December 2021

PROVIDERS' NEWS

Published for providers and their office staffs by Arkansas Blue Cross and Blue Shield

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

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PROVIDERS' NEWS

What's inside?

Arkansas BlueCross BlueShield

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Arkansas Blue Cross and Blue Shield

2021 Open enrollment – Please use Availity

The 2021 Open Enrollment period began October 4 and will continue through December 15. The Open Enrollment period for Metallic individuals will end on January 15, 2022. The enrollment of many new members and renewal of current members has produced extremely high call volumes, which are expected to remain elevated through January 31, 2022.

Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the website for the following:

- **Availity** – Use for information regarding eligibility, benefits and claims status. Availity displays information on benefits to assist providers when scheduling appointments, checking eligibility and identifying benefits.
- **AHIN** – If you need to request a prior authorization for medical inpatient and outpatient services, please continue to use AHIN.
- **AIM** portal – If you need to request a prior authorization for imaging and high-tech radiology, please continue to use the AIM portal.

Like many companies, Arkansas Blue Cross is experiencing staffing shortages resulting from the pandemic. Please be aware that call volume can spike and exceed our ability to answer every call. Availity uses the same information available to our customer service representatives and can save you valuable time. **Effective immediately, we encourage providers to use the appropriate provider portal to request prior authorization. This will help reduce call volume and result in quicker service to members.**

Important reminder regarding provider applications, clinic applications, recredentialing and provider data updates

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

The provider community should continue to use AHIN for functionality that has not transitioned to Availity.

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

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

You will need to maintain your AHIN access and continue to complete the needed provider enrollment, updates and recredentialing on AHIN until these functions have completely transitioned to Availity. In addition, the professional fee schedule is still on AHIN. New providers must sign up for AHIN to access these provider-related functions.

Although Arkansas Blue Cross and its affiliates have accepted paper submissions for provider and clinic enrollment and credentialing in the recent past, we now require providers to use AHIN or risk having paper submissions rejected. Federal law effective January 2022 requires a quick turnaround on revising certain provider data elements, and these functions must be performed through AHIN until they transition to Availity.

Go to https://www.arkansasbluecross.com/providers/resource-center/health-information-network for a complete list of AHIN and Availity functions.

Availity reminders

We previously notified the provider community of an increase in the level of editing and validation of information submitted on claims. Providers were reminded of the importance of submitting claims with a valid member name, alphanumeric prefix and suffix that can be obtained through eligibility queries through the Availity portal or (270/271) eligibility queries. **To minimize additional delays and claim front-end rejections, providers should query for eligibility before submitting the claim**. Staying up to date on communication related to future Availity migration activities and enhancements is vital. We have included important reminders below:

- Eligibility edits apply to both paper and electronic claims. Dropping claims to paper will only delay claim processing time and may result in the claim being returned to you. Paper claims are translated into an electronic claim in Availity before being sent to the payer. Electronic claims are the best method of claim submission.
- To help reduce claim rejections, providers should query Availity for eligibility and benefits at each visit and ensure the patient's record is updated in your practice system. If any of the information is missing or not able to be validated, the claim will reject back to the provider for correction. Providers can receive the latest updates in the Availity Payer Space under News & Announcements.
- Availity communicates changes to providers that affect Arkansas Blue Cross and other payers through a monthly News & Announcement on the Availity home page. To remain up to date on enhancements to the Availity portal and EDI clearinghouse, please review the monthly release communications.
- Excluding FEP, Arkansas member policies have an identification number that includes a suffix unique to the primary policyholder's identification number. For example, if Joe Smith is the primary policyholder and has a member ID of ABC1234501, he is considered the subscriber. Jane Smith is Joe's spouse and is covered on Joe's policy. Jane's member ID is ABC1234502. Jane is regarded as a subscriber as well since she has a unique member ID number. (In this example, the suffix is different.) For Arkansas in-state policies, providers need the correct member ID to include the prefix and suffix to identify the member/subscriber on the claim. The patient's relationship can remain "self" if the identification number is submitted correctly.
- In AHIN, providers could locate and correct claims in error. Did you know you can also correct claims errors in Availity? If a claim rejects in Availity, you can click the "correct this claim" button in CMT, correct the error and resubmit the claim. The only time a provider should submit a claim type of 7 (replacement claim) is when the claim you are correcting has been accepted by the payer. Claims with errors in Availity are not sent to the payer until all errors are corrected. If you do not use the "correct this claim" feature in Availity, you must correct the issue and submit the claim as a first-time claim.
- Providers also could email customer service in AHIN. In Availity, this feature is known as "message the payer." The "message the payer" button is only available when a claim has a status of finalized (by the payer) and is

assigned an ICN. You will not see this button if the claim is still being adjudicated. The "message the payer" button is available in Availity in both Claim Status & CMT.

- Providers continue to be confused by what functionality remains in AHIN and what has moved to Availity. An updated list of available functionality for both portals can be viewed at **Provider Portal - Arkansas Blue Cross and Blue Shield**. As new functionality becomes available in Availity, this list will be updated.
- Provider data management is projected to move from AHIN to Availity in April 2022. Providers can remain up to date by viewing future Providers' News articles, visiting the Payer Space on Availity and reviewing Availity release updates. Availity will also send reminders for training offerings as future functionality goes live in Availity. Joining a live training session is the recommended learning method for Availity portal navigation; however, if you cannot join a live session, the sessions are recorded and available in the Availity Learning Center.

Additional Services Requiring Prior Approval

Notice of material amendment

The following services will require prior approval (PA) as of April 1, 2022.

Health Advantage Fully Insured

- Home Health Visits and Hospice **except metallic**.
- Mental Health Inpatient **except metallic**.
- Prosthodontics services.
- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants **including metallics and the US65 individual plans**.

Arkansas Blue Cross and Blue Shield Fully Insured

- Home Health Visits and Hospice Subject except metallic.
- Mental Health Inpatient except metallic.
- Inpatient Acute, LTAC, rehab: group business only except metallic.
- Prosthodontics services.
- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants **including metallics and the US65 individual plans**.

Health Advantage Exchange

- Additional services require PA as part of the Craniofacial Anomaly reconstructive surgery: Sclera contact lenses, including coatings, ocular impressions of each eye; every two years, two hearing aid molds and a choice of two wearable bone conductions, two surgically implantable bone-anchored hearing aids or two cochlear implants **including metallics and the US65 individual plans**.
- Prosthodontics services.

Arkansas Blue Cross and Blue Shield Exchange

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- Prosthodontics services.

Coding strokes correctly

Stroke is an acute medical emergency that requires urgent attention and can only be accurately diagnosed by confirmation with a CT scan or MRI of the brain. Acute stroke codes (ICD-10 category I63.-) should only be used during the acute inpatient encounter and until discharge of that encounter. Therefore, a coder cannot use the acute stroke codes (163.-) in an office setting due to the nature of the event and the inability to accurately diagnose in the office.

Once discharged from an acute-care facility, the patient now has a history of stroke (ICD-10 code Z86.73) that should be used after the initial stroke encounter. Z86.73 is a billable ICD-10 code used to diagnose a personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits.

Any late effects caused by the stroke being treated should be documented and coded with ICD-10 category I69.- or associated signs and symptoms codes (ICD category R-).

ICD-10 guidelines state suspect conditions cannot be coded in the office setting. As a result, an active stroke should not be coded in the office because it is still suspected until work-up on the patient confirms the diagnosis. However, it is appropriate for a provider to document their suspicion, specifying the associated signs and symptoms (R- codes) present. The documented signs and symptoms should then be coded on the claim. Please refer to the ICD 10 CM Official Coding Guidelines and AHA Coding Clinic for more information.

This article was originally published in the September 2020 issue of Providers' News.

CAA continuity of care provisions

The Consolidated Appropriations Act (CAA) of 2021 contains provisions on continuity of care. Arkansas Blue Cross and Blue Shield and Health Advantage are working to ensure that our policies, processes and practices conform to these legislated requirements. (For self-funded health plan customers, BlueAdvantage, as TPA for such customers, will also follow the applicable law and terms of such self-funded health plans in regard to CAA changes.)

Here's a summary of how these provisions will apply to our valued healthcare providers and their patients.

For plan years **beginning January 1, 2022**, or thereafter, health plans are required to facilitate continuity of care for covered members who have qualifying conditions.

An individual is considered a **continuing care patient** if they are:

- Undergoing a course of treatment for a serious and complex condition that is life-threatening, potentially disabling or congenital and requires specialized medical treatment to avoid death or permanent harm.

- Undergoing a course of institutional or inpatient care.
- Scheduled to undergo nonelective surgery (including postoperative care).
- Pregnant and undergoing a course of treatment related to the pregnancy.
- Terminally ill and receiving treatment for that illness.

Health plans are required to:

- Notify members in writing of any significant changes in the availability or location of covered services, provider terminations, cessation of services or any other significant changes.
- Allow members to notify the health plan or issuer of their need for transitional care.
- Allow members to elect to continue to receive care from the originating provider (under the same terms and conditions that would have applied had the termination not occurred) for the previously covered services for up to 90 days.

We hope this information will be helpful and minimize disruption as you continue to deliver high-quality care. As always, if you have questions about these provisions, feel to reach out to your designated Arkansas Blue Cross representative.

CAA update

Special Note: *The following is offered as general information only; it is not intended as, and should not be relied upon as legal advice or services. Moreover, the information provided herein is subject to interpretation, and may change, depending on further guidance from regulators or developments of the law or regulation. Providers having any questions or concerns about the requirements of laws or regulations should always consult with their own, independent legal counsel because Arkansas Blue Cross and its affiliates do not offer legal advice or services.*

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

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

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

- **Price comparison tools** – This rule is similar to the 2020 Transparency Rule which applied to certain providers/facilities. The CAA requires group health plans and health insurance issuers to provide price comparison tools. It requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.

