



New Arkansas Medicaid Enhancements for 2018

Next year, Arkansas Medicaid will launch a new provider-led entity (PLE) program aimed at creating an organized system of care for individuals with behavioral health (BH) conditions and developmental disabilities (DD). The program will be administered by a new type of care coordination company called a provider-led arkansas shared savings entity (PASSE).

PASSEs will improve care for special needs populations.

A PASSE is designed to create a more organized system of care and help providers better serve their patients. PASSEs are unique organizations formed between a group of providers – which are the majority owners – and an insurance carrier with proven expertise in Medicaid care coordination and population health management.

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Why do CAHPSSM and HOS surveys matter?



New Arkansas Medicaid Enhancements for 2018 (Continued from front cover)

PASSEs will provide care management and other support for individuals with complex medical and social needs such as those with behavioral health conditions and developmental disabilities. Care management will include integrated claims, gaps in care and alerts of acute episodes or changes to risk levels. Each member will have a person-centered care plan that addresses social determinants of health and adherence to care plans, in addition to tracking quality measures. Coordinated care for members will support providers serving individuals with complex health and social needs.

In 2018, Medicaid will remain fee-for-service and PASSEs will perform non-risk care coordination only. In 2019, PASSEs are at risk to administer the Medicaid programs and improve the health and quality of life for PLE individuals they serve.

Individuals in need of developmental disabilities (DD) or behavioral health (BH) services will undergo an independent assessment (IA) and be placed into one of three levels of need by DHS - Tier I (lowest), Tier II (intermediate), and Tier III (highest). In February 2018, individuals placed in Tier II and Tier III will be enrolled in a PASSE in a monthly rollout lasting through the end of the year. Beginning Jan. 1, 2019, individuals with BH or DD service needs who meet the Tier I level of care will be allowed to voluntarily enroll in a PASSE.

Arkansas Advanced Care is a local, provider-owned PASSE focused on care coordination.

Arkansas Advanced Care (AAC) is a partnership of five Arkansas leaders in the

healthcare and Medicaid system that share the common goal of ensuring Arkansas' residents have access to innovative health programs to help transform the Arkansas Medicaid system into an organized system of care and high quality, efficient care with value-based incentives.

The AAC partners are:

- Baptist Health
- University of Arkansas for Medical Sciences
- Arkansas Children's
- Bost, Inc.
- USABLE Corporation (Arkansas Blue Cross and Blue Shield)

All owners are headquartered in Arkansas and are focused on the mission of providing better healthcare and quality of life to Arkansans. AAC is partnering with Shared Health, that is a subsidiary of BlueCross BlueShield of Tennessee, which has over 23 years of experience with Medicaid care coordination, as well as seven years of specialized expertise with intellectually and developmentally disabled individuals

Does the provider focus on medical needs only or do they also treat BH and DD, too?

AAC's goal is for integrated care management of physical, behavioral, social and functional care. Depending on the severity of the BH or DD condition and the provider's comfort level in managing the individual's health or medication needs, treatment can occur in different ways. Overall, AAC population health management programs will provide support to link or integrate physical, behavioral and DD services. In some cases, care management

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will coordinate and link separate physical and behavioral health services. In other cases, care management will provide information or coaching to support medical providers to help patients with co-morbid medical and BH and DD conditions. AAC is also working to create increased supports to develop and incentivize medical providers with more specialized skills and support to serve patients with complex conditions.

Will the PASSE require a social worker to be in the clinic now or in the future?

In many cases, including social workers in a clinic is beneficial to serve individuals with complex behavioral health conditions or developmental disabilities. However, this is not required at this time. Starting February 1, 2018, our care management staff will be field-based and will be attending some medical appointments with our members when indicated. In the future, we will include social workers or RNs in the care management model, which will be located in the field. This will include care managers who are licensed social workers and are actively involved in the interdisciplinary care team. Community health workers and certified peer counselors will also be used.

How is reimbursement calculated?

In 2018, the delivery system will remain FFS and paid by Arkansas DHS Medicaid. The PASSEs will only have a referral network. In 2019, providers will be paid separately by each PASSE. **We are in the early stages**

of developing proposed reimbursement rates and structure for 2019 when providers will contract directly with PASSEs. We will start with the current Arkansas Medicaid fee schedule and aim for value-based delivery and payments where possible.

Do providers need to sign a provider contract?

Arkansas Advanced Care will be sending amendments to all eligible True Blue PPO providers in 2018 to prepare for the 2019 program.

Effective FEBRUARY 1, 2018

This marks the beginning of the care coordination program and the use of the Arkansas Advanced Care's referral network. AAC's network is a preferred provider network whose participants may receive referrals but any Medicaid provider may be used by the patient. As mentioned previously, the delivery system will remain FFS and will be paid by Arkansas DHS Medicaid.

This is an official notice that True Blue PPO participating providers in the True Blue PPO network will be part of the AAC referral network and eligible for care coordination support with AAC members effective February 1, 2018.

We welcome your feedback.

We'd love to hear from you. Please contact your network development representative with any questions.



Utilization management changes for health plans in the individual market

In 2018, Arkansas Blue Cross and Blue Shield is incorporating proven utilization and care management measures for our members enrolled in the individual market metallic health plans. These measures are designed to support quality care, identify and better care for high-risk members, improve patient safety and support better use of healthcare resources. By seeking prior approval for certain designated services, we hope to improve health outcomes for our members while supporting the long-term sustainability of Arkansas' healthcare system.

Prior approval is a general term that determines if a service meets certain criteria to be paid for by the health plan. These criteria include member eligibility, plan benefits, and clinical appropriateness. It is not a sole reflection of the medical necessity of services.

We understand that providers may have concerns regarding the new utilization management measures. We want to clarify that **prior approval will NOT be required for:**

- Emergency services
- Ambulances
- Urgent care
- Primary care office visits
- Screenings and preventive care
- Generic drugs

We **DO NOT** want to stand in the way of needed care for our members or be an obstacle for our providers. We **DO** want to ensure our members receive the highest quality of care in the most appropriate

settings and from the most appropriate providers.

The utilization management measures for Arkansas Blue Cross members with metallic health plans issued in the individual market will focus on prior approval for the following areas:

- Inpatient admissions (behavioral and medical)
- Select outpatient services
- High-tech imaging procedures
- Select behavioral health services
- Transplant services
- Out-of-area/out-of-state services for select individual plans
- Pharmacy services

Many of these measures are currently in effect. The 2018 Utilization Management Program and changes in effect for 2018 are briefly detailed by area below. All measures will only pertain to members with Arkansas Blue Cross individual market coverage.

Providers rendering these services to Arkansas Blue Cross members with Metallic individual coverage without receiving prior approval should expect to write off the charges.

Inpatient Admissions

Coverage of all medical inpatient admissions require prior approval. While emergency care does not need approval, medical* inpatient admissions as a result of emergent situations

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Utilization management changes for health plans in the individual market (Continued from page 4)

do require approval. Medical inpatient admissions include, but are not limited to:

- Medical and surgical admissions (scheduled and elective)
- Inpatient hospice care
- Skilled nursing facilities
- Rehabilitation facility admissions

* In emergent situations, providers **should not** delay admission while waiting on approval.

When submitting a prior approval request, you should submit relevant clinical information. If you must call in a request, it should be followed with written documentation. Calls should be made to 1-800-558-3865, 8 a.m. to 4:30 p.m., Central time, Monday-Friday, except on major holidays. Information also may be submitted through the Provider Portal in AHIN. Requests submitted after hours and on weekends through the Provider Portal will be processed the following business day.

Prior approval information should include:

- Member name, date of birth and Arkansas Blue Cross member ID
- Facility Provider's NPI #
- Facility name
- Admitting or primary diagnosis/procedure codes
- Relevant clinical information to support admission and level of service
- Admission type (SNF, inpatient medical, rehab)

Prior approval decisions for medical inpatient admissions are made by our local team in a time appropriate for the

medical exigencies, but no later than one business day of receiving all relevant clinical documentation. That information is also made available for future, prospective and concurrent review. Utilization management decisions are determined by the Arkansas Blue Cross Medical Coverage Policy and Milliman Care Guidelines (MCG). These policies and guidelines are evidence-based and systematically reviewed and updated by the Arkansas Blue Cross Medical Policy Committee. These guidelines are available on AHIN.

Concurrent review will also be utilized to assure the appropriateness of care, the setting and the progress of discharge plans and to link Arkansas Blue Cross members to care management as needed to improve health outcomes. The ongoing review is directed at facilitating the right care, at the right time, in the right setting (or level) appropriate for the patient.

Outpatient

Utilization management for outpatient services includes changes in thresholds for prior approval of services and the addition of prior approval for pain management. Clinical data will be required with submission.

- Durable medical equipment: over \$500
- Prosthetics: over \$5,000
- Vacuum assisted closure (wound vac)
- Infertility services health plans
- Rehabilitation services
- Habilitation services
- Home health
- Reconstructive surgery
- Outpatient services: certain outpatient

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hospital services and ambulatory surgical center procedures are subject to prior approval. A list of outpatient services needing prior approval is included in the Provider Manual in the “Doctors and Hospitals” section of our website, www.arkbluecross.com.

Pregnancy-related services will be automatically approved but will require prior notification to ensure high-risk pregnancies may be adequately identified and monitored for optimal health outcomes for mother and child.

- Complete the [prior approval request form](http://www.arkansasbluecross.com/providers/forms.aspx) available at <http://www.arkansasbluecross.com/providers/forms.aspx>
- For efficient service, you should submit prior approval requests via AHIN after verifying the member’s benefits. Requests submitted after hours and on weekends through AHIN will be processed the following business day.
- You also may fax your request to 501-378-6647. Be sure to include medical records along with the prior approval form.
- If for some reason you cannot access AHIN, call customer service at 1-800-558-3865, 8:00 a.m. to 4:30 p.m., Central time, Monday-Friday, except on major holidays.

