Arkansas BlueCross BlueShield
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PROVIDERS' NEWS

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Availity® provider portal available now

The teams at Arkansas Blue Cross and Blue Shield and Availity® have been working to create functionality on the Availity portal similar to what you have used in AHIN for eligibility, benefits and claim functions. We are excited to announce the time is finally here for providers to begin moving to Availity!

Realizing that in this time of pandemic your time and resources may be somewhat limited, we are providing you advanced notice of key dates and timelines.

- On **February 15** we invited all providers to begin utilizing the Availity Portal. The AHIN portal will be available as usual, but it is important for your office to register now, take advantage of the training opportunities and begin familiarizing yourself and your staff with Availity functionality.
- **Friday, April 30 will be the last date to utilize the eligibility and benefit functions on AHIN**. Soon after, we will establish a sunset date for the claim functions on AHIN.

Availity will provide support to you during and after the migration. The Arkansas Blue Cross Health Information Network (HIN) team will continue to support the back-end processes and will assist Availity in supporting you through a ticketing system within the Availity portal.

Availity has created a landing page with helpful information and training opportunities to help you through the registration and getting-started process. Providers can access the Availity landing page at https://www.availity.com/arkansasbluecross or by clicking the link in the AHIN alert.

Availity® transition: Filing claims correctly

With the transition to Availity®, Arkansas Blue Cross and Blue Shield and its family of companies will begin to increase the level of editing and validation of information submitted on claims. Claims should be submitted with a valid member name, alpha prefix and suffix that can be obtained through verification of eligibility through Availity or (270/271) eligibility verification. Failure to do so can result in claim rejections. To help prevent claim rejections, providers should obtain verification of eligibility and benefits at each visit.

In the future, Availity will add editing, and if any of the information is missing or not able to be validated, the claim will be rejected back to the provider for correction. Eligibility edits apply to both paper and electronic claims.

Please contact your network development representative if you have any questions.

Bryce Corporation & Windstream to implement prior approval requirements

Effective May 1, 2021, Blue Advantage Administrators of Arkansas' clients Bryce Corporation and Windstream Communications have chosen to implement a prior approval program for their respective employee groups. The services requiring prior approval will include all **inpatient hospital admissions, specific medical services, durable medical equipment (DME), and medical procedures**. Emergency services are exempt, but emergency admissions still require a prior approval (within 48 hours of admission).

Failure to obtain prior approval will result in denial of the claim. If a provider fails to obtain prior approval for a hospital admission, outpatient procedure, medical service or DME that is designated by these group's administrators as requiring prior approval, the provider will be financially responsible, and the member cannot be balanced billed (held harmless). It is the provider's responsibility to verify or make certain the medical services have received prior approval.

Behavioral health/substance abuse for inpatient and outpatient services requiring prior approval will need to be obtained by calling New Directions Behavioral Health at 1-877-801-1159.

The list of services that require prior approval will be available via the Availity portal or AHIN closer to implementation.

Change in Botox (onabotulinumtoxinA) procurement

Beginning April 1, 2021, CVS Caremark will no longer dispense Botox(onabotulinumtoxinA) (J code J0585) for claims billed through the medical or pharmacy benefit. To help this change, Botox will be covered under the pharmacy benefit and pharmacies may now submit claims for employer groups with Arkansas Blue Cross pharmacy benefit management. Botox will still be covered under the medical benefit for all members of Arkansas Blue Cross and Blue Shield and its affiliates. Arkansas Blue Cross and its family of companies will allow J0585 to be submitted on medical claims by contracted pharmacists and pharmacies. Prescribers will now be able to send prescriptions to local community pharmacies who supply Botox. Please check with the pharmacy to ensure they can obtain Botox for your member.

Botox will still be subject to Arkansas Blue Cross coverage policy #2018002 on the medical benefit and will require a prior approval on the pharmacy benefit. If your patient has been receiving their Botox prescription from CVS Specialty pharmacy, you will need to send a new prescription to another pharmacy before April 1. CVS Specialty pharmacy will also not be providing Botox to prescriber offices for buy and bill.

If you have questions about this new process, you may call Arkansas Blue Cross pharmacy customer service at 501-378-3392.

Coverage Policy manual updates

Since November 2020, Arkansas Blue Cross has added or updated several policies in its Coverage Policy manual. The table below highlights these additions and updates. If you want to view entire policies, you can access the coverage policies located on our website at arkansasbluecross.com.