- The tool must be available for 500 covered items and services by **January 1, 2023**, and for all covered items and services by **January 1, 2024**.

- To align the enforcement date of the CAA Price Comparison Tool with the enforcement date of the Transparency in Coverage Tool, **enforcement of [the CAA price comparison tool] requirement will be deferred until January 1, 2023.**

  Effective: January 1, 2023

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

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

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

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

  Effective for plan years: starting January 1, 2022

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

provider networks due to noncompliance with the requirements of the law

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

Effective for plan years: starting January 1, 2022

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

  Effective: Compliance enforcement deferred to January 1, 2023.

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

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

This article was originally published in the September 2021 issue of Providers' News.

CAA – Surprise billing

The Consolidated Appropriation Act will protect our members from surprise billing. As a payer, we are required to notify our membership about these protections, but this will also affect the provider community. Below is what Arkansas Blue Cross and its affiliates will publish on our website to our membership about CAA and Surprise Billing.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

Services provided at an in-network hospital or ambulatory surgical center for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, and services by assistant surgeons, hospitalists, and intensivists cannot balance bill you nor ask you to give up your protections to be balanced billed. In these cases, the most the providers may bill you is your plan's in-network cost-sharing amount.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact us at the customer service phone number on the back of your ID card.

Important Reminder
The Consolidated Appropriations Act (CAA) requires us to verify provider directory information every 90 days. Please help us with this process by responding and attesting as quickly as possible when we request confirmation.

Coverage Policy manual updates

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

Policy ID	Policy Name
1997105	Interferon Gamma-1B
1997112	Intradialytic Parenteral Nutrition
1997113	Immune Globulin, Intravenous and Subcutaneous
1997128	Leuprolide (Lupron)
1997137	Strontium 89, Metastron
1997153	Iron Therapy, Parenteral
1998043	Biofeedback for Miscellaneous Indications
1998109	Chimeric Antigen Receptor Therapy for Hematologic Malignancies (CAR-T)
1998119	Viscosupplementation for the Treatment of Osteoarthritis of the Hip, Knee, and All Other Joints
1998137	Genetic Test: Alzheimer's Disease
1998144	Pulmonary Arterial Hypertension, Infusion and Inhalation therapy
1998155	Respiratory Syncytial Virus, Immune Prophylaxis with Palivizumab (Synagis)
1998156	PET or PET/CT for Non-Small Cell Lung Cancer
1998158	Trastuzumab AND Trastuzumab and Hyaluronidase-oysk
1998161	Infliximab
2000030	Chemotherapy for Malignancy
2001009	Non-Implantable Insulin Infusion Devices, Hybrid Insulin Infusion Devices, and Continuous Glucose Monitoring Devices
2001030	PET or PET/CT for Esophageal or Esophagogastric Junction (EGJ) Cancer
2003035	Antineoplaston Cancer Therapy
2005024	Nesiritide (Natrecor) for Use in the Outpatient Setting
2005025	Radiofrequency Ablation, Bony Metastases
2006016	Rituximab (Rituxan) and Biosimilars- Oncologic Indications
2006020	Abatacept (Orencia) for Rheumatoid Arthritis
2006038	Ultrafiltration in Decompensated Heart Failure
2007024	Genetic Test: HER2 Testing
2008027	Biomarker Testing (including Liquid Biopsy) for Targeted Treatment and Immunotherapy in Colon Cancer (KRAS, NRAS, BRAF Mutation Analysis)
2008031	Rilonacept (Arcalyst)
2009015	Golimumab (Simponi® and Simponi Aria®)
2009036	Intensity Modulated Radiation Therapy (IMRT), Breast
2009040	Radioimmunotherapy in the Treatment of Non-Hodgkin Lymphoma
2009044	Vagus Nerve Stimulation
2009047	Hormone Pellet Implantation for Hormone Replacement Therapy

Policy ID	Policy Name
2010000	Capsaicin (Qutenza) for the Treatment of Post-Herpetic Neuralgia
2010028	Sipuleucel-T (Provenge) for the Treatment of Prostate Cancer
2010035	Lyme Disease Intravenous Antibiotic Therapy and Associated Diagnostic Testing
2011006	Ipilimumab (Yervoy™)
2012051	Surgical Treatment for Headaches
2013003	Stem Cell Growth Factors, Erythropoiesis-Stimulating Agents (ESAs), Darbepoetin, Epoetin, Peginesatide
2013014	Ado-Trastuzumab Emtansine (Trastuzumab-DM1) for Treatment of HER-2 Positive Malignancies
2013023	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: HEPATITIS C VIRUS SCREENING
2013030	Teduglutide (GATTEX®) for Short Bowel Syndrome (SBS)
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment
2013048	Repository Corticotropin Injection
2013049	Ocriplasmin (Jetrea®) for Symptomatic Vitreomacular Adhesion
2014014	Pertuzumab (Perjeta)
2015011	Vedolizumab (Entyvio) for Inflammatory Bowel Disease
2015024	Minimally Invasive Benign Prostatic Hyperplasia (BPH) Treatments
2015026	Pasireotide (Signifor or Signifor LAR)
2015028	Testosterone Replacement Therapy
2015029	Droxidopa (Northera™)
2015034	Telehealth
2016003	Omalizumab (Xolair)
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Nivolumab) (Durvalumab) (Cemiplimab)
2016009	Blinatumomab (Blincyto)
2016010	Mepolizumab (Nucala)
2016011	PCSK9 INHIBITORS (Evolocumab) (Alirocumab)
2016012	Daratumumab (Darzalex) / Daratumumab and Hyaluronidase-fihi (DARZALEX FASPRO)
2016013	C 5 Complement Inhibitors
2016015	Alemtuzumab (Lemtrada)
2016016	Atezolizumab (Tecentriq®)
2016017	Radium Ra 223 dichloride for Symptomatic Osseous Metastatic Prostate Cancer (Xofigo®; Ra 223)
2016018	Natalizumab (Tysabri)
2017001	Alpha-1 Proteinase Inhibitor Therapy
2017003	Ziv-aflibercept (Zaltrap)
2017004	Asfotase alfa (Strensiq®)
2017006	Bevacizumab (Avastin™) for Oncologic Indications
2017007	Cetuximab (Erbitux™)
2017008	Brentuximab (Adcetris™)
2017009	Denosumab (XGEVA™ and Prolia™)
2017012	Nab-Paclitaxel (Abraxane™)
2017013	Elotuzumab (Empliciti™)
2017014	Olaratumab (LARTRUVO™)
2017015	Avelumab (Bavencio™)
2017016	Ramucirumab (Cyramza™)
2017020	Pemetrexed (Alimta)

Policy ID	Policy Name
2017021	Ocrelizumab (Ocrevus)
2017022	Cerliponase Alfa (Brineura™)
2017023	Bezlotoxumab (Zinplava™)
2017024	Panitumumab (Vectibix™)
2017026	Edaravone
2017030	Guselkumab (Tremfya)
2017031	Dupilumab
2017033	Octreotide Acetate for Injectable Suspension (Sandostatin® LAR Depot)
2017034	Inotuzumab Ozogamicin (Besponsa™)
2017035	Gemtuzumab Ozogamicin (Mylotarg™)
2017036	Metreleptin
2017037	Direct Acting Antiviral Medications for Treatment of Chronic Hepatitis C
2018002	Chemodenervation, Botulinum Toxins
2018003	Copanlisib (Aliqopa)
2018004	Letermovir (Prevymis)
2018008	Reslizumab (Cinqair)
2018009	Benralizumab (Fasenra)
2018014	Lutetium Lu 177 Dotatate (Lutathera®)
2018017	Hydrogel Implant for Prostate Radiation Therapy-Absorbable Perirectal Spacer (APS); SpaceOAR System (Augmenix inc)
2018021	Gene Therapy for Inherited Retinal Dystrophy-Voretigene (Luxturna)
2018023	Levodopa-carbidopa Intestinal Gel (Duopa) for Treatment of Advanced Parkinson's Disease
2018024	Burosumab-twza (Crysvita®)
2018025	Mucopolysaccharidoses Agents
2018027	Pegloticase (Krystexxa®)
2019005	Pembrolizumab (KEYTRUDA®)
2019006	Caplacizumab-yhdp (Cablivi)
2019009	Romosozumab-aqqg (Evenity®)
2019010	Esketamine (SPRAVATO™)
2019011	Treatment for Spinal Muscular Atrophy
2019012	Brexanolone (Zulresso™)
2019013	Emapalumab-LZSG (Gamifant)
2020003	Tafamidis (Vyndamax)
2020004	Teprotumumab-trbw (TEPEZZA™)
2020006	Luspatercept-aamt (Reblozyl)
2020007	Eptinezumab-jjmr (VYEPTI™)
2020008	Isatuximab-irfc (Sarclisa)
2020009	Givosiran (GIVLAARI®)
2020011	Crizanlizumab (Adakveo™)
2020012	Tagraxofusp-erzs (Elzonris)
2020013	Afamelanotide (Scenesse™)
2020015	Fam-trastuzumab deruxtecan-nxki (Enhertu®)
2020016	Inebilizumab-cdon (Uplizna™)
2020020	Sacituzumab govitecan-hziy (Trodelvy™)
2020021	Pertuzumab, trastuzumab and hyaluronidase-zzxf (PHESGO™)
2020022	Tocilizumab (Actemra™)

