Arkansas BlueCross BlueShield
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PROVIDERS' NEWS

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This special issue of Providers' News is notice of material amendments that will take effect February 1, 2020.

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NEW! Effective February 1, 2020 - Prior approval requirement for Health Advantage

All Medical Inpatient Hospital admissions are subject to Prior Approval from Health Advantage. Unless the Member's treating Provider or the Hospital submits a pre-service claim for Prior Approval, not only will coverage be denied; but if the Member is admitted to the Hospital without prior approval, the Member will be held harmless from any hospital and professional bills associated with the admission.

Please note: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the Health Intervention meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

For more information, contact Health Advantage Customer Service at 800-843-1329.

Arkansas State Police medical plan changes

Notice of material amendment to the Health Advantage healthcare contract

Effective January 1, 2020, Health Advantage will become the third-party claims administrator for the Arkansas State Police medical health plan – including Active, Retiree (under age 65), Medicare Primary (age 65 and older), and COBRA members. In addition, Health Advantage will administer the:

- Medical management programs
- Pre-certification program – including high-tech radiology through AIM Specialty Health and behavioral health through New Directions Behavioral Health

EBRx (Formulary Manager) will administer prior-authorizations for medical specialty drugs.

Please see additional medical pre-certification information below.

The Arkansas State Police Health Plan is non-ERISA and self-funded. Member plan benefit information can be found by visiting www.asp.arkansas.gov and on AHIN.

All members will receive a new member ID card from Health Advantage with a prefix of 'XCW'.

Pre-certification / Prior-authorization

Pre-certification or Prior-authorization is a review prior to the time a specified procedure is scheduled. This review consists of checking clinical documentation to verify the medical necessity for the procedure. A prior-authorization is required for each separate procedure, even if those procedures are performed on the same day. Failure to obtain prior-authorization will result in denial of the claim. If a provider fails to pre-certify/ prior approve a hospital admission or outpatient procedure that's designated by the group administrator as requiring prior approval, the member is not subject to any penalty (held harmless) for non-certification. It is the provider's responsibility to verify or make certain the procedure has been pre-certified.

Behavioral health/substance abuse pre-certification will need to be obtained by calling New Directions Behavioral Health at 1-877-801-1159.

Medical specialty drug prior-authorizations will need to be obtained by calling EBRx at 1-833-995-0946.
All other medical services that require pre-certification/ prior-authorization will need to be obtained by calling Health Advantage at 1-800-843-1329.

Effective February 1, 2020, all in-patient admissions require pre-certification. In addition, below is a list of medical services, durable medical equipment, radiology and medical procedures that require pre-certification/ prior-authorizations.

Medical Services

- ABA therapy
- Residential treatment
- Intensive outpatient treatment
- Partial hospital /day treatment
- Skilled nursing facility
- Cognitive rehabilitation
- Occupational therapy
- Home health services
- Inpatient rehabilitation
- Physical therapy
- Speech therapy
- Enteral feeds
- Long Term Acute Care Hospital (LTACH)
- Intensity-Modulated Radiation Therapy (IMRT)
- Inpatient Admissions

Durable Medical Equipment

- Spinal cord stimulators (implantation and device)
- Continuous glucose monitoring devices
- Defibrillator vests
- Power mobility devices
- Wound vac

Medical Procedures

- Septoplasty
- UPPP (Uvulopalatopharyngoplasty)
- Varicose vein treatment
- Blepharoplasty and/or brow lift
- Gynecomastia reduction
- Mammoplasty
- Panniculectomy
- Rhinoplasty
- Scar revision outside doctor's office
- Gastric pacemaker

Radiology

- Computerized tomography (CT Scan)
- Computerized tomography angiography (CTA Scan)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET Scan)

Contact Health Advantage customer service for additional information at 1-800-843-1329.

Prepay Review of High-dollar Inpatient Claims

Notice of material amendment to high dollar claims threshold

Beginning in 2019, Arkansas Blue Cross and Blue Shield and its family of companies implemented a new policy required by the Blue Cross Blue Shield Association requiring itemized bills from HOST membership high dollar claims that have a total billed amount of $250,000 or greater. After reviewing the findings and results, the Blue Cross Blue Shield Association is lowering the threshold for 2020 to $200,000. **As of February 1, 2020**, please remit itemized bills for all inpatient claims of $200,000 or more. This process requires providers to submit an itemized bill for review along with inpatient claims of $200,000 or more that have a payment tied to the billed charges (i.e. not paid by per diem, case rate or diagnosis-related group).

Arkansas Blue Cross and its family of companies use the CMS Provider Reimbursement Manual and the UB Editor for guidance, as well as the services of Equian to conduct this prepay review. Arkansas Blue Cross and the Blue Cross Blue Shield Association will continue to evaluate the results of the prepay review to determine whether the billed amount subject to review should be adjusted.

To minimize any delays or interruption of payments of these claims, providers are asked to submit an itemized bill with any claim that meets these criteria.

Please contact your Network Development Representative for specifics on submitting itemized bills with the claims.