High-Tech Imaging Procedures

Ionizing radiation from medical imaging exposes patients to increased risk of radiation induced malignancies over time. There is also increased utilization of imaging procedures. The cumulative risk of patients undergoing frequent or repeated studies is now recognized as a growing public health concern

and an area of ongoing research. Coverage of all enhanced high-tech imaging will require prior approval with submission of relevant medical record documentation. Clinical validation will be required for the following:

- Abdominal and pelvic CT
- Chest/Thorax CT
- Head CT
- Sinus CT

As part of the approval process, providers will need to fax or upload on www.radMD.com to NIA certain pieces of a patient’s medical records and/or additional clinical information as part of the clinical review for determination. Magellan is the parent company of NIA.

1. To initiate a request for an approval please contact Magellan Healthcare Call Center via toll-free number 1-877-642-0722 or www.RadMD.com. (Magellan Healthcare does NOT accept faxes for the initiation of an approval. **Only** via Call Center or RadMD website.)
2. To check the status of an approval please contact Magellan Healthcare Call Center via toll-free number 1-877-642-0722 or www.RadMD.com.
3. Provider will be able to upload requested records on the Magellan Healthcare website www.RadMD.com or through the Magellan Healthcare fax number at 1-877-642-0722.
4. For assistance or technical support for RadMD, please contact RadMD Help Desk at 877-80-RadMD 877-807-2363 or email RadMDSupport@MagellanHealth.com.

If an urgent clinical situation exists outside of

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a hospital emergency room, please contact Magellan Healthcare at 1-877-642-0722 immediately with the appropriate clinical information for an expedited review.

Select Behavioral Health Services

To better address behavioral healthcare needs in our state, Arkansas Blue Cross will be implementing high intensity community-based case management and utilization management that will be coordinated with the patient's mental health provider and primary care physician. Accordingly, prior approval of coverage for select behavioral health services will be required. These services include inpatient behavioral health admissions, intensive outpatient treatment, residential treatment programs, applied behavioral analysis (ABA) and repetitive transcranial magnetic stimulation treatment (rTMS).

- To obtain prior approval contact New Directions directly at 877-801-1159.
- Prior approval may also be requested through New Directions' secure web access portal, Webpass. For information about WebPass and how to access it, contact New Directions at 888-611-6285.
- Requests must include key clinical information such as the patient's diagnoses, mental status, precipitating event or events leading to treatment, prior treatment history, current outpatient providers, medications, proposed treatment plans, risk and safety concerns, family and support systems, tentative discharge plans and estimated length of treatment.

Transplant Services

Prior approval is required for transplant evaluation and treatment. Prior approval is not required for kidney and cornea transplants.

- Fax a letter of request for transplant evaluations and services along with medical records to 501-399-3967, attention: Carolyn Webb/Lisa Todd.

Out-of-Area/Out-of-State Services

Arkansas Blue Cross and Blue Shield recognizes the value of ensuring our exchange members see True Blue PPO providers. As of January 1, 2018, coverage for out-of-area/out-of-state services on some exchange policies will only be provided with prior approval for services not available from a True Blue provider or in emergency situations. There are border state providers participating in the True Blue PPO.

If the medical service is best offered by an out-of-state provider (e.g., certain types of transplants), those services will be permitted upon review of a prior approval request. Continuity of care will be considered for complex conditions that have been maintained for a significant length of time by an out-of-state doctor following a prior approval request. You can identify policies with no out-of- area/out-of state coverage by no suitcase symbol on the member ID card and through AHIN.

- For consideration submit a continuation of care election form, found at www.arkansasbluecross.com/providers/forms.aspx

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Pharmacy Services

To ensure the appropriate use of prescription drugs, in terms of both cost-effectiveness and safety, certain drugs on the formulary for metallic plans on the individual marketplace will require prior approval, quantity limits or step therapy. To see which drugs require these measures, visit www.arkansasbluecross.com/pd_list/default.aspx and reference the Metallic formulary. The forms for prior approval are at

the bottom of that page.

The pharmacy help desk is available at 1-800-364-6331 if assistance is needed.

If you have questions in reference to the Utilization Management Program, please, contact your network development representative, call Customer Service at 1-800-558-3865, or email your question to expriorapproval@arkbluecross.com.

New BlueCard limitation on some individual Metallic plans

Some Arkansas Blue Cross and Blue Shield members may receive new 2018 member ID cards without the small suitcase in the corner. These health plans do not include out-of-area benefits. For these members, the provider should only refer to out-of-area providers when Arkansas True Blue PPO network providers are not available. Prior approval is required for extenuating circumstances and can be obtained by completing a Continuation of Care form. Please do not fill out a Continuation of Care form for these members unless they meet the approved parameters.

The Continuation of Care form provides benefits for continuity of care for any member who is **receiving prenatal care** or is in **active treatment for an acute or chronic condition** with a provider not in our area of coverage. This allows the member to continue through the current period of active treatment or up

to 90 days, depending on the care needs and circumstances of the patient. The patient must then transition to an in-area provider.

Continuation of care only covers:

- Pregnancy in the third trimester and/or
- High-risk, newly diagnosed or relapsed cancer currently receiving chemotherapy, radiation therapy or reconstruction.
- Transplant candidates or transplant recipients in need of ongoing care due to complications associated with a transplant, recent major surgeries in the acute phase and follow-up period.
- Serious acute conditions in active treatment such as heart attacks or strokes.

Routine exams, vaccinations, health assessments, chronic condition care, minor illnesses and elective surgeries do not qualify for continuation of care.



Anthem Blue Cross and Blue Shield announcement

Family Medical Care Plan/NECA/IBEW Members – New ID cards, ID numbers, and prefixes effective 1/1/18

Effective January 1, 2018, the FMCP/NECA/IBEW members will receive new Anthem Blue Cross and Blue Shield member ID cards. Please note that new IDs will have a different ID number and a new ID prefix.

Below is a quick reference guide to show which prefixes are terminating on December 31, 2017 and which new prefixes will go live on January 1, 2018. Please note the change and submit correct ID information with claims after January 1, 2018. If you have any questions, please contact Provider Inquiry Customer Service.

FMCP Members & Employees upcoming ID change				
Current prefix terminating	Prefix from 1/1/18 forward	State	Plan Name	Provider Number
FJJ	Group# 004009986 (Members) – KFM	all, except GA	BlueCard	1-844-594-0393
FFX	Group# 004009986 (Members) – QFM (GA AltNet)	GA	GA Alt Net	1-844-594-0393
FJJ	Group # 004009987 (Employees) – VFE	all, except GA	BlueCard	1-844-594-0393
FFX	Group # 004009987 (Employees) – ZFE (GA AltNet)	GA	GA Alt Net	1-844-594-0393

New member ID cards effective January 2018

Arkansas Blue Cross and Blue Shield Individual Under 65 members will receive new member ID cards, with new member ID numbers for January 2018 coverage as part of an improvement to our internal systems. There are no benefit changes associated with this system update.

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 January, 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 patients' claims are handled efficiently.



2018 Standard Control Formulary removals and updates

Therapy classes with drug removals and updates for 2018.

New Formulary Exclusions

Class	Product	Preferred Alternatives
Dermatology (Tetracycline)	Doryx/Doryx MPC, Monodox	Doxycycline
Multi-Source Brands	Benicar/Benicar HCT, Effexor XR, Nuvigil, Seroquel XR, Zetia	Generic equivalent
Migraine Injectable	Sumavel Dosepro	Sumatriptan tablets, generic sumatriptan injections, sumatriptan nasal sprays
Post-Herpetic Neuralgia	Horizant	Gabapentin
Steroid and Beta Agonists Combos	Dulera	Advair, Symbicort
Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors and Combination Products	Jardiance, Synjardy/Synjardy XR	Invokana, Invokamet/Invokamet XR, Farxiga
Incretin Mimetics	Tanzeum	Victoza, Trulicity
Biologics	Kineret, Simponi, Orencia, Actemra, Xeljanz, Taltz, Cimzia	Humira, Enbrel, Cosentyx, Kevzara, Stelara, Otezla
Opioid Analgesics	Primlev	Oxycontin, Hysingla ER

New Utilization Management Changes

Product	Change	
Lyrica	Adding QL	
Alinia	Adding QL	
Prudoxin, Zonalon, Doxepin Cream	Adding ST	
Ketorolac Tablets and Sprix Spray	Adding QL	
Sivextro	Adding PA	
Short-acting Opioids	Adding seven-day supply limit on first fills	
Long-acting Opioids	Adding ST (short-acting opioid required first)	
Acticlate/Generic Acticlate	Adding ST	PA = prior approval
Topical Brand Name Corticosteroids*, Brand Name Tetracyclines/Select Generic Tetracyclines**, Select Rosacea Products***	Adding PA	QL = quantity limit ST = step therapy

*Products Include: ACLOVATE, APEXICON E, CLOBEX CLODAN, CLODERM, CORDRAN, CORDRAN SP, CORMAX, CUTIVATE, DESONATE, DESOWEN, ELOCON, fluocinonide (generic Vanos), HALOG, KENALOG, LOCOID, LOKARA, NEO-SYNALAR, OLUX, OLUX-E, PANDEL, PSORCON, TEMOVATE, TEMOVATE E, TOPICORT, ULTRAVATE, TRIANEX, VANOS, VERDESO

**Products Include: ADOXA, Doxycycline DR (generic DORYX, MINOCIN, MINOLIRA, SOLDYN, VIBRAMYCIN

***Products Include: FINACEA, MIRVASO, NORITATE, RHOFADÉ, SOOLANTRA



2018 Metallic Formulary removals and updates

Therapy classes with drug removals and updates for 2018.