Policy ID	Policy Name
2020023	Bimatoprost (Durysta™)
2020024	Belantamab mafodotin-blmf (Blenrep™)
2020026	Canakinumab (Ilaris™)
2020029	Covid-19 Monoclonal Antibody Therapy
2020030	Alglucosidase alfa (Lumizyme™)
2021001	Lurbinectedin (ZepzelcaTM)
2021002	Enfortumab Vedotin-ejfv (PadcevTM)
2021003	Carfilzomib (KyprolisTM)
2021005	Tafasitamab-cxix (Monjuvi)
2021006	Satralizumab-mwge (Enspryng™)
2021007	Levoleucovorin Agents (Fusilev) and (Khapzory)
2021008	Moxetumomab pasudotox-tdfk* (LUMOXITI)
2021009	Romidepsin (ISTODAX)
2021010	Mogamulizumab- kpkc (Poteligeo)
2021011	Eribulin mesylate (HALAVEN)
2021012	Mitomycin Gel (JELMYTO)
2021013	Cabazitaxel (JEVTANA)
2021014	Siltuximab (SYLVANT)
2021015	Ofatumumab (Arzerra)
2021017	Naxitamab-gqgk (Danyelza)
2021018	Irinotecan Liposomal (Onivyde)
2021019	Obinutuzumab (Gazyva)
2021020	Polatuzumab Vedotin-piiq (Polivy)
2021021	Omacetaxine (Synribo)
2021022	Trabectedin (Yondelis)
2021024	White Blood Cell Growth Factors (Colony Stimulating Factors)
2021025	Margetuximab-cmkb (MARGENZA)
2021026	Melphalan Flufenamide (Pepaxto)
2021027	Evinacumab-dgnb (Evkeeza)
2021028	Ustekinumab (Stelara)
2021031	Pilot Policy: SKY 92 Gene Expression Classification for Multiple Myeloma
2021032	Lumasiran (Oxlumo)
2021033	Belimumab (Benlysta)
2021034	Rituximab (Rituxan) and Biosimilars – Non-Oncologic Indications
2021036	Iobenguane I 131 (Azedra®)
2021037	Samarium SM 153 lexidronam (Quadramet®)
2021038	Digital Health Therapies for Attention Deficit/Hyperactivity Disorder
2021039	Genetic Test: Molecular Testing for Variants Associated with Hereditary Ovarian Cancer
2021040	Amivantamab-vmjw (Rybrevant™)
2021042	Aducanumab (Aduhelm)
2021043	Leuprolide Acetate (Lupron Depot®; Fensolvi®, Eligard®) for Non-oncologic Indications
2021044	Cabotegravir extended release – rilpivirine extended release (Cabenuva)

Jefferson Regional Medical Plans administered by BlueAdvantage Administrators of Arkansas

Claims for benefits under Jefferson Regional Medical Plans will be administered by BlueAdvantage, effective January 1, 2022. Jefferson Regional will have three plans for their employees to choose from: High Deductible/ HSA, Network PPO (former Select Plan) and Open-Access PPO. **The HSA and Network PPO plans have a nested network—referred to as the Jefferson Regional Network. This means that the Jefferson Regional Network must be utilized to receive the highest level of benefits for these two Plans.** The Open-Access PPO does not have a nested network.

The Jefferson Regional Network is comprised of True Blue PPO providers designated by Jefferson Regional who have primary locations within the **Jefferson Regional** service area, which consists of the following 11 counties: Arkansas, Ashley, Bradley, Chicot, Cleveland, Dallas, Desha, Drew, Grant, Jefferson and Lincoln.

Important: Jefferson Regional determines which True Blue PPO providers shall be in the Jefferson Regional Network. T**he number of provider carve-outs is expected to be small, but within the 11 county area, it is possible that some True Blue PPO providers will not be in the Jefferson Regional Network.** Outside of this 11 county area, Jefferson Regional Medical Plan will utilize the True Blue PPO and Blue Card PPO.

Members can access the online directory to identify which providers are in the Jefferson Regional Network at https://www.blueadvantagearkansas.com effective January 1, 2022.

Member and provider appeals or requests for re-review for Arkansas Blue Cross and Blue Shield, Health Advantage and BlueCard®

All re-review and appeal requests should be submitted in writing within 180 days of the denial of benefits on a claim and include:

- Issue being questioned.
- Date of service.
- Patient's name and ID number.
- Provider's name.
- Assigned claim number(s).
- Procedure and/or related CPT/ HCPCS/DRG code(s) and applicable diagnosis code(s).
- Reasons why the provider/ member believes that the claim was incorrectly denied in whole or in part.
- Medical records relevant to the appeal.

For greater efficiency, providers are encouraged to pursue a resolution with customer service prior to filing a re-review or appeal with Arkansas Blue Cross and Blue Shield or Health Advantage. An appeal or re-review request should not be submitted with a corrected claim form; this will only delay the appeal or re-review response.

Appeals and re-review requests on Arkansas Blue Cross and Health Advantage covered members

- **Provider Re-Reviews**

  To request a re-review of a denied claim (in whole or in part) prior to the submission of an appeal, please mark request RE-REVIEW and submit re-reviews to:

Arkansas Blue Cross
Attn: Medical Re-Review
P. O. Box 3688 Little Rock, AR 72203

A request for appeal will not be considered if the claim has not been reconsidered by the Medical Re-Review department first.

- **Provider Appeals**

  If the denial of the service continues to be disputed after the re-review is completed, a provider appeal may be submitted within 180 days of the original denial of the service. An appeal request on an Arkansas Blue Cross, Health Advantage or Health Advantage Exchange member can be mailed, faxed or emailed to the appropriate line of business:

  Arkansas Blue Cross - Appeals
  Attn: Appeals Coordinator
  P.O. Box 2181 Little Rock, AR 72203

  Fax: 501-378-3366

  Email: **appealscoordinator@arkbluecross.com**

- **Health Advantage - Appeals**

  Attn: Member Response
  P. O. Box 8069 Little Rock, AR 72203

  Fax: 501-212-8518

  Email: **appeals@healthadvantage-hmo.com**

- **Health Advantage Exchange – Appeals**

  Attn: Appeals Coordinator
  P.O. Box 2181
  Little Rock, AR 72203

  Fax: 501-378-3366

  Email: **appealscoordinator@arkbluecross.com**

- **Member appeals**

  Members should submit appeal requests in writing to the appeals coordinator or the member response coordinator at the appropriate address above within 180 days of the denial of the service. The same information listed for provider appeals is required for member appeals.

Appeals and re-review requests on out-of-state Blue Cross and Blue Shield Plan Members (BlueCard®)

Each Blue Cross and Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association. Therefore, each Plan develops its own certificates and policies and controls benefits and benefit determination for its members. Arkansas Blue Cross and Blue Shield acts as the Host Plan for other Blue Cross Plans (Home Plans) when Arkansas providers are used for services to the Home Plan's members.

As Host Plan, the role of Arkansas Blue Cross is limited to applying 'scope of practice' contractual arrangements and pricing claims when the member is covered under a Blue Cross Plan other than Arkansas Blue Cross, and the provider is in Arkansas, giving the Home Plan's member access to the contract rates/discounts that participating

Arkansas providers have agreed upon with Arkansas Blue Cross. The member's Home Plan determines if benefits are due and is responsible for any denial of benefits coverage decisions and handling of the appeal.

Arkansas Blue Cross does not administer the insurance policies or health plans of any other Blue Plan licensee company (Home Plan), nor does Arkansas Blue Cross make any benefit/claims decisions, denials or prior authorization or precertification decisions for any Home Plan.

Providers who disagree with how a BlueCard® claim was processed or paid may contact BlueCard® customer service at 1-800- 880-0918 for assistance.

- **Provider re-review of the allowance for a service processed through BlueCard**

  Provider requesting re-review should send their request in writing to the Arkansas Blue Cross Medical Re-Review team.

  Arkansas Blue Cross
  Attn: Medical Re-Review
  P. O. Box 3688
  Little Rock, AR 72203

- **Provider appeals**

  If the provider continues to dispute the allowance for a service after the re-review team's response, a written appeal may be mailed, faxed or emailed to the Arkansas Blue Cross Appeals Coordinator:

  Arkansas Blue Cross
  Attn: Appeals
  P. O. Box 2181
  Little Rock, AR 72203

  Fax: 501-378-3366

  Email: **appealscoordinator@ark-bluecross.com**

- **Arkansas provider appeals related to benefits available under an out-of-state Blue Cross Plan**

  Providers should send their written appeal to:

  Arkansas Blue Cross
  Attn: Appeals
  P. O. Box 2181
  Little Rock, AR 72203

  Arkansas Blue Cross will communicate with the member's out-of-state Plan (the Home Plan) asking the Home Plan for benefit information, and the for benefit information. The Arkansas Blue Cross Appeals staff will communicate the out-of-state Plan response to the provider.

- **Member appeals**

  Members should submit their appeals directly to the Blue Cross and Blue Shield Plan in the state that issued their coverage (the Home Plan).

Please Note:
Arkansas Blue Cross does **not** make benefit determinations or serve as final decision maker with respect to the provision or denial of benefits where the patient involved is a member covered by another independent Blue

Plan in another state. In such circumstances, Arkansas Blue Cross serves only as a communication conduit to get an appeal to the correct source, and in that role will forward the appeal to the member's correct Home Plan for response by the Home Plan, which retains all control over administration of Home Plan benefits and appeals.

This article was originally published in the September 2009 issue of Providers' News.

Provider third-party liability or subrogation

Arkansas Blue Cross and Blue Shield would like to provide the following notice regarding applicable claims filing policies and procedures of Arkansas Blue Cross and its affiliate, Health Advantage, in situations in which a third party or their liability carrier are responsible for the injuries an Arkansas Blue Cross or Health Advantage member sustains (generally referred to for shorthand convenience as "Third Party Liability" or "Subrogation" matters).

These policies and procedures have been in place for many years but are being restated for emphasis due to increasing Third Party Liability or Subrogation activities of some providers. Providers are reminded that their network participation agreements obligate them to comply with all claims filing policies and procedures, including those published in Providers' News.