Policy ID	Policy Name
1997153	Iron Therapy, Parenteral
1997208	Spinal Cord Neurostimulation for Treatment of Intractable Pain
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1997229	Cardiac Event Recorder, External Loop or Continuous Recorder

Policy ID	Policy Name
1998026	Insulin Infusion Pumps, External
1998108	Ventricular Assist Devices
1998109	Chimeric Antigen Receptor Therapy for Hematologic Malignancies (CAR-T)
1998161	Infliximab
2000047	HDC & Autologous Stem &/or Progenitor Cell Support for Primitive Neuroectodermal Tumors (PNET) & Ependymoma
2001028	Magnetic Resonance Imaging (MRI), Breast
2002008	Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon
2003015	Intensity Modulated Radiation Therapy (IMRT)
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)
2004038	Genetic Test: Lynch Syndrome and Inherited Intestinal Polyposis Syndromes
2004053	Circulating Tumor Cells in the Management of Patients with Cancer, Detection of
2005010	Cardiac and Coronary Artery Computed Tomography, CT Derived Fractional Flow Reserve and CT Coronary Calcium Scoring
2006016	Rituximab (Rituxan)
2006030	Balloon Ostial Dilation (Balloon Sinuplasty)
2009015	Golimumab (Simponi® and Simponi Aria®)
2010014	Genetic Test: Genetic Testing for Evaluation of Patients with Developmental Delay/Intellectual Disability or Autism
2011002	Positron Emission Mammography (PEM)
2011012	Preventive services for non-grandfathered (PPACA) plans: Alcohol and drug misuse counseling and/or screening
2011017	Preventive services for non-grandfathered (PPACA) plans: Breast cancer preventive medication
2011053	Autism Spectrum Disorder, Applied Behavioral Analysis
2011066	Preventive services for non-grandfathered (PPACA) plans: Overview
2012009	Skin and Soft Tissue Substitutes, Bio-Engineered Products
2012019	Genetic Test: FLT, NPM1, and CEBPA Variants in Cytogenetically Normal Acute Myeloid Leukemia
2013010	Genetic Test: PTEN Hamartoma Tumor Syndrome
2013017	Fecal Microbiota Transplantation for the Treatment of Clostridioides Difficile
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment
2014013	Genetic Test: Li-Fraumeni Syndrome
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients With Non-Small-Cell Lung Cancer
2015003	Patient-actuated Mechanical Devices (Range of Motion & Stretching Devices)
2015004	Genetic Test: Breast Cancer Risk Assessment (PALB2, CHEK2, ATM)
2015007	Laboratory Tests for Chronic Heart Failure and Heart and Kidney Transplant Rejection
2015024	Minimally Invasive Benign Prostatic Hyperplasia (BPH) Treatments
2016002	Genetic Test: Neurofibromatosis
2016010	Mepolizumab (Nucala)
2016012	Daratumumab (Darzalex) / Daratumumab and Hyaluronidase-fihi (DARZALEX FASPRO)

Policy ID	Policy Name
2016014	Genetic Test: Use of Common Genetic Variants (Single Nucleotide Polymorphisms) to Predict Risk of Nonfamilial Breast Cancer
2016016	Atezolizumab (Tecentriq®)
2017005	Noninvasive Fractional Flow Reserve Using Computed Tomography Angiography
2017015	Avelumab (Bavencio™)
2017030	Guselkumab
2017035	Gemtuzumab Ozogamicin (Mylotarg™)
2018030	Site of Care or Site of Service Review
2019007	Electrical Stimulation, Advanced Transcutaneous Electrical Stimulation (Interferential Current Stimulation, Electrical Stimulation Treatment, Combined Electrical Stimulation Treatment, H-Wave Electrical Stimulation)
2019010	Esketamine (SPRAVATO™)
2019011	Treatment for Spinal Muscular Atrophy
2020001	Adoptive Immunotherapy
2020007	Eptinezumab-jjmr (VYEPTI™)
2020013	Afamelanotide (Scenesse™)
2020016	Inebilizumab-cdon (Uplizna™)
2020020	Sacituzumab govitecan-hziy (Trodelvy™)
2020021	Pertuzumab, trastuzumab and hyaluronidase-zzxf (PHESGO™)
2020023	Bimatoprost (Durysta™)
2020025	Dexamethasone intraocular suspension (DEXYCU®)
2020026	Canakinumab (Ilaris™)
2020028	Vestibular Function Testing
2020029	Covid-19 Monoclonal Antibody Therapy
2020030	Alglucosidase alfa (Lumizyme™)
2021001	Lurbinectedin (ZepzelcaTM)

Coverage policy material amendments

Effective May 1, 2021, the following new coverage polices have been adopted:

- 2021005 Tafasitamab-cxix (Monjuvi)
- 2021002 Enfortumab vetotin-ijfv (Padcev)
- 2021003 Carfilzomib (Kyprolis)

This notice was posted in AHIN on 02/01/2021.