New Formulary Exclusions

Class	Product	Preferred Alternatives
Antidepressants	Aplenzin	Generic bupropion SR or XL
Multi-Source Brands	Lamictal, Ziana, Effient, Sabril, Kristalose	Generic equivalent
Oral Corticosteroids	Dexpak, Millipred	Generic dexamethasone tablets, prednisone, methyl-prednisolone
Hormones	Estring, Femring	Estradiol, estradiol vaginal tablets
Antipsychotics	Fanapt	Paliperidone, quetiapine
Neuropathic Agents	Gralise	Generic gabapentin
Opioid Analgesics	Meperidine, Butrans	Morphine, tramadol, oxycodone
Ophthalmic Anti-infectives	Moxeza	Vigamox, tobramycin eye drops
Antirheumatic Agents	Trexall	Generic methotrexate
Topical Corticosteroids	Trianex, Taclonex	Generic triamcinolone ointment, calcipotriene
Misc. Topicals	Zyclara	Generic imiquimod 5%
	Veltin	Generic tretinoin, generic clindamycin
	Naftin	Naftinifine cream
Physician-Administered Medications	Rituxan, Remicade, Botox, Prolastin-C, Cerezyme, Benlysta	Check medical benefits
Vitamins	Vitamin D3 50,000 IU, Decara	Vitamin D2 50,000 IU
Gastrointestinal	Kristalose	Lactulose

New Utilization Management Changes

Product	Change
Long-acting opioids*	Changing QL, Adding ST (short-acting opioid required first)
Short-acting opioids	Adding seven-day supply limit on first fills
Inhalers**, Topical Corticosteroids and Anti-inflammatories†, Diabetic testing supplies, Antiretroviral Products and Combinations	Adding QL

PA = prior approval
QL = quantity limit
ST = step therapy

*Products Include: BUTRANS, EMBEDA, FENTANYL, HYDROMORPHONE ER, HYSINGLA, MORPHINE ER, NUCYNTA, OXYCODONE ER, OXYCONTIN, OXYMORPHONE ER, TRAMADOL ER

**Products Include: QVAR, ADVAIR, SPIRIVA

***Products Include: DICLOFENAC GEL 1%, ALCLOMETASONE, BETAMETHASONE, CLOBETASOL, DESONIDE, DESONATE, DESOXIMETASONE, DIFLORASONE, FLUOCINOLONE, FLUOCINONIDE, FLUTICASONE, HALOG, HALOBETASOL, HC VALERATE, HC BUTYRATE, MOMETASONE, HYDROCORTISONE



Six medical specialty medications to need prior approval beginning April 2018

Due to dramatic costs and complexity associated with the administration of certain specialty medications, effective April 1, 2018, prior approval will be required by Arkansas Blue Cross and Blue Shield and its family of companies for payment of the following specialty medications used in treating rare, complex conditions that may go through the medical benefit:

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

Specialty medications already needing prior approval include:

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

By establishing a prior approval process, members and providers will know whether the member qualifies for these drugs. A concurrent review will be conducted six months after approval to determine whether a patient is benefitting from the prescribed medication.

Modifier FX: X-ray taken using film

Effective January 1, 2017, CMS change request (CR) 9727 was implemented. HCPCS Modifier FX reduces the technical component (TC) (including the TC portion of a global service) of X-ray imaging services provided using film. The FX modifier must be included for X-ray services using film. A

payment reduction of 20 percent applies to the technical component for X-ray services furnished using film for which payment is made. This payment reduction will apply to claims submitted for all Arkansas Blue Cross and Blue Shield plans and its affiliates and subsidiaries.



Correct complete coding and payer policy reminder

The need for correct and specific diagnosis and procedure coding has never been more important. Gone are the days of always using “unspecified” or “not otherwise specified” coding. It’s not just a matter of ensuring claims contain a payable diagnosis, it now includes proving to our state and federal regulators that Arkansas needs additional funding to improve the state’s health status.

Because Arkansas Blue Cross and Blue Shield and its family of companies are involved in state federal government programs, we must submit our claims data to regulators in order for them to gather health statistics. Coding your claims to the very most specific diagnosis codes is very important in this endeavor, and may help us avoid having to request medical records from your office to get more accurate details for some of the members or conditions. In addition, the clinical documentation of these diagnoses within your medical records is also critical, as these regulators may choose your particular patient in an audit, thereby requiring our request and review of these medical records.

As a reminder, all of our provider network agreements indicate that facilities and providers agree “to accept and comply with the claims filing and coding policies or procedures established by the applicable

payer for health plan claims.” Most of our policies have been placed in the online provider manual as well as this quarterly newsletter, *Providers’ News*. Our agreements also state that facilities and providers agree “that all reimbursement is subject to all terms, conditions, limitations and exclusions of the member’s health plan, and to the application of a payer’s coverage policy and coding, billing and claims processing and appeals policies and procedures (Payer Policies and Procedures) as established by payers and as modified from time to time.”

More specificity is being added to our coverage policies to ensure we capture the claim information accurately and more completely. This will lead to enhancements to our claims filing and coding procedures. Our payer policies and procedures and claims filing and coding policies use various coding criteria and protocols including, but not limited to, the CPT Manual published by the American Medical Association, the National Correct Coding Initiative, Specialty Society guidelines and industry coding standards from the Centers for Medicare & Medicaid Services (CMS).

The agreements require that facilities and providers follow these noted industry coding standards.



Coverage policy manual updates

Since May 2017, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The table highlights the additions and updates. To view entire policies, access the coverage policies located on the Doctors and Hospitals section of our website at arkansasbluecross.com.

Policy ID#	Policy Name
1998023	Ultrasound Accelerated Fracture Healing Device
1998095	Intraoperative Neurophysiologic Monitoring
1998158	Trastuzumab
1998161	Infliximab
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)
2006026	Genetic Test: Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts & Leukoencephalopathy (CADASIL) (NOTCH3)
2009013	Testing for Drugs of Abuse or Drugs at Risk of Abuse including Controlled Substances
2010011	Myoelectric Prosthesis for the Upper Limb
2010023	Orthopedic Applications of Stem Cell Therapy
2010038	Lymphedema Pumps (Pneumatic Compression Devices) for the Treatment of Lymphedema and Venous Ulcers
2011005	Digital Breast Tomosynthesis
2011029	Preventive Services for Non-Grandfathered (PPACA) Plans: Dental Caries Prevention in Preschool Children
2011036	Preventive Services for Non-Grandfathered (PPACA) Plans: Hearing Loss Screening in Newborns up to Age 21
2011045	Preventive Services for Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening
2011061	Genetic Test: Melanoma, V600 Mutation Testing to Predict Response to BRAF Inhibitor Targeted Therapy
2012005	Genetic Test: Molecular Testing of Tumors for Genomic Profiling as a Therapeutic Guide
2012043	Genetic Test: Rett Syndrome
2014011	Corneal Collagen Cross-linking
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015028	Testosterone Replacement Therapy

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Policy ID#	Policy Name
2016004	Lab test: Identification of Microorganisms Using Nucleic Acid Probes
2016016	Atezolizumab (Tecentriq)
2016024	Gender Reassignment Surgery for Gender Dysphoria
2017015	Avelumab (Bavencio™)
2017021	Ocrelizumab (Ocrevus)
2017028	Genetic Test: Proteogenomic Testing for Patients with Cancer (GPS Cancer Test)
2017029	Immobilized lipase cartridge for enteral feedings (Relizorb)
2017030	Guselkumab
2017031	Dupilumab
2017032	Synthetic Cartilage Implant for Metaphalangeal (MTP) Joint Disorders
2017033	Octreotide Acetate for Injectable Suspension (Sandostatin® LAR Depot)

Billing services to family members prohibited

Arkansas Blue Cross and Blue Shield wishes to remind all providers of a long-standing policy of billing for services to family members. Arkansas Blue Cross, Health Advantage and USABLE Corporation have published claims filing policies and procedures which prohibit a participating provider from billing for services* provided to any immediate family member. The immediate family, for this purpose, includes a spouse, parent, child, brother, sister, grandparent or grandchild, whether the relationship is by blood or exists in law (e.g. legal guardianship).

In addition, all underwritten health plans or policies issued by Arkansas Blue Cross and Health Advantage expressly exclude coverage of services to immediate relatives. Any claim intentionally or mistakenly filed and that is subsequently paid for such services, requires the offending provider to

immediately refund all such payments upon request.

Violation of these policies and procedures, and/or failure to make prompt refunds for erroneous payments, will subject the offending provider to termination from the networks sponsored by Arkansas Blue Cross, Health Advantage and USABLE Corporation. Moreover, filing claims for services to immediate relatives, and receiving payment on such claims, is an abusive claims filing practice that may also constitute fraud, leading to permanent exclusion from the networks.

**Services to immediate family members include not only those personally performed by the provider, but also any services, equipment, drugs or supplies ordered by the provider and performed by another, including any pharmacy charges resulting from prescriptions written by the provider.*



Referring provider requirement on all claims with laboratory services

Effective April 1, 2018, Arkansas Blue Cross and Blue Shield, Health Advantage and Blue Administrators (ABCBS) are changing their claims billing policy on laboratory service claims to require the referring provider on all professional service claims. Any outpatient claim (physician, nurse practitioners, independent lab, etc.) submitted with a laboratory service must contain the referring provider name and NPI. This referring provider will need to be a provider registered/enrolled in the provider database of Arkansas Blue Cross or its family of companies. Listing a referring provider who is not registered with Arkansas Blue Cross will result in claim rejection or denial.

Over the last few years Arkansas Blue Cross has been required to submit risk adjustment data to state and federal agencies. We have discovered there are many members having lab work done for risk adjustable conditions, but we have no other associated providers' claims in our system. When a referring provider is listed on the laboratory claim, we are able to contact that provider to get additional information necessary for our data submission for our state and federal government affiliated business. We ask that provider offices begin adding the referring providers on these claims immediately, if possible. This request will become a requirement on lab services claims beginning April 1, 2018.

New telemedicine coverage policy

Several changes to the telemedicine coverage policy will become effective on **January 1, 2018**, for policies which have a telemedicine benefit. Currently, the member must be in a clinical location such as office or hospital; effective January 1, 2018 there is no restriction on the physical location of the member during the telemedicine encounter. Currently, except for mental health visits, the provider must be a physician; effective January 1, 2018, this restriction no longer applies. However, the service must be within the allowable scope-of-practice for the provider type performing the service.