1. Arkansas Blue Cross and Blue Shield and Health Advantage encourage providers to file all claims, rather than holding such claims to pursue Third Party Liability or Subrogation. Filing the claim allows quick provision of any available health plan or insurance contract benefits to our members and provides the fastest payment to providers.
2. Although the filing of claims is strongly encouraged and preferred, Arkansas Blue Cross and Health Advantage provider contracts do not require that claims be filed with them and recognize that state law specifically grants a lien to providers for Third Party Liability (i.e., providers can claim a part of any third party recovery the member may otherwise seek or be entitled to recover).
3. While Arkansas Blue Cross and Health Advantage understand this state lien law, and do not purport to change or challenge it, Arkansas Blue Cross and Health Advantage do require as an express term of their network participation agreements that participating providers must not pursue the member for any amounts in excess of the Arkansas Blue Cross or Health Advantage payment ("Excess Amounts") although participating providers may collect applicable member deductible, coinsurance or copayments. This means that while a provider can go after the third party or their carrier without violating their network participation agreement, the provider cannot attempt to recover "Excess Amounts" from the member. Any attempt to bill the member or collect against the member or their assets for Covered Services will be deemed a violation of the network participation agreement.
4. Providers are reminded that network participation agreements impose a 180-day timely filing requirement for all claims, and expressly bar collection – either from Arkansas Blue Cross or Health Advantage or the member – on claims not filed within 180 days. Thus, if a provider elects not to file a claim in favor of exclusively pursuing Third Party Liability or Subrogation, if that effort causes a delay in filing the claim past the 180-day filing deadline, providers cannot thereafter bill either the member or Arkansas Blue Cross or Health Advantage for any amount on such claims.
5. Providers are also reminded that while they may elect not to file a claim, members may still file the claim with Arkansas Blue Cross or Health Advantage based on the provisions of their member certificate or evidence of coverage. If the member files a claim that a provider has withheld, Arkansas Blue Cross

or Health Advantage will attempt to develop and process that member-submitted claim. Providers are contractually obligated in such circumstances to provide to Arkansas Blue Cross and Health Advantage information needed to evaluate and process the claim. Any payments determined due on such claims will be paid to the provider. Providers may not decline to accept the Arkansas Blue Cross or Health Advantage payment in such situations. If a provider does breach the participation agreement by declining to accept payment, Arkansas Blue Cross or Health Advantage will then make payment to the member. In either case, whether the payment is accepted or declined, and whether payment is made to the provider or the member (following provider refusal to accept), the provider cannot pursue collection against the member for excess amounts.

6. Arkansas Blue Cross and Health Advantage do not take a position regarding a provider's option to (a) file claims and receive the Arkansas Blue Cross or Health Advantage payment and also (b) pursue Third Party Liability or Subrogation for the remaining portion of their bills (the Excess Amounts). The only interest for Arkansas Blue Cross and Health Advantage is in ensuring that providers understand that once they become a participating provider in these networks, they cannot pursue the member for amounts beyond the Arkansas Blue Cross or Health Advantage payments.

7. To the extent that any of the preceding rules of network participation have not been clearly understood or interpreted by any provider or party, this Providers' News article shall be deemed to constitute notice of an amendment to the network participation agreement of Arkansas Blue Cross and Health Advantage participating providers.

8. With respect to Arkansas' FirstSource® PPO and True Blue PPO networks of USAble Corporation, the same policies and procedures as referenced above shall apply, with the only variation being that USAble Corporation is not a payer of any claims of self-funded groups that access these networks; accordingly, payment of all such self-funded group claims is always subject to funding and direction of the employer sponsor as Plan Administrator of such plans.

**This article was originally published in the September 2008 issue of Providers' News.*

Prior authorization of CPT 21089*

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

Real-Time Benefits: Saves You Time and Your Patients Money on Prescription Drug Coverage

As we quickly approach the new year, your patients may experience changes in their drug coverage beginning January 1, 2022. A great way to handle this change is through an application that may be available with your electronic health record (EHR). Real-Time Benefits will allow you to view, in real-time, patient-specific drug coverage at the point of prescribing, including insight into:

- If the drug you want to prescribe is covered under your patient's prescription drug plan.
- How much the patient will pay out of pocket (OOP) based on their specific benefits. This cost may be based on

copay or coinsurance and/or where they are in their deductible.

- A list of clinically appropriate lower-cost brand and generic alternatives that you could consider prescribing to save your patients money (Response time within 1 second).
- Which therapy options require prior approval (PA) or have other restrictions such as step therapy or quantity limits.
- The ability to initiate a prior approval request.
- If the pharmacy you select is in your patient's network.

There is **no charge** for this functionality — you just need the latest version of your EHR. The following systems and versions are currently integrated with Real-Time Benefits, providing real-time prescription benefit information.

EHR Systems and Versions Enabled	
AdvancedMD AdvancedEHR	MD Office Manager GeeseMed EHR
Allscripts Professional	Medical Office Solutions Adaptamed
Aprima (v2016 – 16.0.1612.2146)	MedNet Medical Solutions emr4MD
Cerner Millennium (v2015.01.25)	Modernizing Medicine EMA
Claimat	MTBC ChartsPro
Comtron Medgen EHR	Office Ally EHR 24/7
eMedicalNotes (v3.0)	Practice Fusion
Enabledoc Enablemypractice EHR	Quest Quanum EHR
Epic EpicCare (Epic2018)	Waiting Room Solutions WRS Health (v5.0)
e-Prescribing Solutions Enabled	Specialty Portal/Hub Solutions Enabled
Allscripts ePrescribe	Asembia
DrFirst	ReMY Health
eazyScripts (v3.0)	United Biosource
InstantDx OnCallData (v5.0)	VirMedica
MD Toolbox	
eClinical Works implementation coming in 2022	
e-Prescribing Solutions Enabled	**Specialty Portal/Hub Solutions Enabled**
Allscripts ePrescribe	Asembia
DrFirst	ReMY Health
eazyScripts (v3.0)	United Biosource
InstantDx OnCallData (v5.0)	VirMedica
MD Toolbox	
eClinical Works implementation coming in 2022	

If your EHR vendor or version is not listed, contact them to let them know your providers need patient-specific drug benefit and cost information in their e-prescribing workflow. Ask if they have contracted with Surescripts for real-time prescription benefits.

If you are not using the most recent version of your EHR's system, contact your EHR vendor account manager to have the most recent update installed.

Still having trouble accessing Real-Time Benefits? Contact your EHR vendor's help desk support line. For Epic users, work with your Ambulatory and Bridges TS representative and log a ticket with Surescripts.

Join over 3300 Arkansas prescribers for Arkansas Blue Cross, Health Advantage and select groups with Blue Advantage Administrators, who have used this functionality through innovations from CVS Caremark.

Physicians with access to **Real-Time Benefits** at the point of prescribing are selecting lower-cost alternatives 40% of the time and when available, saving around $130 per fill on average.

Medical specialty medications prior approval update

On April 1, 2018, Arkansas Blue Cross and Blue Shield and its affiliates enacted prior approval for payment of specialty medications used in treating rare, complex conditions that may go through the medical benefit. Since then, medications have been added to the initial list as products come to market.

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

Drug	Indication	Benefit
Abecma (idecabtagene vicleucel)	Multiple Myeloma	Medical
Adakveo (crizanlizumab-tcma)	Sickle cell disease	Medical
Aldurazyme (laronidase)	MPS I Hurler syndrome	Medical
Arcalyst (rilonacept)	CAPS DIRA Recurrent pericarditis	Medical
Benlysta (belimumab)	Systemic lupus erythematosus Lupus nephritis	Medical
Berinert (c1 esterase, inhib, human)	Hereditary angioedema	Medical
Breyanzi (lisocabtagene maraleucel)	Large B-cell lymphoma	Medical
Brineura (cerolipонase alfa)	CLN2 disease	Medical
Cabenuva (cabotegravir & rilpivirine)	HIV	Medical
Cablivi (caplacizumab-yhdp)	Thrombocytic thrombocytopenia	Medical & Pharmacy
Cinqair (reslizumab)	Severe asthma	Medical
Cinryze (c1 Esterase, inhib, human)	Hereditary angioedema	Medical
Crysvita (burosumab – twza)	Hypophosphatemia Tumor induced steomalacia	Medical & Pharmacy
Duopa (levodopa-carpidopa intestinal gel)	Parkinson's	Medical

Drug	Indication	Benefit
Durysta (bimatoprost)	Open-angle glaucoma Ocular hypertension	Medical
Elaprase (idursulfase)	MPS II Hunter syndrome	Medical
Elzonris (tagraxifusp-erzs)	BPDCN	Medical
Enspryng (satralizumab-mwge)	NMOSD	Medical & Pharmacy
Evenity (romosozumab-aqqg)	Severe Osteoporosis	Medical
Evkeeza (evinacumab-dgnb)	Homozygous familial hypercholesterolemia	Medical
Fabrazyme (agalsidase beta)	Fabry disease	Medical
Fasenra (benralizumab)	Mod to severe asthma	Pharmacy
Firazyr (icatabant acetate)	Hereditary angioedema	Pharmacy
Gamifant (emapalumab-lzsg)	Hemophagocytic lymphohistiocytosis	Medical
Givlaari (givosiran)	Acute hepatic porphyria	Medical
Haegarda (c1 esterase, inhib, human)	Hereditary angioedema	Pharmacy
Ilaris (canakinumab)	Periodic fever syndrome Still's disease	Medical & Pharmacy
Kalbitor (ecallantide)	Hereditary angioedema	Medical & Pharmacy
Krystexxa (pegloticase)	Gout	Medical
Kymriah (tisagenlecleucel)	Cancers	Medical *Reviewed by Transplant Coordinator
Lemtrada (alemtuzumab)	Multiple Sclerosis	Medical
Lumizyme (alglucosidase alfa)	Pompe Disease	Medical
Lutathera (lutetium Lu 177 Dotatate)	Neuroendocrine tumors	Medical
Mepsevii (vestronidase-Alfa)	MPS VII Sly syndrome	Medical
Myalept (metreleptin)	Lipodystrophy	Pharmacy
Nagalzyme (galsulfase)	MPS VI Maroteaux-Lamy syndrome	Medical
Nucala (mepolizumab)	Mod to severe asthma Hypereosinophilic syndrome	Pharmacy