Effective May 1, 2021, coverage criteria related to Phototherapy for Psoriasis have been revised:

- Criteria for in-office targeted phototherapy have been amended.
- Coverage for in-home Ultraviolet B (UVB) light therapy when criteria are met has been added.

For specific coverage criteria, please see coverage policy 2002009.

Canakinumab (Ilaris™) Policy #2020026

Effective February 25, 2021, Arkansas Blue Cross and Blue Shield and its family of companies have a new policy for Canakinumab (Ilaris™), (J0638 – Injection, canakinumab, 1mg). Ilaris is a monoclonal antibody used in the treatment for Cryopyrin-Associated Periodic Syndromes, Familial Mediterranean fever, Hyperimmunoglobulin D syndrome/Mevalonate Kinase deficiency, Tumor Necrosis Factor Receptor Associated Periodic Syndrome and Adult-Onset Still's disease and systemic JIA. Prior approval will be needed for this medication. For specific coverage criteria, please see coverage policy 2020026.

This notice was published in AHIN on 11/18/2020.

Levoleucorvin Agents

Effective May 12, 2021, Arkansas Blue Cross and Blue Shield and its family of companies have a new policy for Levoleucovorin Agents (Fusilev) and (Khapzory). These agents are folate analogues primarily used to diminish the toxicity and counteract the effects of impaired folic acid antagonists (such as methotrexate) and to enhance the therapeutic effects of fluoropyrimidines (such as 5-fluorouracil) in the treatment of various types of cancer. Please refer to coverage policy #2021007 for specific details.

This notice was published in AHIN on 2/11/2021.

Satralizumab-mwge (Enspryng)

Effective May 12, 2021, Arkansas Blue Cross Blue Shield and its family of companies have a new policy for Satralizumab-mwge (Enspryng™). Enspryng is a humanized monoclonal antibody that targets interleukin-6 receptors and is indicated for the treatment of adult patients with neuromyelitis optica spectrum disorder (NMOSD), who are anti-aquaporin-4 (AQP4) antibody positive. Enspryng will require prior approval. Please refer to coverage policy #2020005 for specific coverage criteria.

This notice was published in AHIN on 2/11/2021.

Focus Care

For providers taking care of Focus Care plan members:

- Please review the member's ID card. The front of their ID card will indicate "Focus Care."
- Members that are on the Focus Care plan must assign and obtain services from that selected primary care provider. Referrals are also required from the assigned PCP to in-network specialists participating in the Focus Care plan.
- As a reminder, Focus Care members are required to use the HMO Plus provider network, a specifically contracted subset network of Health Advantage.

If you have any questions, please contact Customer Service at 800-843-1329.

Metallic formulary changes effective May 1, 2021

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

Drugs no longer covered

Product/Drug Label Name	Formulary Alternatives
CIPRODEX SUS OTIC	Brand no longer covered. Use generic form of the drug.
DESOXIMETAS OIN 0.05%	betamethasone valerate aer, cre, lot, oin, desoximetasone cream 0.05%, fluocinolone acetonide cre, oil, oin, sol, fluticasone propionate cre, lot, oin, hydrocortisone butyrate cre, oin, sol, hydrocortisone valerate cre, oin, mometasone cre, oin, sol, triamcinolone cre, lot 0.025%, triamcinolone cre, lot, and oin 0.1%
FENOFIBRATE CAP 130MG	fenofibrate caps 43 mg, 67 mg, 134 mg, 150 mg, 200 mg, fenofibrate tabs 48 mg, 54 mg, 145 mg, 160 mg