Q3014 (originating site fee) will continue to be allowed in most clinical locations (as specified in the coverage policy); Q3014 will not be allowed for other locations (e.g. home, school, pharmacy) where a patient

might be located during an encounter. Remember to use site-of-service 02 on professional claims; on Q3014 claims use the site-of-service where the member is physically located during the encounter. The telemedicine clinician is responsible for ensuring that a HIPAA-compliant audio-visual connection is used, and that an appropriate relationship is in place with the communication service. Email, text (including photographs), or voice-only interactions are not covered. Finally, telemedicine is allowed only when the service is one which can be performed remotely to the same standard of care that can be provided in a face-to-face visit. See coverage policy 2015034 for a list of codes which are covered when done by telemedicine.



Outpatient and ASC surgery fee schedule

ASC surgery fee schedule

The final outpatient hospital and ambulatory surgery center (ASC) surgery fee schedule was emailed to providers on November 21, 2017. As a reminder, the allowances now include the embedded implants. If you did not receive the email or have additional questions, please contact your network development representative or email providerreimbursement@arkbluecross.com.

DME: Oxygen and supplies

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers that oxygen reimbursement is a bundled payment. All options, supplies and accessories are considered included in the monthly rental payment for oxygen equipment. Separately billed options, accessories or supply items will be denied as unbundling.

Oxygen accessories, including but not limited to trans-tracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent

(E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with beneficiary-owned oxygen equipment will be denied as non-covered.

Oxygen billing codes

E1392 includes the oxygen concentrator, an integrated battery or beneficiary-replaceable batteries that are capable of providing at least two hours of remote portability at a minimum of 2 LPM equivalency, a battery charger, an AC power adapter, a DC power adapter, and a carrying bag and/or cart. When code K0738 is billed, code E0431 (portable gaseous oxygen system, rental) must not be used. When code E0433 is billed, code E0434 (portable liquid oxygen system, rental) must not be used.

E1352 is an all-inclusive code consisting of a control unit, flow regulator, connecting hose, and nasal interface (pillows). For questions or more information, please email providerreimbursement@arkbluecross.com.

2017 claims filing deadline

Please file all Arkansas Blue Cross and Blue Shield and its family of companies claims with 2017 dates of service by March 15, 2018. With the Affordable Care Act, there are new reinsurance requirements for insurers to have processed 2017 dates of service claims

by March 31, 2018.

In order for Arkansas Blue Cross to have the most up to date information, we are encouraging providers to please file 2017 dates of service claims as soon as possible.



Filing claims timely

As a reminder, the following information regarding timely claims filing applies to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage and includes claims for members of other Blue Cross Plans.

Filing Original Claim

Providers must submit claims for any service, supply, prescription drug, test, equipment or other treatment within 180 days after such service, supply, prescription drug, test, equipment or treatment is provided. In the case of a claim for inpatient services for multiple consecutive days, a written proof must be submitted no later than 180 days following the date of discharge for that admission.

Re-submitting Claims

Arkansas Blue Cross and its affiliates also require providers to use this 180-day timely filing limit for re-submitting claims for adjustments, or for submitting additional information on a previously filed claim.

Adjudicated Claims/COB

Arkansas Blue Cross and its affiliates extends the timely filing requirements to include 180 days after the primary insurer adjudicates the claim. Timely deadline for secondary claims is 180 days from the date processed by the primary carrier.

Member Responsibility

The 180-day timely filing provision is applicable for both providers and members. When a patient covered by Arkansas Blue Cross or an affiliate does not provide their provider with proof of coverage until after the 180-day timely filing has expired, that patient is responsible for the services and the provider should not bill Arkansas Blue Cross or its affiliates.

All contract holders should have a member identification card and should present their member ID card prior to each service. Arkansas Blue Cross and its affiliates encourage all providers to have their patients complete insurance coverage update forms at the time of each service. By completing an insurance coverage update form, patients are given every opportunity to provide up-to-date insurance information.

For questions regarding coverage, providers should refer to AHIN (Advanced Health Information Network) for member eligibility and claims status or call The BlueLine, our voice activated response service, available 24 hours a day, 7 days a week. (This information does not apply to the Federal Employee Program (FEP)).



Guidelines for responding to medical record requests

Requests for medical records are generated using a fax process. The request is faxed to a provider and includes a bar-coded cover letter with a tracking number. When faxing the requested medical record information or fact sheet, please use the bar-coded letter first as the cover letter. The bar-coded letter will allow the information to be tracked and processed faster. The bar-coded letter is unique for each medical record request and cannot be reused for other patients or request.

Once the completed requests are faxed with the bar code sheet on top, the medical records will automatically be forwarded to the member's home plan. Paper copies of medical records, operative reports, etc. should not be mailed unless the document is too large to fax.

Please remember that medical records and other documents sent on a computer disc (CD) will not be acceptable.

Alpha numeric prefixes coming in 2018

Arkansas Blue Cross and Blue Shield and its family of companies would like to remind providers of the change from all alpha (only) prefixes to the use of alpha numeric prefixes in 2018. This change results from the potential of the current pool of alpha prefixes running out as early as 2018 and will slow the rate of consumption.

The Blue Cross and Blue Shield Association is changing the field from an alpha (only) prefix to an alpha numeric prefix. The move to an alpha numeric prefix solution increases the prefix pool and mitigates the risk of impacting the Plans business and new initiatives. The software update was distributed in Release 17.5 on October 15,

2017, with utilization **effective on April 15, 2018.**

These six combinations will be released once the current set is exhausted:

- A2A
- 2AA
- 22A
- AA2
- 2A2
- A22

Additional information printed in the June 2017 issue of *Providers' News*. Please contact your network development representative with any questions.



The Value-Based Compensation Initiative: Rewarding value over volume

Arkansas Blue Cross and Blue Shield is working on the development of a new payment model intended to reduce the growth rate in premiums while improving the quality, affordability and sustainability of healthcare by partially transitioning from fee-for-service to value-based compensation.

As purchasers, healthcare is unaffordable for many, and medical inflation is unsustainable for all of us. There are many reasons that healthcare costs so much and that it increases so much every year. Some of those reasons include:

- Member/patient compliance
- Pharmacy inflation
- Malpractice risks
- Redundancy, waste and lack of coordination
- Provision of low-value care
- Volume-based payments

There is no single solution that will comprehensively address the growing cost of healthcare, and this new payment model is not an attempt to address all of these issues. Rather, this initiative is an effort to address fee-for-service. Fee-for-service incents volume of services rather than value of services. Under the current system, the more covered services that are performed, the more that is paid, regardless of whether those services result in better outcomes.

We believe that it's time to change from simply paying for volume, and begin paying for value, and that's what this initiative is about.

How does VBCI work?

Arkansas Blue Cross and Blue Shield's **Value-Based Compensation Initiative (VBCI)** is a new healthcare provider payment model that partially transitions from fee-for-service to value-based compensation.

Under this payment model, providers who provide high-value care and reduce low-value care have the opportunity to receive more compensation than they would have under fee-for-service only.

Beginning in 2019, we will begin stepping down fee-for-service compensation over a 4 – 5 year period until base fee-for-service compensation approximates Medicare. The funds from this step down of fee-for-service monies will be placed into three separate value pools - hospital, specialist and primary care. These value pools make up the value-based compensation component.

In 2019, on a quarterly basis, 100% of the value pool funds will be distributed to providers based upon their relative outcomes on a set of value-based performance metrics using the most recent and available 12-month performance period, which will roll forward every quarter.

The performance metrics will be based primarily upon provider scoring using a claims-based scoring methodology developed by a company named RowdMap (www.RowdMap.com). The RowdMap methodology identifies low-value care using

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The Value-Based Compensation Initiative: Rewarding value over volume (Continued from page 20)

widely accepted sources such as Choosing Wisely (www.ChoosingWisely.org), the Dartmouth Atlas (www.DartmouthAtlas.org), and other evidence based clinical guidelines and research studies.

Choosing wisely is an initiative of the American Board of Internal Medicine that now includes more than 70 societies comprising more than a million physicians that are supporting efforts to promote more effective use of healthcare resources. Dartmouth Atlas analyzes Medicare claims data for hospital and outpatient care to provide information about the distribution and use of health care resources in hospital referral regions and hospital service areas nationwide.

RowdMap developed algorithms using these sources that define low-value care as care that is delivered in place of an alternative treatment, where the alternative yields at least similar, if not better outcomes at a lower cost. Low-value services are not necessarily inappropriate for each and every patient, but when a provider is performing substantially more of these services compared to his or her peers it signifies diminished value for the patient population.

For 2020 and beyond, total available compensation will be tied to a reasonable trend factor. Our goal is not to reduce total compensation - rather, our goal is to find a way to create a reasonable trend in the growth of healthcare cost that results in sustained affordability for purchasers.

We believe that volume-based compensation does not incentivize high-value care. This is what this initiative is about – reducing the

incentives associated with volume-based compensation and beginning to reward providers for value through the addition of a value-based financial component.

For the remainder of 2017

- We will continue communicating to as many stakeholders as possible the high-level introduction to the initiative,
- We will be responding to as many questions from stakeholders as possible and making that information available to stakeholders via FAQ's, and
- We will continue working thru details of the initiative and begin preparing to communicate those details to stakeholders.

During 2018

- We will continue communicating with stakeholders,
- No later than early 2018, we plan to release information on the specific Metrics and Measures by provider specialty type by which providers will be compared to their peers (cohorts), and
- No later than mid-2018 we plan to release shadow reporting that lets providers know how they're scoring based upon historical claims and provide information to help them improve their scores.

Ultimately, in 2019, we'll begin step downs to fee-for-service, and we'll begin distribution of value pool funds quarterly based upon providers' historical performance scores.

Arkansas Blue Cross and Blue Shield's other value-based programs (patient-centered medical homes (PCMH), Comprehensive

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The Value-Based Compensation Initiative: Rewarding value over volume (Continued from page 21)

Primary Care Plus (CPC+) episodes of care (EOC) and Collaborative Health Initiatives (CHI) will continue as we implement the VBCI. We will continue to evaluate the effectiveness of each of these programs as we continue moving forward.