Drug	Indication	Benefit
Oxlumo (lumasiran)	Primary hyperoxaluria	Medical
Reblozyl (luspatercept)	Beta thalassemia	Medical
	Myelodysplastic syndrome	
Ruconest (c1 esterase, inhib, recombinant)	Hereditary angioedema	Medical
Soliris (eculizumab)	PNH	Medical
	aHUS	
	Myasthenia Gravis	
	NMOSD	
Spinraza (nusinersen)	Spinal muscle atrophy	Medical
Spravato (esketamine)	Treatment resistant depression	Pharmacy
	Major depressive disorder with suicidality	
Stelara (ustekinumab)	Crohn's disease	Medical & Pharmacy
	Plaque psoriasis	
	Psoriatic arthritis	
	Ulcerative colitis	
Strensiq (asfotase alfa)	Hypophosphatasia	Pharmacy
Takhzyro (lanadelumab)	Hereditary angioedema	Pharmacy
Tecartus (brexucabtagene autoleucel)	Mantle cell lymphoma	Medical
Tepezza (teprotumumab)	Thyroid eye disease	Medical
Ultomiris (ravulizumab-cwyz)	PNH	Medical
Uplizna (inebilizumab)	Neuromyelitis optica spectrum disorder	Medical
Vimizim (elosulfase alfa)	MPS IV	Medical
	Morquio A	
Yescarta (axicabtagene ciloleucel)	Cancers	Medical *Reviewed by Transplant Coordinator
Xolair (omalizumab)	Mod to severe asthma	Pharmacy
	Urticaria	
Zolgensma (onasmnogene abeparvovec-XIOI)	Spinal muscle atrophy	Medical
Zulresso (brexanolone)	Postpartum depression	Medical

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

Customer service will direct callers to the prior approval form specific to the member's group.

BlueAdvantage members can find the form at the following link: https://www.blueadvantagearkansas.com/providers/forms.aspx.

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

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

Self-administered medication policy #2020005 update

In March 2020, Arkansas Blue Cross and Blue Shield and its affiliates began requiring self-administered medications to be obtained through the member's pharmacy benefit. Medications are determined as self-administered primarily when the medication does not require administration or direct supervision by a qualified healthcare provider. As an update to the Self-Administered Medication Policy #2020005 published in March 2020, a list of medications covered by that policy has been added. Below is a list of medications that are considered self-administered by FDA labeling.

All newly initiated self-administered medications should be directed to the pharmacy benefit as of April 1, 2021. Please refer to the Self-Administered Medication Policy #2020005 for additional information.

Brand Name (generic name)	HCPCS Code
Actimmune (interferon gamma-1b)	J9216
Aimovig (erenumab)	J3590
Ajovy (fremanezumab-vfrm)	J3031
Avonex (interferon beta-1a)	J1826
Betaseron (interferon beta-1b)	J1830
Copaxone (glatiramer acetate)	J1595
Cosentyx (secukinumab)	J3590
Dupixent (dupilumab)	J3590
Egrifta (tesamorelin acetate)	J3490
Emgality (galcanezumab-gnlm)	J3590
Enbrel (etanercept)	J1438
Extavia (interferon beta-1b)	J1830
Fasenra (benralizumab)	J0517
Firazyr (icatibant)	J1744
Genotropin (somatropin)	J2941
Glatopa (glatiramer acetate)	J1595
Haegarda (c-1 esterase inhibitor)	J0599
Humatrope (somatropin)	J2941
Humira (adalimumab)	J0135
Increlex (mecasermin)	J2170
Kesimpta (ofatumumab)	J3590
Kevzara (sarilumab)	J3590
Kineret (anakinra)	J3590
Kynamro (mipomersen sodium)	J3490
Myalept (metreleptin)	J3950
Norditropin (somatropin)	J2941
Nutropin (somatropin)	J2941

Brand Name (generic name)	HCPCS Code
Nucala (mepolizumab)	J2181
Omnitrope (somatropin)	J2941
Plegridy (Peginterferon beta-1a)	J3490
Praluent (alirocumab)	J3490
Rebif (Interferon beta-1a)	Q3028 Q3026
Repatha (evolucumab)	J3490
Saizen (somatropin)	J2941
Siliq (brodalumab)	J3590
Skyrizi (risankizumab-rzaa)	J3590
Sogroya (somapacitan-beco)	J3590
Strensiq (asfotase alfa)	J3490
Takhzyro (lanadelumab-flyo)	J0593
Taltz (ixekizumab)	J3590
Tremfya (guselkumab)	J1628
Xolair (omalizumab)	J2357
Zomacton (somatropin)	J2941
Zorbtive (somatropin)	J2941

Metallic formulary changes effective January 1, 2022

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.

Drug Affected	Change	Alternatives
APTIOM TAB 200MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
APTIOM TAB 400MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
APTIOM TAB 600MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
APTIOM TAB 800MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
BENAZEP/HCTZ TAB 5-6.25	Not Covered	benazep/hctz tab 10-12.5, 20-12.5, 20-25, benazepril tab, hydrochlorot cap/tab
BEPREVE SOL 1.5% OP	Not Covered	generic bepotastine dro 1.5%
BEVESPI AER 9-4.8MCG	Move to Higher Copay Tier	ANORO ELLIPT AER, STIOLTO AER
BEVESPI INH 9-4.8MCG	Move to Higher Copay Tier	ANORO ELLIPT AER, STIOLTO AER
BRIVIACT TAB 100MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
BRIVIACT TAB 50MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
BUTALBITAL-ACETAMINOPHEN TAB	Prior Approval with Quantity Limit	
BUTALBITAL-ACETAMINOPHEN-CAFF W/ CODEINE CAP	Prior Approval with Quantity Limit	
BUTALBITAL-ACETAMINOPHEN-CAFFEINE CAP/TAB	Prior Approval with Quantity Limit	
BUTALBITAL-ASPIRIN-CAFFEINE CAP	Prior Approval with Quantity Limit	
CALCIPOT/BET OIN .005/.06	Step Therapy Required	"generic topical steroid; Quantity limit 60 gm every 25 days "

Drug Affected	Change	Alternatives
CALCIPOTRIEN SOL 0.005%	Step Therapy Required	"generic topical steroid; Quantity limit 60 ml every 25 days "
CALCITRIOL OIN 3MCG/GM	Step Therapy Required	"generic topical steroid; Quantity limit 100 gm every 25 days "
CRESEMBA	Not Covered	fluconazole, itraconazole, posaconazole, voriconazole
EDARBI TAB 40MG	Not Covered	candesartan tab, irbesartan tab, losartan pot tab, olmesa medox tab, telmisartan tab, valsartan tab
EDARBI TAB 80MG	Not Covered	candesartan tab, irbesartan tab, losartan pot tab, olmesa medox tab, telmisartan tab, valsartan tab
FC2 FEMALE MIS CONDOM	Quantity Limit Added	Quantity limit 12 condoms every 25 days
FML FORTE SUS 0.25% OP	Not Covered	dexameth pho sol op, DUREZOL EMU, FML OIN, loteprednol sus, PRED SOD PHO SOL OP, prednisolone sus op
FYCOMPA TAB 12MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
FYCOMPA TAB 2MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
FYCOMPA TAB 4MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
FYCOMPA TAB 6MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
FYCOMPA TAB 8MG	Not Covered	carbamazepine, divalproex, felbamate, lamotrigine, levetiracetam, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, VIMPAT, XCOPRI, zonisamide
GABAPENTIN CAP 100MG	Quantity Limit Added	Quantity limit 6 capsules every day
GABAPENTIN CAP 300MG	Quantity Limit Added	Quantity limit 6 capsules every day
GABAPENTIN CAP 400MG	Quantity Limit Added	Quantity limit 6 capsules every day
GABAPENTIN TAB 600MG	Quantity Limit Added	Quantity limit 6 capsules every day
GABAPENTIN TAB 800MG	Quantity Limit Added	Quantity limit 4 tablets every day
HUMATROPE INJ 12MG	Not Covered	NORDITROPIN INJ
HUMATROPE INJ 24MG	Not Covered	NORDITROPIN INJ
HUMATROPE INJ 6MG	Not Covered	NORDITROPIN INJ
HYOSCYAMINE ODT 0.125MG	Not Covered	dicyclomine cap/soln/tab, glycopyrrol tab, methscopolam tab
HYOSCYAMINE SUB 0.125MG	Not Covered	dicyclomine cap/soln/tab, glycopyrrol tab, methscopolam tab