Product/Drug Label Name	Formulary Alternatives
FENOFIBRATE CAP 50MG	fenofibrate caps 43 mg, 67 mg, 134 mg, 150 mg, 200 mg, fenofibrate tabs 48 mg, 54 mg, 145 mg, 160 mg
HYOSCYAM ER TAB 0.375MG	dicyclomine cap 10mg, sol 10 mg/5 ml, tab 20mg, Ed-Spaz disintegrating tab 0.125 mg, hyoscyamine sublingual 0.125 mg, hyoscyamine tab 0.125mg Nulev tab 0.125mg, Oscimin sublingual 0.125 mg, Oscimin tab 0.125 mg, Symax-SL sublingual 0.125 mg
JYNARQUE TAB 15MG	Brand no longer covered. Use generic form of the drug.
KUVAN TAB 100MG	Brand no longer covered. Use generic form of the drug.
MONUROL-1PKT PAK GRANULES	Brand no longer covered. Use generic form of the drug.
MOVIPREP SOL	Brand no longer covered. Use generic form of the drug.
TAYTULLA CAP 1MG/20MC	Brand no longer covered. Use generic form of the drug.
TECFIDERA CAP 240MG	Brand no longer covered. Use generic form of the drug.
TECFIDERA MIS STARTER	Brand no longer covered. Use generic form of the drug.
TRUVADA TAB 200-300	Brand no longer covered. Use generic form of the drug.
TYKERB TAB 250MG	Brand no longer covered. Use generic form of the drug.

Drugs moving to a higher tier

Product	Formulary Alternatives
CLOCORTOLONE CRE PIV 0.1%	betamethasone valerate aer, cre, lot, oin, desoximetasone cream 0.05%, fluocinolone acetonide cre, oil, oin, sol, fluticasone propionate cre, lot, oin, hydrocortisone butyrate cre, oin, sol, hydrocortisone valerate cre, oin, mometasone cre, oin, sol, triamcinolone cre, lot 0.025%, triamcinolone cre, lot, and oin 0.1%

Standard formulary changes effective April 1, 2021

Drugs no longer covered

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

Product/Drug Name	Formulary Alternatives
ADDERALL	amphetamine-dextroamphetamine mixed salts, methylphenidate
ANDROGEL	testosterone gel (except authorized generics for TESTIM and VOGELXO), testosterone solution, ANDRODERM
AZOR	amlodipine-olmesartan, amlodipine-telmisartan, amlodipine-valsartan
CLOCORTOLONE PIVALATE	hydrocortisone butyrate cream, hydrocortisone butyrate ointment, hydrocortisone butyrate solution, mometasone, triamcinolone cream, triamcinolone lotion, triamcinolone ointment (except triamcinolone ointment 0.05%)
COZAAR	candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan
CYTOMEL	levothyroxine, liothyronine, SYNTHROID

Product/Drug Name	Formulary Alternatives
DESOXIMETASONE	hydrocortisone butyrate cream, hydrocortisone butyrate ointment, hydrocortisone butyrate solution, mometasone, triamcinolone cream, triamcinolone lotion, triamcinolone ointment (except triamcinolone ointment 0.05%)
DOXYCYCLINE HYCLATE DR	doxycycline hyclate 20 mg, doxycycline hyclate capsule, minocycline, tetracycline
ELIDEL	pimecrolimus, tacrolimus, EUCRISA
FENOFIBRATE	fenofibrate (except fenofibrate capsule 50 mg, 130 mg; fenofibrate tablet 40 mg, 120 mg), fenofibric acid delayed-rel
FOCALIN XR	amphetamine-dextroamphetamine mixed salts ext-rel (excluding certain NDCs), dexmethylphenidate ext-rel, methylphenidate ext-rel (excluding certain NDCs), MYDAYIS, VYVANSE
HYDROCORTISONE BUTYRATE	hydrocortisone butyrate cream, hydrocortisone butyrate ointment, hydrocortisone butyrate solution, mometasone, triamcinolone cream, triamcinolone lotion, triamcinolone ointment (except triamcinolone ointment 0.05%)
HYOSCYAMINE SULFATE ER	dicyclomine
HYZAAR	candesartan-hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan-hydrochlorothiazide, valsartan-hydrochlorothiazide
LYRICA	duloxetine, pregabalin
MAXALT	eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan
MICARDIS	candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan
OSCIMIN SR	dicyclomine
PAROXETINE	paroxetine HCl