There will be some providers that are excluded from the VBCI. A current non-facility

inclusion/exclusion listing can be found on AHIN, along with a video introduction to the VBCI and a current FAQ document. A webinar is being planned for January 2018 in which further details of the program will be communicated.

Feel free to send additional questions to vbci@arkbluecross.com.

2018 updates for the AHCPPII

The Arkansas Healthcare Payment Improvement Initiative (AHCPPII) has been fully operational for almost four years for many physicians and hospitals participating in Arkansas Blue Cross and Blue Shield's Preferred Payment Plan (PPP), Health Advantage's HMO network, USABLE Corporation's Arkansas' FirstSource® PPO and True Blue PPO networks.

New for 2018! Arkansas Blue Cross and its family of companies are continuing the Arkansas Health Care Payment Improvement Initiative (AHCPPII) with three additional episodes of care: **Lumbar Spinal Fusion**; **Hysterectomy**, and **Pneumonia in the ED**. Principal accountable providers (PAPs) currently have preparatory reporting available through 2017 for this membership on the AHIN "APII Portal" under "Episodes."

The **congestive heart failure (CHF) episode of care** remains suspended for the 2018 performance period. This is not a complete suspension of the congestive heart failure episode program; we will evaluate the volume and impact on an annual basis to determine program viability. As a reminder,

the CHF episode of care was also suspended for the 2017 performance period.

Reminder: As of January 1, 2017, there are financial and quality targets for the **individual metallic business** sold through the Arkansas Marketplace. These services are reimbursed at different fee rates than usual commercial business, thus the need for separate financial targets.

As it was in the 2017 performance period, the **tonsillectomy and adenoidectomy episode of care** will only impact the commercial business in 2018, due to low volume in the individual metallic membership.

Please refer to the Episodes of Care Provider Manuals (under *Doctors and Hospitals > Value-Based Programs*) at www.arkansasbluecross.com for details on each of the active episode programs included in the AHCPPII. We hold our partnerships with providers in the highest regard and we look forward to working together to ensure cost viability in the near term and creating a foundation for healthcare innovation and transformation in the future.



Colonoscopy episode of care: GIQuIC registry pilot for 2017

For providers participating in GIQuIC (GI Quality Improvement Consortium, Ltd.), Arkansas Blue Cross and Blue Shield is piloting a new process for capturing colonoscopy episode of care quality information. Arkansas Blue Cross recognizes that participating in a benchmarking registry initiative like GIQuIC requires facilities to establish the processes for tracking and reporting in an efficient and reliable manner, and readies facilities for future quality and performance expectations.

Principal accountable providers (PAPs) that participate in the GIQuIC registry may

supply their year-end report to satisfy the portal entry requirements. Submission of the GIQuIC registry information for the reporting time period (January-December 2017) to the APIICustomerSupport@arkbluecross.com email address will suffice for documentation. Arkansas Blue Cross will review the GIQuIC reports and manually update the quality metrics for these providers. If you have questions about our Colonoscopy Episode of Care or the GIQuIC registry pilot, please contact the Arkansas Blue Cross Episodes of Care Analyst Team at 1-888-800-3283 or APIICustomerSupport@arkbluecross.com.

HMO Plus network reminder

Health Advantage created a new provider network that focuses on clinically integrated health systems that can provide optimal coordinated healthcare. This new provider network is called **HMO Plus** and was effective January 2017.

The initial creation of this network is in central Arkansas and is centered around the health systems of Arkansas Children's Hospital, Baptist Health and the University of Arkansas for Medical Sciences. Baptist Health employees who work in central AR have been eligible to use this network since January 2017. Beginning January 2018, Arkansas Blue Cross Blue Shield employees may chose the use of the HMO Plus network.

Please note that this network **is different than Health Advantage**. Just because a

provider participates in the Health Advantage HMO network does not mean that the provider is in the HMO Plus network. It will be important to ensure referral patterns stay within the HMO Plus network HMO Plus is a smaller, closed-model HMO network that will eventually spread statewide and will be used primarily by self-insured employer groups.

The benefit program using the HMO Plus network is called FocusCare. If a member indicates that his/her Plan is FocusCare, the member must utilize a provider contracted with HMO Plus for non-emergency situations. **A referral is required from a member's PCP-self referrals are not allowed. There are no out-of-network benefits.**



Continued success with Arkansas CPCi practices

The Centers for Medicare & Medicaid Services (CMS) recently announced shared savings results in the Comprehensive Primary Care initiative (CPCi). These results reflect the work of 441 practices that served more than 327,000 Medicare FFS beneficiaries and more than 2.8 million patients in 2016.

Of the seven regions participating in CPCi, Arkansas (statewide) is one of only two regions that realized net savings (after accounting for the care management fees paid). CMS will be distributing a savings of \$1,052,683 to CPCi practices.

Of Arkansas CPCi practices, 95 percent met or exceeded the quality measure targets to achieve shared savings. Arkansas Blue Cross and Blue Shield also has experienced shared savings for the 2016 performance period, and will be distributing a total of \$374,697 to these CPCi practices.

CPCi practices demonstrated improvement in many areas including, but not limited to: increased quality outcomes, reduced hospital admission and readmission rates, enhanced efforts for patient satisfaction, and surpassed national benchmarks on preventive health measures.

“I’m excited to see CMS’ announcement of the savings in the CPCi program,” said Alicia Berkemeyer, vice president of the Enterprise Primary Care and Pharmacy Program. “We’re seeing similar savings with Arkansas Blue Cross membership, and will distribute those shared savings soon. These providers are leading the nation in transforming primary care into patient-focused, innovative practices.

I congratulate these providers for their commitment to the betterment of primary care in Arkansas.”

The Comprehensive Primary Care initiative (CPCi) was a four-year multi-payer pilot led by CMS that promotes collaboration between public and private healthcare payers to strengthen primary care. Practices enrolled in CPCi earned per-member, per-month (PMPM) fees for the patients in their care to support practice transformation and care coordination efforts.

Arkansas Blue Cross believes healthcare should focus on a triple aim of better care, smarter spending and healthier people. As the healthcare system transitions to models that reward value over volume, CPCi and patient-centered medical home (PCMH) practices are at the forefront of quality improvement, measurement and reporting.

The following 49 Arkansas CPCi clinics were identified by CMS as eligible for 2016 shared savings. Arkansas Blue Cross congratulates these providers on this accomplishment, as each of these CPCi providers met or exceeded the cost and quality metrics determined by CMS.

Clinic Name	City
Bradley Bibb MD PLLC	Ash Flat
Beebe Family Clinic	Beebe
Saline Medical Peds Group Inc	Benton
Bryant Medical Clinic	Bryant
Benton Family Clinic	Benton
Baptist Health Family Clinic Bryant	Bryant
Baptist Health Family Clinic Cabot	Cabot
Ouachita Valley Family Clinic	Camden

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Continued success with Arkansas CPCi practices (Continued from page 24)

Clinic Name	City
Internal Medicine Diagnostics	Cherokee Village
B Brooks Lawrence MD PA	Conway
Freeman Family Medicine	Conway
Barry V Thompson MD PA	Crossett
Family Clinic Of Ashley Co PA	Crossett
Lofton Family Clinic MD PA	De Queen
Randy Walker MD PLLC	De Queen
SAMA Healthcare Services PA	El Dorado
Washington Regional Senior Clinic	Fayetteville
UAMS AHEC Family Medical Center	Fayetteville
Shiple And Sills Family Doctors	Fort Smith
UAMS AHEC Fam Med Center	Fort Smith
Glenwood Family Medicine	Glenwood
Greenbrier Family Clinic	Greenbrier
Main Street Medical Clinic	Harrison
Harrison Family Practice Clinic Washington Region	Harrison
Leslie Clinic PA	Harrison
Garner Family Medical Clinic	Highland
West Gate Medical Clinic	Hot Springs
Hamilton West Family Medicine	Hot Springs
AHEC Family Practice	Jonesboro
Clopton Clinic Of Jonesboro	Jonesboro
West Washington County Clinic	Lincoln
Baptist Health Family Clinic West	Little Rock
Baptist Health Family Clinic Hillcrest	Little Rock
Baptist Health Family Clinic	Little Rock
St. Vincent Physician Clinic LLC	Little Rock
Autumn Road Family Practice PA	Little Rock
Arkansas Family Care Network	Little Rock
John E Alexander Jr MD PA	Magnolia
Baptist Health Family Clinic Malvern	Malvern
Baptist Health Family Clinic Maumelle	Maumelle
North Central AR Medical Association	Mountain Home
Dr Andys Family Practice	Mountain View
Baptist Health Family Clinic Lakewood	North Little Rock
Baptist Health Family Clinic Perryville	Perryville
Sherwood Family Medical Center	Sherwood

Clinic Name	City
Community Physicians Group	Siloam Springs
UAMS Family Medical Center Springdale	Springdale
SW Family Practice Residency and Clinic	Texarkana
Alliance Senior Health PLLC	West Memphis

CPCi ended in December 2016; however, a new model took its place on January 1, 2017. Arkansas was selected as one of 18 regions for the **Comprehensive Primary Care Plus (CPC+)** initiative. While there will be similarities, CPC+ is an expanded version, with more regions, more participating clinics, two track options, and an enhanced payment methodology. CMS has announced that CPC+ is an eligible advanced payment model (APM) in MACRA, CMS's new quality payment program.

CMS expects up to 3,850 primary care practices and over 13,090 clinicians to participate in **Comprehensive Primary Care Plus (CPC+)** over the next five years. As of November 2017, there are 182 primary care practices and 617 clinicians participating in Arkansas.

Arkansas Blue Cross continues its collaboration with other Arkansas payers (Arkansas Superior Select, Inc., Arkansas Health & Wellness Solution, HealthSCOPE Benefits, Arkansas Medicaid, and QualChoice HealthPlan Services, Inc.) to assist providers in the way they deliver care, centered on key comprehensive primary care functions. These include: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement; and (5) planned care and population health.