Drug Affected	Change	Alternatives
HYOSCYAMINE TAB 0.125MG	Not Covered	dicyclomine cap/soln/tab, glycopyrrol tab, methscopolam tab
INCRUSE ELPT INH 62.5MCG	Not Covered	SPIRIVA AER/CAP HANDIHLR/SPR
INTELENCE	Not Covered	etravirine tab
KALETRA TAB 200-50MG	Not Covered	generic lopin/riton tab 200-50MG
KETOCONAZOLE SHA 2%	Quantity Limit Added	Quantity limit 120 ml every 25 days
LASTACAFT SOL 0.25% OP	Not Covered	azelastine dro, bepotastine dro, cromolyn sod sol op, epinastine dro, olopatadine dro, olopatadine sol
MALATHION LOT 0.5%	Step Therapy Required	permethrin
MAXIDEX SUS 0.1% OP	Not Covered	dexameth pho sol op, DUREZOL EMU, FML OIN, loteprednol sus, PRED SOD PHO SOL OP, prednisolone sus op
METHYLDOPA TAB 500MG	Move to Higher Copay Tier	clonidine dis/tab, guanfacine tab, hydralazine tab, labetalol tab
NEULASTA INJ 6MG/0.6M	Not Covered	ZIEXTENZO INJ
OSPHENA TAB 60MG	Move to Higher Copay Tier	estradiol cre, IMVEXXY MAIN SUP/STRT SUP
OXYCONTIN ER TAB 10MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN ER TAB 15MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN ER TAB 20MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN ER TAB 30MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN ER TAB 40MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN ER TAB 60MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN ER TAB 80MG	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN TAB 10MG CR	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OXYCONTIN TAB 20MG CR	Not Covered	hydrocodone tab er, oxycodone tab er, XTAMPZA ER CAP
OZEMPIC	Added Quantity Limit; Prior Approval required	
PERFOROMIST NEB 20MCG	Not Covered	generic formoterol neb 20/2ML
PRED MILD SUS 0.12% OP	Move to Higher Copay Tier	dexameth pho sol op, DUREZOL EMU, FML OIN, loteprednol sus, PRED SOD PHO SOL OP, prednisolone sus op
SPINOSAD SUS 0.9%	Step Therapy Required	permethrin
SURPREP BOWEL PREP KIT	Not Covered	CLENPIQ SOL
SUTENT CAP 37.5MG	Not Covered	generic sunitinib cap 37.5MG
TRACLEER TAB 32MG	Not Covered	ambrisentan tab, bosentan tab, OPSUMIT TAB
TRANDO/VERAP TAB 2-180 ER	Not Covered	trando/verap tab 1-240 er, 2-240 er, trandolapril tab, verapamil cap er/tab/tab er

Drug Affected	Change	Alternatives
TRANDO/VERAP TAB 4-240 ER	Not Covered	trando/verap tab 1-240 er, 2-240 er, trandolapril tab, verapamil cap er/tab/tab er
TRULICITY	Added Quantity Limit; Prior Approval required	
UDENYCA	Not Covered	ZIEXTENZO INJ
V-GO	Not Covered	Omnipod DASH
VICTOZA	Added Quantity Limit; Prior Approval required	
ZILEUTON ER TAB 600MG	Prior Approval Required	Consult prescriber

Standard formulary changes effective January 1, 2022

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

Standard Formulary changes - Effective 1/1/2022

Drug Affected	Change	Alternatives
AFINITOR TAB 10MG	Not Covered	everolimus, AFINITOR DISPERZ
AIMOVIG 1PK INJ 70MG/ML	Not Covered	AJOVY, EMGALITY
AIMOVIG PEN 140MG/ML	Not Covered	AJOVY, EMGALITY
Aranesp	Not Covered	Retacrit (epoetin alfa-epbx)
ATRIPLA TAB	Not Covered	efavirenz-emtricitabine-tenofovir disoproxil fumarate, efavirenz-lamivudine-tenofovir disoproxil fumarate, BIKTARVY, DOVATO, GENVOYA, ODEFSEY, STRIBILD, SYMTUZA, TRIUMEQ
BALCOLTRA TAB 0.1-20	Not Covered	ethinyl estradiol-drospirenone, ethinyl estradiol-drospirenone-levomefolate, ethinyl estradiol-levonorgestrel, ethinyl estradiol-norethindrone acetate, ethinyl estradiol-norethindrone acetate-iron, ethinyl estradiol-norgestimate
BOTOX INJ 100UNIT	Not Covered	Consult doctor
BOTOX INJ 200UNIT	Not Covered	Consult doctor

Drug Affected	Change	Alternatives
Cleocin T	Move to Higher Copay Tier	adapalene, adapalene-benzoyl peroxide, benzoyl peroxide, clindamycin gel (except NDC 68682046275), clindamycin lotion, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin gel 2%, erythromycin solution, erythromycin-benzoyl peroxide, sulfacetamide lotion 10%, tazarotene, tretinoin, tretinoin – Avita, tretinoin gel microsphere, Benzac AC (benzoyl peroxide), Benzamycin (erythromycin-benzoyl peroxide), Epiduo (adapalene-benzoyl peroxide)
COMPLERA TAB	Not Covered	efavirenz-emtricitabine-tenofovir disoproxil fumarate, efavirenz-lamivudine-tenofovir disoproxil fumarate, BIKTARVY, DOVATO, GENVOYA, ODEFSEY, STRIBILD, SYMTUZA, TRIUMEQ
Doptelet	Move to Higher Copay Tier	Promacta (eltrombopag) and Tavalisse (fostamatinib)
DDAVP TAB 0.1MG	Move to Higher Copay Tier	desmopressin spray, desmopressin tablet
ELIQUIS ST P TAB 5MG	Not Covered	warfarin, XARELTO
ELIQUIS TAB 2.5MG	Not Covered	warfarin, XARELTO
ELIQUIS TAB 5MG	Not Covered	warfarin, XARELTO
Glucotrol XL	Move to Higher Copay Tier	glimepiride, glipizide, glipizide ext-rel and Amaryl (glimepiride)
HAEGARDA INJ 2000UNIT	Not Covered	ORLADEYO, TAKHZYRO
HAEGARDA INJ 3000UNIT	Not Covered	ORLADEYO, TAKHZYRO
ICLUSIG TAB 30MG	Not Covered	imatinib mesylate, BOSULIF, SPRYCEL
Mulpleta	Not Covered	Consult doctor
Nplate	Not Covered	Promacta (eltrombopag) and Tavalisse (fostamatinib)
REYVOW TAB 100MG	Move to Higher Copay Tier	eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan, NURTEC ODT, ONZETRA XSAIL, UBRELVY, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY
REYVOW TAB 50MG	Move to Higher Copay Tier	eletriptan, naratriptan, rizatriptan, sumatriptan, zolmitriptan, NURTEC ODT, ONZETRA XSAIL, UBRELVY, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY
Trusopt	Move to Higher Copay Tier	brinzolamide and dorzolamide
TRUVADA TAB 200-300	Not Covered	abacavir-lamivudine, emtricitabine-tenofovir disoproxil fumarate, CIMDUO, DESCOVY, TEMIXYS

Standard Formulary additions - Effective 1/1/2022

Product brand drug	Therapeutic category/subcategory
Auvi-Q (epinephrine) intramuscular/ subcutaneous solution for injection	Respiratory/ Anaphylaxis Treatment Agents
Avonex (interferon beta-1a) intramuscular solution for injection	Central Nervous System/ Multiple Sclerosis
Brukinsa (zanubrutinib) oral capsule	Antineoplastic Agents/ Kinase Inhibitors
Enspryng (satralizumab-mwge) subcutaneous solution for injection	Immunologic Agents/ Immunosuppressants/ Monoclonal Antibodies
Imbruvica (ibrutinib) oral capsule, oral tablet	Antineoplastic Agents/ Kinase Inhibitors
Kerendia (finerenone) oral tablet	Endocrine and Metabolic/ Diabetic Kidney Disease
Lupron Depot-PED (leuprolide acetate) intramuscular suspension for injection	Endocrine and Metabolic/ Central Precocious Puberty
Myfembree (relugolix-estradiol-norethindrone acetate) oral tablet	Endocrine and Metabolic/ Uterine Fibroids
Orladeyo (berotralstat) oral capsule	Immunologic Agents/ Hereditary Angioedema
Plegridy	Central Nervous System/ Multiple Sclerosis
Promacta (eltrombopag) oral powder for suspension, oral tablet	Hematologic/Thrombocytopenia Agents
Qelbree (viloxazine ext-rel) oral extended-release capsule	Central Nervous System/ Attention Deficit Hyperactivity Disorder
Rozlytrek (entrectinib) oral capsule	Antineoplastic Agents/ Kinase Inhibitors
Tavalisse (fostamatinib) oral tablet	Hematologic/Thrombocytopenia Agents
Verquvo (vericiguat) oral tablet	Cardiovascular/ Heart Failure
Vitrakvi (larotrectinib) oral capsule, oral solution	Antineoplastic Agents/ Kinase Inhibitors
Wakix (pitolisant) oral tablet	Central Nervous System/ Narcolepsy
Xywav (calcium, magnesium, potassium, and sodium oxybates) oral solution	Central Nervous System/ Narcolepsy
Zykadia (ceritinib) oral tablet	Antineoplastic Agents/ Kinase Inhibitors

Federal Employee Program

2022 FEP Benefit Changes

Open Season takes place November 8 - December 13. Here are the changes and updates for the three FEP benefit plans.

Changes to all FEP plans

All EKGs will be covered under regular medical benefits. Previously, FEP covered one per calendar year for adults as a preventive benefit with no member cost-share.

Standard Option changes

- Member cost share associated with care received from non-participating providers who cannot balance bill under the No Surprises Act (NSA) will be applied to the Preferred Provider catastrophic out-of-pocket maximum.
- For Self Only contracts, the Preferred Provider catastrophic out-of-pocket maximum will be $6,000. For Self Plus One and Self and Family contracts, the Preferred Provider catastrophic out-of-pocket maximum will be $12,000.
- For Self Only contracts, the non-preferred provider catastrophic out-of-pocket maximum will be $8,000. For Self Plus One and Self and Family contracts, the non-preferred provider catastrophic out-of-pocket maximum will be $16,000.
- Member or non-member facility admissions due to a medical emergency or accidental injury will have a $350 per admission copayment for unlimited days. FEP will then provide benefits at 100% of the Plan allowance.

Basic Option changes

- For Self Only contracts, the Preferred Provider catastrophic out-of-pocket maximum will be $6,500. For Self Plus One and Self and Family contracts, the Preferred Provider catastrophic out-of-pocket maximum will be $13,000.
- Member cost share for some services to treat a covered accidental dental injury will be subject to a 30% coinsurance.
- Pharmacy benefit changes:
  - The member cost-share for a Tier 4 preferred specialty drug will be an $85 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy.
  - The member cost-share for a Tier 5 non-preferred specialty drug will be a $110 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy.
  - For members with Medicare Part B primary, the cost share for a Tier 4 preferred specialty drug will be an $80 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy.