Product/Drug Name	Formulary Alternatives
REMODULIN	treprostinil
TRAVATAN Z	latanoprost, travoprost, LUMIGAN, ZIOPTAN
TRIAMCINOLONE ACETONIDE	hydrocortisone butyrate cream, hydrocortisone butyrate ointment, hydrocortisone butyrate solution, mometasone, triamcinolone cream, triamcinolone lotion, triamcinolone ointment (except triamcinolone ointment 0.05%)
ULORIC	allopurinol
YASMIN 28	ethinyl estradiol-drospirenone, ethinyl estradiol-drospirenone-levomefolate, ethinyl estradiol-norethindrone acetate, ethinyl estradiol-norethindrone acetate-iron
ZILEUTON ER	montelukast, zafirlukast
ZOLOFT	citalopram, escitalopram, fluoxetine (except fluoxetine tablet 60 mg, fluoxetine tablet [generics for SARAFEM]), paroxetine HCl, paroxetine HCl ext-rel, sertraline, TRINTELLIX

HEDIS®

HEDIS® season medical record retrieval timeline

HEDIS® Medical Record Requests have been sent to providers of our Medicare Advantage (MA), Arkansas Works (ACA), and FEP populations following the timeline below:

- Beginning date: February 1, 2021
- Estimated End date: April 16t, 2021

Record requests will be processed at Arkansas Blue Cross and Blue Shield as well as at the following vendors:

- Inovalon
- Optum
- CIOX

We ask that you respond to any records request within ten days of receipt.
Please use the link below to find contact information specific to your location, along with other helpful contact information.
https://www.arkansasbluecross.com/providers/resource-center/network-development-reps

HEDIS is a registered trademark of the National committee for Quality Assurance (NCQA).

Medicare Advantage

Centers for Medicare and Medicaid Services (CMS) preclusion list

Effective January 1, 2019, CMS began releasing a monthly list of individual providers or entities that have been precluded from receiving payment for Medicare items, services, and Part D medications under the following two categories:

1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or

2) Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Effective April 1, 2019, any Part D sponsor and/or Medicare Advantage Plan are required to deny payment for any pharmacy claim or health care item prescribed or furnished by an individual listed on the Preclusion List.

Please note that any provider or entity that falls on the preclusion list will be terminated and removed from the networks in accordance with the network participation agreement(s). There

will be an option to appeal the network termination decision at time of notice or upon removal from the CMS preclusion list.

Additional resources and reference guide can be found on the CMS website at Preclusion List.

Medical record retention reminder

Any provider who participates in the Arkansas Blue Medicare and Health Advantage Medicare Advantage networks is required to follow the Centers for Medicare & Medicaid Service (CMS) medical record retention requirements and guidance within their practice. The CMS guidance mandates that any Medicare Advantage member's medical record should be retained for up to 10 years from the date of service.

All network agreements indicate by way of signature that facilities and providers agree to accept and comply with the record accuracy requirements stating the following:

> "(1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them."

Please note that medical records may be requested to render a medical management decision or to investigate potential quality concerns. Both the provider's agreement and the member's contract allow Arkansas Blue Medicare and Health Advantage Medicare Advantage to review all medical records. Arkansas Blue Medicare and Health Advantage Medicare Advantage must receive all records within 7–10 days of the request. Urgent requests may be made in accordance with expedited CMS requests.

Providers are contractually required to furnish member medical records without charge when the medical records are required for Arkansas Blue Medicare, Health Advantage Medicare Advantage HMO and government use.

CMS Reference: 42 C.F.R. §§ 422.504(a)(13) and 422.118

CMS Resources: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1022.pdf, https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/Model_Contract_Amendment_080714.pdf

Reminder on billing qualified Medicare beneficiaries

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

QMBs who are enrolled in any Medicare Advantage plan to administer their Medicare benefits would have Medicare Advantage as their primary coverage and Medicaid as their secondary coverage. Payments are considered accepted in full even if the provider does not accept Medicaid. Providers are subject to sanctions if billing a QMB patient for amounts not paid by any Medicare Advantage plan and Medicaid.

Providers are subject to sanctions if billing a QMB patient for amounts not paid by Arkansas Blue Cross and Blue Shield and Medicaid.

Additional information about dual-eligible coverage is available under the Medicare Learning Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

Requirements for outpatient observation care

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

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

For some Medicare Advantage members, observation stays have pre-authorization or pre-notification requirements.

The notice should explain the following using contemporary language:

- The patient is classified as outpatient
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage for services furnished by a skilled nursing facility
- Advise patients to contact his or her insurance plan with specific benefit questions
- The notice and accompanying instructions are available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Photo by Kouji Tsuru on Unsplash