

Effective October 1, 2021, Arkansas Blue Medicare and Health Advantage Medicare Advantage plans will be implementing a process change for the codes listed below. The current process for listed codes triggers a post service medical review. At that time, a letter requesting medical records will be sent to the servicing provider. Once received, the records will be reviewed by the plan to determine medical necessity. Effective October 1, 2021, prior authorization will be required for the following codes prior to services being rendered.

Code	Description
33975	Insertion of ventricular assist device; extracorporeal
33983	Replacement of ventricular assist device pump(s)
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement
L8621	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each

eviCore healthcare, on behalf of the Arkansas Blue Medicare and Health Advantage Medicare Advantage plans, has added the following planned updates to its radiology and cardiology programs. As a result, the following codes will be added to its list of codes requiring prior authorization.

Code	Description
0648T	Quantitative magnetic resonance for analysis of tissue composition, including multiparametric data acquisition, data preparation and transmission, interpretation, and report, obtained without diagnostic MRI examination of the same anatomy during the same session.
0649T	Quantitative magnetic resonance for analysis of tissue composition, including multiparametric data acquisition, data preparation and transmission, interpretation, and report, obtained with diagnostic MRI examination of the same anatomy during the same session.
0623T	Automated quantification and characterization of coronary atherosclerotic plaque is a service in which coronary computed tomographic angiography (CCTA) data are analyzed using computerized algorithms to assess the extent and severity of coronary artery disease.
0624T	
0625T	
0626T	

Updates for Radiology Clinical Guidelines effective November 1, 2021.

eviCore healthcare has completed the annual review process for the Radiation Oncology Clinical guidelines. Please note there are no changes to the managed list of CPT codes requiring Prior Authorization. The following updates to the Radiation Oncology guidelines impact the current clinical decision making and due to the high volume of material changes the following list does not include changes where an increase in approvals is likely. The material changes referenced below could impact adverse decisions or the frequency and/or duration of treatment:

- **Neutron beam therapy**
  All indications for use are considered experimental, investigational, and/or unproven (EIU).
- **Bladder cancer**
  Changes in fractionation schedule for treatment — Changed from 20 fractions, to fractionation schedules including 36 Gy in 6 fractions, 21 Gy in 3 fractions, 30 Gy in 10 fractions, 20 Gy in 5 fractions and 8-10 Gy in 1 fractions. Spanos et al. evaluated up to 12 fractions for palliation of advanced pelvic malignancies. In an individual with evidence of metastatic disease, palliative radiation is considered medically necessary, up to 15 fractions using 3D techniques.
- **Breast cancer**
  Intraoperative radiation therapy (IORT) — All indications for use are considered experimental, investigational, and/or unproven (EIU).

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Prior authorization fax change - reminder

Effective January 1, 2021, Arkansas Blue Medicare and Health Advantage Medicare Advantage HMO removed the prior authorization process from Blue Cross and Blue Shield of Michigan (also referred to as "Advantasure") and implemented a new, in-house utilization management program. Although providers received notice of this change prior to the implementation and after the transition was completed, faxes are still being misrouted to Advantasure in error, which can result in a delay in care for the members. The former Advantasure prior authorization fax (1-844-869-4073) number has now been disconnected. Any new requests need to be sent using the following priority fax numbers:

Standard Requests – Fax: 1-816-313-3014

Expedited Requests – Fax: 1-816-313-3013

Resource: The 2021 Medicare Advantage Prior Authorization Requests can be found online under the Resource Center – Provider Forms.

2021 Medicare Risk Adjustment medical records requests

Arkansas Blue Cross and Blue Shield vendors Optum and CIOX along with internal stakeholders have begun contacting providers for retrieval of 2020 and 2021 medical records for Medicare populations. In August, Medicare Risk Adjustment started sending medical records requests to providers. The estimated end date for the medical records retrieval will be January 14, 2022.

We ask that you please respond to any records request within ten days of receipt. If you have a preferred method for chart retrieval, please communicate this with one of our Network Development Representatives (NDRs). Please use the following link to find contact information specific to your location, along with other helpful contact information.
https://www.arkansasbluecross.com/providers/resource-center/network-development-reps

Medicare Advantage COVID-19 skilled nursing facility prior authorization waiver

Due to the increase in COVID-19 cases in Arkansas, Blue Medicare and Health Advantage Medicare are extending the waiver for Skilled Nursing Facility Prior Authorizations for members transferring from acute inpatient stay. Arkansas Blue Cross will continue to require notification from skilled nursing facilities for our tracking and discharge planning purposes to ensure our members have the services they need as they transition back into the community.

The COVID-19 waiver will be in effect through September 30, 2021, and applies to skilled nursing facilities only. Admissions to long term acute care hospitals and inpatient rehabilitation facilities will continue to require prior authorization.

Skilled nursing providers can contact Blue Medicare by calling 1-800-287-4188 or by faxing a facility notification to 1-816-313-3013.

Medicare Advantage benefit guidelines: Colonoscopy

For all dates of service for Plan Year Effective 2021, Arkansas Blue Medicare and Health Advantage Medicare Advantage plans cover all colonoscopies at $0 copay. This includes both preventative and diagnostic. If a member comes in for a preventative screening and a polyp is removed during the procedure, please continue to code those with the appropriate surgical procedure code and include the modifier PT. This modifier indicates that the procedure was originally preventative and was changed during the course of the procedure.

Please note, the $0 copay only applies to 2021. New benefits will begin in 2022.

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 any Medicare Advantage plan to administer their Medicare benefits would have Medicare Advantage as their primary coverage and Medicaid as their 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 any Medicare Advantage plan 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.

Requirements for outpatient observation care

In compliance with the Centers for Medicare and Medicaid Services (CMS) Medicare Outpatient Observation Notice (MOON), Arkansas Blue Medicare and Health Advantage Medicare Advantage require all acute care and critical access hospitals to provide written notification and an oral explanation of the notification to patients receiving outpatient observation services for more than 24 hours and no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.
- Beneficiaries for whom Medicare is either the primary or secondary payer.

For some Medicare Advantage members, observation stays have 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.

Upcoming holiday closings

Labor Day – Monday, September 6

Thanksgiving – Thursday, November 25, and Friday, November 26

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