- For members with Medicare Part B primary, the cost share for a Tier 5 non-preferred specialty drug will be a $100 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy.

Standard and Basic Option changes

- Prior approval of coverage will no longer be required for surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth for care provided within 72 hours of the accidental injury.
- Members will no longer be responsible for the difference between the FEP allowance and a non-participating provider's billed charges in certain situations described under the No Surprises Act (NSA) federal legislation.
- Group counseling on prevention and reducing health risks will be covered, and group nutritional counseling will be covered under the preventive benefit.
- Under the maternity benefit, breast pump and milk storage bags for members who are pregnant and/or nursing will be covered when ordered through our fulfillment vendor.
- Kidney transplants will be part of the Blue Distinction Centers for Transplants® Program and will require prior approval.
- Nipple reconstruction after a mastectomy for female to male gender reassignment surgery will be covered.
- We will no longer offer pancreas transplants as part of the Blue Distinction Centers for Transplants® Program.
- We will cover tubeless insulin delivery systems under the Tier 2 and Tier 3 pharmacy benefit instead of the durable medical equipment benefit.
- For inpatient stays at non-member facilities resulting from medical emergencies, accidental injuries or for emergency deliveries, our allowance will be the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations.
- For outpatient services resulting from a medical emergency or accidental injury and billed by a non-member facility, our allowance will be the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations.
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA that do not contract with the member's local Blue Cross and Blue Shield Plans and cannot balance bill you under this regulation, our allowance is now equal to the lesser of the billed amount or the qualifying payment amount (QPA).
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered healthcare professionals that do not contract with the member's local Blue Cross and Blue Shield Plan, our allowance will be equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations.
- We will no longer limit the difference between the Non-participating Provider Allowance (NPA) and the amount billed to $5,000 when care is received in a Preferred facility from certain non-participating professional providers. Federal regulations now limit what members can be billed in these situations.

Blue Focus changes

- Members will no longer be responsible for the difference between our allowance and a non-participating provider's billed charges in certain situations described under the No Surprises Act (NSA) federal legislation.
- For Self Only contracts, the catastrophic out-of-pocket maximum will be $8,500. For Self Plus One and Self and Family contracts, the catastrophic out-of-pocket maximum will be $17,000.
- All EKGs will be covered under regular medical benefits. Previously, FEP covered one per calendar year for adults as a preventive benefit with no member cost-share.
- We will cover group counseling on prevention and reducing health risks and group nutritional counseling

under the preventive benefit.

- Under the maternity benefit, breast pump and milk storage bags for members who are pregnant and/or nursing will be covered when ordered through our fulfillment vendor.
- Nipple reconstruction after a mastectomy for female to male gender reassignment surgery will be covered.
- We will no longer offer pancreas transplants as part of the Blue Distinction Centers for Transplants® Program.
- We will provide coverage for tubeless insulin delivery systems under the Tier 2 pharmacy benefit instead of the durable medical equipment benefit.
- For inpatient stays at non-member facilities resulting from medical emergencies, accidental injuries or for emergency deliveries, our allowance will be the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations.
- For outpatient services resulting from a medical emergency or accidental injury and billed by a non-member facility, our allowance will be the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations.
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA that do not contract with the member's local Blue Cross and Blue Shield Plans and cannot balance bill the member under this regulation, our allowance is now equal to the lesser of the billed amount or the qualifying payment amount (QPA).
- For emergency medical and mental health and substance use disorders services performed in the emergency department of a hospital provided by physicians and other covered healthcare professionals that do not contract with the local Blue Cross and Blue Shield Plan, our allowance is equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations.
- We will no longer limit the difference between the Non-participating Provider Allowance (NPA) and the amount billed to $5,000 when care is received in a Preferred facility from certain non-participating professional providers. Federal regulations now limit what members can be billed in these situations.

FEP adds high-tech radiology authorization program using AIM

Beginning in the second quarter of 2022, Arkansas Blue Cross and Blue Shield will require prior authorization for outpatient, non-emergent imaging for the Federal Employee Program (FEP). We will inform providers of the specific date as soon as possible.

The following procedures are included in the program:

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

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

The prior authorization requirement has been in effect for Arkansas Blue Cross, Health Advantage and Blue Advantage Administrators of Arkansas members since January 2019. This requirement does not apply to Medicare Advantage members.

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

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

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

Magellan to manage specialty drugs for Federal Employees Program

Notice of material amendment to the Arkansas Blue Cross and Blue Shield Federal Employee Program

In the coming weeks, Arkansas Blue Cross and Blue Shield's Federal Employee Program (FEP) will be implementing a change in the way we manage **certain specialty drugs** that fall under the FEP medical benefit. This new program will be administered by **Magellan Rx Management** (Magellan Rx).

This new program supports the provision of high-quality healthcare that is consistent with evidence-based, nationally recognized clinical criteria and guidelines.

Beginning **February 21, 2022**, providers should contact Magellan Rx to obtain **prior authorizations** for applicable drugs for FEP members for **dates of service** on or after **March 1, 2022.**

Providers will be able to complete the prior authorization process via the internet or by phone. Prior authorization will be required for the medical specialty drugs when they are administered in the following settings:

- Physician office (CMS Place of Service code 11)
- Patient homes (CMS Place of Service code 12)
- Outpatient facilities (CMS Place of Service codes 19 and 22)
- Inpatient – Chimeric antigen receptor T cell (CAR-T) therapy only – (CMS Place of Service code 21)

A Frequently Asked Questions (FAQ) document and list of affected drugs may be found on the **Arkansas Blue Cross and Blue Shield website**.

Magellan Rx Management will host the following web-based training sessions:

- **February 9, 2022:**
  - 8 a.m. CST
  - Noon CST
- **February 15, 2022**
  - 8 a.m. CST
  - Noon CST
- **February 17, 2022:**
  - 8 a.m. CST
  - Noon CST

Please watch for an email, AHIN alerts, Availity alerts and this newsletter for information on how to sign up for an online training session.

We appreciate your support to ensure our members continue receiving high-quality and clinically appropriate care. If you have questions, please contact the provider service line at 800-482-6655.

Medicare Advantage

Prior authorization updates

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

Updates for Medicare Advantage Prior Authorization List effective January 1, 2022

Effective January 1, 2022, Arkansas Blue Medicare and Health Advantage Medicare Advantage plans will implement a process change for the codes listed below. The current process for listed codes triggers a post-service medical review. Effective January 1, 2022, prior authorization of coverage for the following codes will be required prior to administering medications by a health care professional. Prior authorization requests can be made by calling Arkansas Blue Medicare Customer Service at 1-844-463-1088 (TTY call 711).

Brand Name	HCPCS Code
ABECMA	
ACTEMRA	J3262
ADAKVEO	J0791
ADVATE	J7192
ADYNOVATE	J7207
AFSTYLA	J7210
AKYNZEO	J1454
ALDURAZYME	J1931
ALOXI	J2469
ALPHANINE SD	J7193
ALPROLIX	J7201
ARALAST NP	J0256
ARANESP ALBUMIN FREE	J0881
ASCENIV	J1554
AVEED	J3145
AVSOLA	Q5121
BEBULIN	J7194
BENEFIX	J7195
BENLYSTA	J0490
BEOVU	J0179
BIVIGAM	J1556
BLENREP	C9069

Brand Name	HCPCS Code
BOTOX/BOTOX COSMETIC	J0585
BREYANZI	C9076
CARIMUNE NANOFILTERED	J1566
CEREZYME	J1786
CIMZIA/CIMZIA STARTER KIT	J0717
CINQAIR	J2786
CINVANTI	J0185
COAGADEX	J7175
COSENTYX	
CRYSVITA	J0584
CUTAQUIG	
CUVITRU	J1555
DEPO-TESTOSTERONE	J1071
DOXIL	J9001
DOXORUBICIN HYDROCHLORIDE LIPOSOMAL	J9001
DUROLANE	J7318
DURYSTA	J7351
DYSPORT	J0586
ELAPRASE	J1743
ELELYSO	J3060
ELITEK	J2783

Brand Name	HCPCS Code
ELOCTATE	J7205
EMEND	J1453
ENTYVIO	J3380
EPOGEN	J0885
EPOPROSTENOL SODIUM	J1325
ESPEROCT	J7204
EUFLEXXA	J7323
EVENITY	J3111
EYLEA	J0178
FABRAZYME	J0180
FASENRA	J0517
FERAHEME	Q0138
FERUMOXYTOL	
FIBRYGA	J7177
FLEBOGAMMA DIF	J1572
FLOLAN	J1325
FOSAPREPITANT DIMEGLUMINE	J1453
FULPHILA	Q5108
GAMASTAN	J1460/J1560
GAMIFANT	J9210
GAMMAGARD LIQUID	J1569
GAMMAGARD S/D IGA LESS THAN 1MCG/ML	J1566
GAMMAKED	J1561
GAMMAPLEX	J1557
GAMUNEX-C	J1561
GEL-ONE	J7326
GELSYN-3	J7328
GENVISC 850	J7320
GIVLAARI	J0223
GLASSIA	J0257
GRANIX	J1447
HELIXATE FS	J7192
HEMLIBRA	J7170
HEMOFIL M	J7190
HIZENTRA	J1559
HYALGAN	J7321
HYDROXYPROGESTERONE CAPROATE	J1726
HYMOVIS	J7322
HYQVIA	J1575
IDELVION	J7202
ILUMYA	J3245
INFLECTRA	Q5103
INJECTAFER	J1439
ISTODAX (OVERFILL)	J9314