AHIN corner

The Advanced Health Information Network (AHIN) recently launched a popular new feature, document transfer. This new functionality allows users to electronically respond to requests from various areas within Arkansas Blue Cross and Blue Shield. On the AHIN home page, a convenient green banner alerts users to document requests. Providers can easily respond to quality gap, diagnosis gap and primary care or CPC+ document requests. AHIN continues to make improvements to the way medical records and other documents are requested from providers. Alerts will be posted as improvements and new functionality are added.

AHIN now allows providers to view member

ID cards. Member ID cards can be viewed for most Arkansas members/in-state. Providers can access a member's ID card from the Member Results page when checking eligibility.

The AHIN Outreach Team is available to assist providers with any training need. Should your staff need training, please contact us at ahinuniversity@ahin.net.

Providers are encouraged to sign up for our provider user group (PUG), by sending an email to the same address with the subject "PUG". This pilot group was created to give feedback to assist AHIN in the development of future functionality.

Re-credentialing packets on AHIN coming soon

Arkansas Blue Cross and Blue Shield and its family of companies strive to streamline processes for providers. AHIN offers the gateway and will begin including access to re-credentialing packets in the near future. For providers with no access to AHIN, the packets will be faxed to providers 90 days prior to the provider's due date for re-credentialing. If the fax fails to transit, the packet will be mailed to providers.

In addition, AHIN will begin including

provider profiles that will enable providers to change their information. Federal and state agencies are placing high demands of the reliability of provider directory information and are mandating frequent review and approval from the provider community. Adding AHIN accessibility to provider data profiles will allow providers to review data and submit changes efficiently.

Be watching AHIN for upcoming details on this new functionality.



2017 Open Enrollment: please use AHIN

2017 Open Enrollment periods began on October 1, 2017, and runs through December 15, 2017. Due to the anticipated enrollment of many new members and current member renewals, we are expecting extremely high call volume through January 31, 2018. Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use AHIN (Advanced Health Information Network) for verifying eligibility,

benefits, and claims status. AHIN displays information on benefits to assist providers when scheduling appointments, checking eligibility and benefits. Arkansas Blue Cross is planning and staffing to answer a higher call volume, but call volumes can spike and exceed our ability to answer every call. AHIN uses the same information available to our customer service representatives and can save you valuable time.

ASE/PSE inpatient discharge dates

In an effort to process prior authorizations (PAs) in a more timely manner, ActiveHealth Management (AHM) has requested providers inform of a discharge date for an inpatient stay. Once AHM has a discharge date on file, the approved open PA will be closed and transmitted to Health Advantage (HA)

for claims processing. If a claim is filed prior to the PA being closed, the claim will deny. Upon notification of an approved closed prior authorization to HA customer service, denied claims will be adjusted for processing.

ASE/PSE worksite health checkups now available

Catapult Health, a national provider of biometric measurements combined with clinical risk assessments and nurse practitioner counseling, is now offering 30-minute preventive care checkups for state and public school employees at workplaces across Arkansas.

Catapult uses lab-accurate mobile technology to evaluate each patient's lipids, blood glucose, and liver enzymes. A1C tests are administered to those who have a history of diabetes. Blood pressure, height, weight and abdominal circumference are measured, and depression screening is conducted. Cotinine test will be administered to check for nicotine use. Personal and family

history information is captured, along with current medications.

During consultation with a board-certified nurse practitioner, gaps in care are identified; including past due cancer screenings and vaccinations, and a personal action plan is created. Each patient's results are sent the same day via secure eFax to his or her local PCP.

Catapult Health's lab and test results are high quality and designed to aid the participant's PCP in the development of and/or continuation of a patient's care plan. Catapult directs all patients to their local PCP for prescriptions and medication management.



Federal Employee Program (FEP) news

Telehealth Services

- Members can speak to board-certified healthcare providers via phone or online video chat for the treatment of minor injuries, illnesses, counseling for substance abuse disorders and mental healthcare services. \$10 copayment for Standard and \$15 copayment for Basic.

Wellness Incentives

- The contract holder or spouse, age 18 or older, is eligible to earn rewards through our incentive programs.
- Pregnant members do not have to register for My Pregnancy Assistant to earn rewards through the Pregnancy Care Incentive Program.

Preventive Care

- Members of all ages can receive generic cholesterol lowering drugs (known as statins).
- Members age 50 to 59 can receive aspirin to prevent heart disease and colon cancer.
- Members age 18 and older can receive a screening for latent tuberculosis infections.
- Expanded benefits for colon cancer screenings to include DNA analysis of stool samples.

Provider/Facility Care

- Skilled nursing facility (SNF) care for all Standard Option members, not just Standard Option members with Medicare Part A primary. Precertification is required.
- Vasectomies now covered under the family planning benefits.
- Blood and stem cell transplants limited to the treatment of specific diseases.

Pharmacy

- Reduced out-of-pocket costs for generic and preferred brand-name asthma drugs.
- Reduced out-of-pocket costs for generic drugs used to lower high blood pressure.
- Increased out-of-pocket costs for non-preferred brand-name drugs (Tier 3) for both the retail and mail service pharmacies.
- When a brand-name drug is purchased instead of a generic, the member pays the brand-name cost share plus the difference between the cost of the brand-name and the generic drug, unless dispense as written is indicated.
- The Specialty Pharmacy Program will be administered by AllianceRx Walgreens Prime.
- Medical foods received by mouth must be purchased using the retail or mail service pharmacy and receive prior approval.
- Expanded the Basic Option “Managed Not Covered” list to include additional non-covered drugs.
- The age limit has been removed on drugs to treat gender dysphoria.

Overseas Care

- Cost shares waived for covered inpatient care received at overseas Department of Defense (DoD) facilities.
- Precertification is required for residential treatment center admissions.

Medicare

Basic Option members with Medicare Part A and B can receive a \$600 reimbursement account to pay the Medicare Part B premiums.



FEP 2018 guidelines on submitting a professional electronic replacement or voided claim

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

Claim Frequency Codes Accepted on Professional Claims:

- 1 – Original Claims
- 7 – Replacement (Corrected Claim)
- 8 – Voided Claim

Replacement (Corrected Claims)

A replacement claim, also referred to as a corrected claim, is most often filed when information that affects payment was billed incorrectly (e.g. wrong or missing procedure code, diagnosis code, wrong date of service, wrong billed amount, etc.) These claims should be billed with a claim type (frequency code) of 7 and the original claim that is being replaced. Claims submitted with a claim type 7 **will not** be accepted without a valid approved original claim number.

The replacement claim will replace the entire previously processed claim. Therefore, when submitting a correction, send the claim with all changes exactly how the claim should be processed.

Examples:

1. The original claim was submitted with 99212, 88003 and 76100. 76100 should have been billed as 76101. A

replacement claim should be submitted with all procedures 99212, 88003 and 76101, frequency code 7 and the original reference claim. This indicates that the claim is a correction to a previously processed claim that needs to be adjusted.

2. If a service was omitted from the original claim the replacement claim should be submitted with all previously submitted lines, the additional service line, frequency code 7 and the original reference claim.
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 reference claim. This indicates 81000 was removed.

Voided Claims

In situations where a claim was billed with the correct services but under the wrong contract number or member, the original claim will need to be voided and replaced with a new claim. These claims should be billed with a claim type (frequency code) 8 and the original claim that is to be voided and replaced. Claims submitted with a claim type 8 **will not** be accepted without a valid approved original claim number.

Note: If the previously processed claim is denied or voided, a new claim with claim type (frequency code) 1 should be submitted.



FEP hypertension management program

The Blue Cross and Blue Shield Federal Employee Program® (FEP) and the American Medical Association (AMA) have come together in a collaborative effort to provide physicians with resources designed to improve health outcomes for patients with hypertension and suspected hypertension. This effort supports the goals of the Million Hearts initiative®.

Prevention and early detection of high blood pressure or hypertension require self-monitoring in addition to physician treatment plans. The AMA released new guidelines for considering high blood pressure classifications for patients with persistent measurements at or above 130 for systolic and 80 for diastolic. The new guideline categories remove the diagnosis of “prehypertension.”

- Normal: Top number under 120 and bottom less than 80
- Elevated: Top number 120-129 and bottom less than 80
- Stage 1: Top of 130-139 or bottom of 80-89
- Stage 2: Top at least 140 or bottom at least 90

In support of this effort, FEP initiated a program to provide free blood pressure

monitors* to FEP enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If your patient completes the Blue Health Assessment (BHA) and reports they have high blood pressure and you and your patient discuss home monitoring, your patient is eligible to receive a free blood pressure monitor. The BHA is a health-risk assessment and the first step in the FEP Wellness Incentive Program. In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle (www.fepblue.org/bha).

Please do not hesitate to contact Arkansas Federal Employee Program for more details regarding this program and other programs available to those enrolled in the Blue Cross Blue Shield Federal Employee Program. Information is also available on www.fepblue.org or by calling FEP customer service at 800-482-6655 (Arkansas only) or 501-378-2531 for additional information.

*The blood pressure monitors were selected by Blue Cross and Blue Shield. The AMA does not endorse any particular brand or model of blood pressure monitor.



FEP skilled nursing facility benefits

Federal Employee Program Skilled Nursing Facility benefits up to 30 days only for standard option members not enrolled in Medicare Part A

Effective January 1, 2018, benefits will be available for up to 30 days of inpatient skilled nursing facility (SNF) care per benefit year for Standard Option Members who are not enrolled in Medicare Part A.

- The member must be enrolled in case management (CM) and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the hospital discharge planning staff collaborate with the Plan case manager, and in some cases, will necessitate the hospital case manager/discharge planner's assistance in delivering the consent to the member and having it returned to the Plan after the member/proxy signs the document.
- The transferring facility must submit a detailed description of the patient's clinical status and the proposed treatment plan for the Plan's review of the proposed admission.
- Once the member is admitted and subsequently within the timeframes established by the Plan, the SNF representative must provide specific information regarding the patient's status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the member from achieving the goals.

- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the patient's admission. Patients admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the facility 24 hours/day.

Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 2 hours of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to the Plan to document therapy time).

- Hospital staff must be proactive in identifying members for whom a SNF stay is an appropriate level of care in the continuum toward transition home. It may also be necessary for hospital staff to facilitate obtaining the member's written consent for CM. This may include identifying of the member's surrogate decision maker/proxy, assisting the Plan in delivering the case management consent to the member/proxy and/or having the signed consent returned to the Plan's case manager prior to the Plan rendering a benefit determination on the proposed SNF admission.
- Contact FEP Customer Service at 1-800-482-6655 or visit <http://www.fepblue.org>



Medi-Pak[®] Advantage HMO: AIM high-tech radiology provider notification

The Arkansas Blue Cross and Blue Shield Medi-Pak[®] HMO program 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 a new high tech radiology program to support 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 patients and \$600 to \$900 for commercial health plan patients, the costs of inappropriate imaging are staggering. Cardiovascular imaging, in particular, represents 29 percent of all imaging workload.

Arkansas Blue Cross and Blue Shield Medi-Pak[®] HMO program 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 members in understanding the range of choices they have in selecting among imaging providers and increasing their ability to make informed decisions.

New Imaging Management Solution
Beginning, January 1, 2018, the Arkansas Blue Cross and Blue Shield Medi-Pak[®] HMO

program will require prospective clinical case review (prior authorization) for high tech radiology procedures for outpatient, non-emergent imaging service. The following procedure codes are:

- **Computed tomography (CT/CTA), including cardiac**
 - o Included primary procedure codes: 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, , 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74263, 75571, 75572, 75573, 75574, 75635, 77078, G0297
- **Magnetic resonance (MRI/MRA), including cardiac**
 - o Included primary procedure codes: 70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 74712, 74713, 75557, 75559, 75561, 75563, 75565, 76390, 77058, 77059, 77084,
- **Positron emission tomography (PET) scans, including cardiac**
 - o Included primary procedure codes:

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AIM high-tech radiology provider notification (Continued from page 32)

- 78491, 78492, 78608, 78609, 78811, 78812, 78813, 78814, 78815, 78816
- **Nuclear cardiology**
 - o Included primary procedure codes: 78451, 78452, 78453, 78454, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496
- **Stress echocardiography (SE)**
 - o Included Primary Procedure Codes: 93350, 93351
 - o Secondary Procedure Codes*: 93320, 93321, 93325, 93352
- **Resting transthoracic echocardiography (TTE)**
 - o Included primary procedure codes: 93303, 93304, 93306, 93307, 93308,
 - o secondary procedure codes*: 93320, 93321, 93325
- **Transesophageal echocardiography (TEE)**
 - o Included primary procedure codes: 93312, 93313, 93314, 93315, 93316, 93317
 - o Secondary Procedure Codes*: 93320, 93321, 93325

**Note: Secondary codes are add-on codes to be used in conjunction with primary codes. As such, these codes do not require separate review.*

Providers should contact Arkansas Blue Cross Medi-Pak® HMO to obtain an authorization number before scheduling or performing any elective outpatient imaging service.

For all order requests, the following information is required:

- Patient first and last name, member

- contract number and date of birth
- Ordering provider first and last name
- CPT code and the name of the exam being requested
- Diagnostic code (ICD10) or name of your patient's diagnosis
- Name and location of the facility where the exam will be performed

For most order requests, the following supporting information may be required:

- Reason for ordering the exam (eg, what is the provider looking for or differential diagnosis)
- Physical exam findings
- Patient history (including prior surgery)
- Prior imaging dates and results

To submit your outpatient imaging service authorization request, you may contact Arkansas Blue Cross Medi-Pak® HMO, via fax at 844-869-4073 or toll-free at 866-427-8680, Monday-Friday 8 to 4:30 p.m. Central time.

For questions regarding the High Tech Radiology program requirements, please contact Arkansas Blue Cross Blue Shield Medi-Pak® HMO, toll-free at 866-427-8680, Monday through Friday 8 to 4:30 p.m. Central time.

Standard Time Frames for All Requests for Service

Arkansas Blue Cross Medi-Pak® HMO conducts timely reviews of all requests for service, according to the type of service requested. Decisions are made:

Type of Request	Decision
Pre-service urgent/concurrent	Within 72 hours of receipt of request
Pre-service non-urgent	Within 14 days of receipt of request
Post-service	Within 30 days of receipt of request



CMS issues reminder for hospice providers

The Centers for Medicare & Medicaid Services (CMS) has issued a reminder to all Medicare Advantage plans and Part D plan sponsors of the requirement to reinforce guidance relative to Part D payments for drugs for beneficiaries enrolled in the Medicare hospice benefit. For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment unrelated to the terminal illness or related conditions.

Reminder to hospice providers – Hospice organizations should submit notices of hospice election to CMS within five days. However, there is a lag between when the beneficiary elects the benefit and when the Part D sponsor can see that election. CMS is once again encouraging hospice providers to use the first page of the standardized form (Information for Medicare Part D Plans; OMB 0938-1269) to immediately notify the appropriate Medicare Advantage or Part D sponsor of the election. In order to prevent inappropriate payment of drugs by Medicare Advantage or Part D sponsors, the form should be faxed to the sponsor as soon as possible. Arkansas Blue Cross and Blue Shield will use all information included on the form to properly administer this benefit.

In the event that Arkansas Blue Cross paid for drugs prior to receiving notification of a hospice election, and if the drug is the hospice's liability, the hospice is expected to work with us in coordinating a timely repayment.

Use of Maintenance Drugs – Hospice care typically includes services necessary for the palliation and management of the terminal illness and related conditions. As such, there may be some medications which were used prior to the hospice election that will continue as part of the hospice plan of care. After a hospice election many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, there are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis.

A lack of coordination between hospices and Medicare Advantage and Part D sponsors ultimately affects the quality of care rendered to our members/your patients. Please help us help these patients by providing timely notification of a hospice election made by an Arkansas Blue Cross member.



Reminder: Annual compliance training must be completed by December 31

As a contractor with Centers for Medicare & Medicaid Services (CMS) and a qualified health plan (QHP) through the U.S. Department of Health and Human Services (HHS) through the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act), Arkansas Blue Cross and Blue Shield is required to develop and maintain a compliance program and ensure annual compliance training is satisfied by our first-tier, downstream and related entities (FDRs) and delegated entities (DEs). According to the Federal Register Notice CMS-4124-FC and 45 C.F.R. Subpart D §156.340, providers are considered first tier and/or delegated entities because there is a direct contract for Medicare/ACA services between Arkansas Blue Cross and each provider.

Who must complete the training?

General compliance training should be completed annually, not only by the provider, but also by the provider's staff members who have contact (indirect or direct) with Medicare beneficiaries and ACA members; this includes billing, receptionist, lab and clinical staff.

Methods for completing the training

As a CMS plan sponsor we must ensure that our FDRs/DEs receive general compliance training as well as fraud, waste and abuse (FWA) training. FDRs/DEs are deemed to have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation

as a supplier of DMEPOS are NOT exempt from the general compliance training requirement and must complete annual general compliance training, through one of the three (3) methods below.

1. FDRs/DEs can complete the general compliance and/or FWA training modules located on the CMS MLN. The updated and FREE Medicare Parts C and D General Compliance web-based training (WBT) and Medicare Parts C and D fraud, waste and abuse (FWA) web-based training (WBT) courses are available through the Learning Management and Product Ordering System here: <https://learner.mlnlms.com/Default.aspx>

Each individual must create an account to receive credit for the course. If you are not a current user, select "new user" to create an account.

- In the 'Association' section, if you do not see an organization you are associated with or do not want to enter the information, select "none."
- When you get to the Organization Section; click on "Select," search and then select "CMS-MLN Learners Domain Organization" and select "save."
- Select "Create" once all required fields are complete.

Once your account is created or you have logged in, proceed with the following steps:

- Select the "Training Catalog" tab on the menu bar.

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Annual compliance training reminder (Continued from page 35)

- Under the menu bar labeled “Browse by Category,” select “Provider Compliance.” The first two boxes “Combating Medicare Part C and D Fraud, Waste, and Abuse (January 2017) (Contact hours: 30 min)” and “Medicare Parts C and D General Compliance Training (January 2017) (Contact hours: 20 min)” appear.
- Select the title of the training you need to complete and then select “Enroll.”
- The Enroll Screen will default to “Credit” for course credit and ‘Normal’ course mode; proceed with selecting “Enroll.”
- Select “Open Item” to begin course or return to the Training Catalog to select the additional course by repeating the steps a through e.
- To return to the courses after enrolling, choose the “My Upcoming Learning” and select the title of the course you are completing, select “Open Item” to begin course.

Once the training is complete with a score of 70 percent or higher (with contact hours); the system will generate a certificate of completion at the end of each web-based training (WBT) events.

For MLN specific instructions and course help: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LMPOS-FAQs-Booklet-ICN909182.pdf>

2. Sponsors and FDRs/DEs can incorporate the content of the CMS standardized training modules from the CMS website into their organizations’ existing compliance training materials/systems.

The PDF version is provided as a service to organizations to incorporate the CMS training content into existing training systems and written documents and is not intended to take the place of the WBT; no certificate is provided with the PDF download. The download is available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf>

3. Sponsors and FDRs/DEs can incorporate the content of the CMS training modules into written documents for providers (e.g. Provider Guides, Participation Manuals, Business Associate Agreements, etc.). Although training content cannot be modified, CMS will allow modification to the appearance of the content (font, color, background, format, etc.). Additionally, organizations may enhance or wrap around the CMS training content by adding topics specific to the organization or the employee’s job function. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

What do we do with our training records?

Whichever method you choose to complete from the options above, no documentation should be returned to Arkansas Blue Cross.