Brand Name	HCPCS Code
IXINITY	J7195
JELMYTO	J9281
JIVI	J7208
KALBITOR	J1290
KANUMA	J2840
KOATE	J7190
KOATE-DVI	J7190
KOGENATE FS	J7192
KOVALTRY	J7211
KRYSTEXXA	J2507
KYMRIAH	Q2042
LEMTRADA	J0202
LEUKINE	J2820
LUCENTIS	J2778
LUMIZYME	J0221
LUTATHERA	A9513
LUXTURNA	J3398
MACUGEN	J2503
MAKENA	J1726
MARGENZA	J9353
MEPSEVII	J3397
MIRCERA	J0888
MONJUVI	C9070
MONOCLATE-P	J7190
MONOFERRIC	J1437
MONONINE	J7193
MONOVISC	J7327
MOZOBIL	J2562
MYOBLOC	J0587
NAGLAZYME	J1458
NEULASTA	J2505
NEULASTA ONPRO KIT	J2505
NEUPOGEN	J1442
NIVESTYM	Q5110
NOVOEIGHT	J7182
NPLATE	J2796
NUCALA	J2182
NUWIQ	J7209
NYVEPRIA	Q5112
OCREVUS	J2350
OCTAGAM	J1568
OCTREOTIDE ACETATE	J2354
ONPATTRO	J0222
ORENCIA/ORENCIA CLICKJET	J0129
ORTHOVISC	J7324

Brand Name	HCPCS Code
OXLUMO	J0224
PALONOSETRON HYDROCHLORIDE	J2469
PANZYGA	
PARSABIV	J0606
PHESGO	J9316
PRIVIGEN	J1459
PROBUPHINE IMPLANT KIT	J0570
PROCRIT	J0885
PROFILNINE/PROFILNINE SD	J7194
PROLASTIN-C	J0256
PROLIA	J0897
RADICAVA	J1301
REBINYN	J7203
REBLOZYL	J0896
RECOMBINATE	J7192
REMICADE	J1745
REMODULIN	J3285
RENFLEXIS	Q5104
RETACRIT	Q5105
RIABNI	Q5123
RIASTAP	J7178
RIXUBIS	J7200
ROMIDEPSIN	J9314
SANDOSTATIN	J2354
SANDOSTATIN LAR DEPOT	J2353
SARCLISA	J9227
SCENESSE	J7352
SIGNIFOR LAR	J2502
SIMPONI ARIA	J1602
SINUVA	J7402
SODIUM HYALURONATE	J7323
SOLIRIS	J1300
SOMATULINE DEPOT	J1930
SPINRAZA	J2326
STELARA	J3357
SUBLOCADE	Q9992
SUBLOCADE	Q9991
SUPARTZ FX	J7321
SUSTOL	J1627
SYNAGIS	C9003
SYNVISC/SYNVISC ONE	J7325

Brand Name	HCPCS Code
SYNVISC ONE	J7325
TALTZ	
TECARTUS	Q2053
TEGSEDI	
TEPEZZA	J3241
TESTOPEL	S0189
TESTOSTERONE CYPIONATE	J1071
TESTOSTERONE ENANTHATE	J3121
TREPROSTINIL	J3285
TRILURON	J7332
TRIVISC	J7329
TRODELVY	C9066
TYSABRI	J2323
UDENYCA	Q5111
ULTOMIRIS	J1303
UNITUXIN	
UPLIZNA	J1823
VELETRI	J1325
VIMIZIM	J1322
VISCO-3	J7321
VISCO-3	7321
VISUDYNE	J3396
VIVITROL	J2315
VPRIV	J3385
VYEPTI	J3032
XEMBIFY	J1558
XEOMIN	J0588
XGEVA	J0897
XIAFLEX	J0775
XOLAIR	J2357
XYNTHA	J7185
XYNTHA SOLOFUSE	J7185
YESCARTA	Q2041
ZARXIO	Q5101
ZEMAIRA	J0256
ZEPZELCA	J9223
ZEVALIN Y-90	A9543
ZIEXTENZO	C9058
ZOLGENSMA	J3399

Updates for Medicare Advantage Prior Authorization List effective February 1, 2022

Effective February 1, 2022, all Arkansas Blue Medicare and Health Advantage Medicare Advantage plans will implement a process change for the eviCore healthcare Durable Medical Equipment (DME) program. As of February 1, 2022, the following codes will be added to the list for prior authorization of coverage to be reviewed prior to services being rendered.

HCPCS	Description	Class
K1021	Exsufflation belt, includes all supplies and accessories	OXYGEN AND RELATED RESPIRATORY EQUIPMENT
K1022	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	ORTHOSES & PROSTHESES
K1023	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS -TENS
K1024	Non-pneumatic compression controller with sequential calibrated gradient pressure	NON-PNEUMATIC COMPRESSOR AND APPLIANCES
K1025	Non-pneumatic sequential compression garment, full arm	NON-PNEUMATIC COMPRESSOR AND APPLIANCES
K1027	Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment	OXYGEN AND RELATED RESPIRATORY EQUIPMENT

Benefit guidelines: extended day supply

As a continued benefit for Plan Year 2022, Arkansas Blue Medicare and Health Advantage Medicare Advantage plans will continue to cover 100-day supplies of medications. This benefit saves money with members' having fewer copays. Members who have been receiving 30-day supplies have potentially greater savings. The program is designed to increase adherence to medications for diabetes, hypertension and cholesterol while decreasing trips to the pharmacy.

The benefit applies to both mail order and preferred retail pharmacies. Similar programs have resulted in increased adherence rates on STAR medications. Members with three 100-day fills will meet the measure requirements.

Prior authorization fax change reminder

On January 1, 2021, Arkansas Blue Medicare and Health Advantage Medicare Advantage HMO removed the Prior Authorization process from Blue Cross and Blue Shield of Michigan (also referred to as "Advantasure") and started a new Utilization Management program in-house. Providers received notification of this change prior to the implementation and after the transition was complete, but faxes are still misrouted to Advantasure in error, which can result in delays in response. The former Advantasure Prior Authorization fax (1-844-869-4073) number is now

disconnected. **New requests should be sent using the following priority fax numbers:**

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

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

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

This article was originally published in the September 2021 issue of Providers' News.

Annual compliance training

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

Prenatal and Postpartum Care Measures (PPC)

The percentage of deliveries that received a prenatal care visit in the first trimester.

The percentage of deliveries that received a postpartum visit between 7 and 84 days after of delivery.

To Improve Your Score:

- ✓ Code office visits on claim forms for EACH patient visit. (Global billing codes will not capture the first prenatal care visit or the first postpartum visit, and are therefore not useful for HEDIS measurement).
- ✓ Keep a small number of appointment openings on your schedule to accommodate patients requiring a first prenatal care visit in the first trimester, and postpartum visits between 7 and 84 days after of delivery.
- ✓ Schedule postpartum visits from 7 to 84 days after delivery. (Please note that staple removal following a cesarean section does not count as a postpartum visit for HEDIS®)
- ✓ Encourage FEP members who are pregnant to enroll in the Pregnancy Care Incentive Program.

Stand Alone Codes – Visit Date Must Be Specified

Code System	Codes	Definition
CPT-CAT-II Tracking and performance measurement codes	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit, and in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)
	0502F	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care).]
HCPCS	H1000	Prenatal care, at-risk assessment
	H1001	Prenatal care, at-risk enhanced service; antepartum management
	H1002	Prenatal care, at risk enhanced service; care coordination
	H1003	Prenatal care, at-risk enhanced service; education
	H1004	Prenatal care, at-risk enhanced service; follow-up home visit
CPT	99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring

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Global Billing Codes – Visit Date Must Be Specified

Code System	Codes	Definition
CPT	59400	Routine Obstetric Care Including Vaginal Delivery
	59425	Antepartum Care Only; 4-6 Visits
	59426	Antepartum Care Only; 7 or More Visits
	59510	Routine Obstetric Care Including Cesarean Section
	59610	Routine Obstetric Care Vaginal Delivery, Previous Cesarean Section
	59618	Routine Obstetric Care Cesarean Section, Following Attempted Vaginal Delivery After Previous Cesarean Delivery
HCPCS	H1005	Prenatal care, at-risk enhanced service package (includes H1001-H1004) (H1005)

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Blue & You Fitness Challenge

Start 2022 strong and register your team for the Blue & You Fitness Challenge.

Group registration for the 2022 Blue & You Fitness Challenge is open. You can register your team or group now by visiting https://form.jotform.com/bluecares/2022-byfc. The deadline to register your group to participate is January 24!

The Fitness Challenge underwent a complete makeover last year, which includes a new and improved experience with an interactive health and wellness platform that tracks activity and measures standings more easily. The platform includes:

- A point tracking system.
- Ability to sync with wearables.
- New group size categories.
- Automated support from Wellable (the platform host) for reminders, troubleshooting and team maintenance.
- A mobile app (for Apple and Android).
- Ability to earn additional points for engaging in healthy behaviors like drinking eight glasses of water, sleeping seven hours, meditating, etc.
- Ability to view team standings in real time.
- Some online surprises in case we're still socially distanced.

Important Deadlines for the 2022 Challenge:

- **January 24** – deadline for group registration.
- **February 1** – individual participant registration opens.
- **February 28** – deadline for individual registration in groups.
- **March 1** – Challenge begins.

What is the Blue & You Fitness Challenge?

The Blue & You Fitness Challenge, founded in 2004 and hosted by Arkansas Blue Cross and Blue Shield, the Arkansas Department of Health and the Arkansas Department of Human Services, is a free three-month fitness competition in which participants exercise and log their activity. The Challenge is held from March 1 through May 31. Companies and organizations participate in the event as part of their wellness programs, while friends and family use the contest to focus on fitness goals, infuse new energy into their routines, remain connected and have fun! Points gained from logging activity lead to contest recognition and rewards. But the best bonuses are better health and fitness.

For more information, call 1-800-686-2609.

Strong starts here!