Arkansas Blue Cross has developed an online attestation, administered through AHIN, where the AUA will attest on behalf of the each FDR/DE, that the appropriate general compliance and FWA training has been completed, either through their organization or through the Medicare Learning Network® (MLN).

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Annual compliance training reminder (Continued from page 36)

Should your organization provide general compliance and FWA training specific to your organization, a copy of all training documents, including a copy of the training materials and training logs, must be retained by your organization for 10 years, in accordance with CMS/HHS record retention guidelines. For more information about General Compliance Training and Medicare Parts

C and D Fraud, Waste and Abuse Training requirements can be found at: <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html>

Please direct additional questions to regulatorycompliance@arkbluecross.com.

New benefit for Arkansas Blue Cross and Blue Shield Medicare supplement members

Beginning December 1, Arkansas Blue Cross and Blue Shield will begin a new cost reduction program with USA Senior Care Network for our Medicare supplement members. USA Senior Care Network, which is also known as the Accountable Alliance, has entered into agreements with dozens of hospitals across the state.

Eligible Arkansas Blue Cross members will receive \$100 Part A Deductible refunds when they have an inpatient admission at a hospital which participates in the USA Senior Care Network. If you would like to learn more about the program, please contact your network development representative.

Medi-Pak[®] Advantage claims

Claim processing reminder

Please note that all Medi-Pak Advantage claims must be filed 365 days from the date of service. The deadline to ask for a review of the claim decision is 60 days from the remittance advice.

Ambulatory Surgical Centers

Ambulatory surgery centers (ASC) should not include the surgeon name in the

rendering provider field on claim forms. This is causing MUE edit denials for the surgeon claim and the ASC claim when billed after the surgeon's bill submission. In effort to assist providers with this change, we will be manually adjusting claims billed in error through January 31, 2018. Please note, effective February 1, ASC claims billed with a rendering provider will be denied.



Why do CAHPSSM and HOS surveys matter?

CAHPS and HOS surveys help providers better understand how to provide a positive patient experience. Providing a positive patient experience not only improves patient outcomes, but it also simply makes good business sense. The annual surveys are sent to a sampling of Medi-Pak[®] Advantage, Marketplace Exchange, and Federal Employees Program plan members by a certified survey vendor.

In this article, learn more about how CAHPS and HOS surveys measure the patient experience and how improving it can help your patients and your practice. We provide sample survey questions that your patients may see and recommendations for driving improvement in the various areas measured by the surveys.

What are CAHPS and HOS?

The **Consumer Assessment of Healthcare Providers and Systems and Health Outcomes Survey** are patient-experience surveys developed by the Centers for Medicare & Medicaid Services.

The annual surveys are sent to a sampling of Medicare Advantage members by a certified survey vendor.

- CAHPS measures members' satisfaction with their overall healthcare experience. The survey covers the following areas:
 - o Healthcare in the last six months with the member's personal doctor and specialists
 - o General rating of the quality of healthcare received
 - o Experience with the health plan
- HOS measures patient-reported health outcomes. The survey covers the following areas:
 - o Their health and the quality of the healthcare they received
 - o Changes in their self-reported health status two years later

Why are CAHPS and HOS Important?

- A good patient experience is associated with positive clinical outcomes.
 - o A good patient experience has a positive effect on processes of care for both prevention and disease management. For example, diabetic patients demonstrate greater self-management skills and quality of life when they report positive interactions with their healthcare providers.
 - o Patients' positive experiences with care can result in adherence to medical advice and treatment plans. This is especially true for patients with chronic conditions where a strong commitment from patients to work with their physicians is essential to achieving positive results.
 - o Patients with better care experiences often have better health outcomes. For example, studies of patients hospitalized for heart attacks showed that patients with positive reports about their care experiences had better health outcomes a year after discharge.
 - o Measures of patient experience can reveal important system problems, such as delays in returning tests results and gaps in communication that may have quality, safety and efficiency implications.

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Why do CAHPSSM and HOS surveys matter? (Continued from page 38)

- Improving patient experience is good business because it correlates with key financial indicators.
 - o A good patient experience is associated with a lower medical malpractice risk. A 2009 study** found that for each drop in scores on a five-point scale of “very good” to “very poor,” the likelihood of a provider being named in a malpractice suit increased by 22 percent.
 - o Good patient experience results in greater employee satisfaction and less employee turnover. Patients usually keep or change providers based on their experience — and the quality of their relationship with the provider’s staff is a major predictor of patient loyalty.

What are the CAHPS and HOS Questions?

Survey Name and Measure	Sample Survey Question to Patient	Recommendation to Provider Where Applicable
CAHPS: Annual flu vaccine	Have you had a flu shot since July 1, 2017?	Administer flu shot after July 1, 2017 and before February 1, 2018.
CAHPS: Getting appointments and care quickly	<p>In the last six months:</p> <ul style="list-style-type: none"> • How often did you see the person you came to see within 15 minutes of your appointment time? • When you needed care right away, how often did you get care as soon as you thought you needed it? • Not counting the times when you needed care right away, how often did you get care as soon as you thought you needed it? 	<ul style="list-style-type: none"> • If you’re behind schedule, have the front office staff update patients often and explain why. Patients are more tolerant of delays if they know the reasons. • Show respect to the patient if you’re behind schedule and apologize. • Ensure that a few appointments are open each day for urgent visits, including post-inpatient discharge visits. • Offer appointments with a nurse practitioner or physician’s assistant to patients who want to be seen on short notice. • Ask patients to make routine check-up and follow-up appointments in advance.

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Why do CAHPSSM and HOS surveys matter? (Continued from page 39)

Survey Name and Measure	Sample Survey Question to Patient	Recommendation to Provider Where Applicable
CAHPS: Overall rating of health care quality	Using any number between zero and 10, where zero is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your health care in the past six months?	Ask patients how they think you should improve their healthcare.
CAHPS: Care coordination	<ul style="list-style-type: none"> • When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray or other test for you, did someone from your personal doctor's office follow up to give you those results? • Did your personal doctor talk to you about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about specialist care? 	<ul style="list-style-type: none"> • Before walking in the exam room, read the current symptoms and determine if anything needs a follow-up from previous visits. • When ordering tests, let your patients know when they can expect results. Implement a system to ensure timely notifications of results. • Ask your patients if they saw another provider since you last met with them. If you know patients received specialty care, discuss their visit and if the specialist prescribed any additional medication.
HOS: Improving or maintaining physical health	<ul style="list-style-type: none"> • During the past four weeks, has pain stopped you from doing things you want to do? • Have you had any of the following problems with your work or other regular daily activities because of your physical health? <ol style="list-style-type: none"> 1. Accomplished less than you would like 2. Didn't do work or other activities as carefully as usual 	<ul style="list-style-type: none"> • Identify ways to improve the pain problem. Determine if your patient could benefit from a consultation with a pain specialist or rheumatologist. • Consider physical therapy, cardiac or pulmonary rehab when appropriate.

(Continued on page 41)



Survey Name and Measure	Sample Survey Question to Patient	Recommendation to Provider Where Applicable
HOS: Improving or maintaining mental health	<p>Have you had any of the following problems with your work or other regular daily activities because of emotional problems?</p> <ul style="list-style-type: none"> Accomplished less than you would like Didn't do work or other activities as carefully as usual Didn't have a lot of energy or felt sad or depressed most days 	<ul style="list-style-type: none"> Empathize with the patient. Consider therapy with a mental health professional when appropriate. Offer ideas to improve mental health: Take daily walks, socialize, stay involved with family, own a pet, do crossword puzzles, volunteer, participate in a church, go to senior community centers or meditate. Consider a hearing test when appropriate as loss of hearing can be isolating.
HOS: Monitoring physical activity	<p>In the past 12 months, did:</p> <ul style="list-style-type: none"> You talk with a doctor or other health care provider about your level of exercise of physical activity? A doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity? 	<ul style="list-style-type: none"> Offer physical activity suggestions based on the patient's ability. Offer ideas for where patients can engage in activities such as senior classes at the Area Agency on Aging YMCA and community centers. These also offer opportunities.
HOS: Improving bladder control	<ul style="list-style-type: none"> In the past six months, have you leaked urine? How much of a problem, if any, was the urine leakage for you? (e.g., changed daily activities or interfered with sleep) 	<ul style="list-style-type: none"> When talking to patients, note that urinary leakage problems can be common as we grow older, but there are treatments that can help. This opens the conversation if they are too embarrassed to bring it up.

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Why do CAHPSSM and HOS surveys matter? (Continued from page 41)

Survey Name and Measure	Sample Survey Question to Patient	Recommendation to Provider Where Applicable
<p>HOS: Improving bladder control Continued</p>	<ul style="list-style-type: none"> Have you talked with your doctor about ways to manage urine leakage? 	<ul style="list-style-type: none"> Do they have leakage problems? Discuss potential treatments options, such as medications, exercises and surgery.
<p>HOS: Reducing the risk of falling</p> <p>Please note that the HOS measure for reducing the risk of falling was temporarily removed and will be put back in the 2019 HOS survey. However, it's still an important topic to discuss with patients.</p>	<ul style="list-style-type: none"> Did you fall in the past 12 months? In the past 12 months, did your doctor or other health provider talk with you about falling or problems with balance or walking? Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? 	<ul style="list-style-type: none"> Ask patients if they experienced a fall. Many won't report falls to their doctor in fear of losing their independence. Several medications can be responsible for falls, and dosage changes may be all that is needed. Some things your patients might do to reduce the risk of falling are: <ol style="list-style-type: none"> Using a cane or walker Engaging in an exercise or physical therapy program Having a vision or hearing test Taking vitamin D

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Arkansas Blue Cross Blue and Shield offices will be closed



for Christmas on **Monday, December 25,** and **Tuesday, December 26.**



Our offices will also be closed on **Monday, January 1, 2018,** in observance of New Year's Day.



Arkansas Blue Cross offices will **reopen on January 2, 2018.**



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PLEASE NOTE

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies. The newsletter does not pertain to traditional Medicare. Traditional Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

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