

2026

Arkansas Blue Medicare Provider Manual



Arkansas Blue
MEDICARE
An Independent Licensee of the Blue Cross and Blue Shield Association



Updated March 1, 2026

Please note: This document pertains to all Arkansas Blue Medicare networks and plans.

Document Change Log

Change Date	Section and Sub-Section	Description of Substantive Change
3/1/26	Overall Manual	Reorganized content
3/1/26	Throughout Manual	Removed references to BlueMedicare PPO
3/1/26	Preamble	New content
3/1/26	Section 3: Arkansas Blue Medicare Member Identification and Eligibility	Added member identification (ID) card images
3/1/26	Section 11: MA Star Ratings Program (Quality)	Updated Star Ratings measure information

Preamble

This manual applies to all Arkansas Blue Medicare networks and plans.

This manual is available for providers participating in any Medicare Advantage network offered by Arkansas Blue Medicare. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs, or supplies because coverage or non-coverage is always governed exclusively by the terms of the member's health benefit plan. Accordingly, in case of any question or doubt about coverage, providers should always review the member's particular health benefit plan.

Arkansas Blue Medicare may update this manual at any time. These updates may result from a change in Arkansas Blue Medicare policy and/or procedure, or changes required by CMS. Arkansas Blue Medicare may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a letter to providers, publication in the Providers' News or other publications of Arkansas Blue Medicare, or posting to either the Arkansas Blue Medicare website, www.arkansasbluecross.com, or the Arkansas Blue Medicare website, www.arkbluemedicare.com, or CMS may provide notice of changes on the CMS website, www.cms.gov, or through other forms of CMS-approved communications.

Arkansas Blue Medicare makes no representations or warranties with respect to the content hereof. Further, Arkansas Blue Medicare reserves the right to revise this publication without obligation of the Medicare Advantage Organization to notify any person of such revision or changes.

Arkansas Blue Cross and Blue Shield (Arkansas Blue Medicare) is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage and Part D prescription drug plans in the market.

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SECTION 1

Medicare Advantage

Medicare Advantage (MA) Overview

Medicare Advantage (MA) plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B), as well as enhanced benefits beyond the scope of Original Medicare within a single healthcare plan. This flexibility allows Arkansas Blue Medicare to offer enriched plans by using Original Medicare as the base program and adding supplemental benefits, including a Part D prescription drug benefit.

The Arkansas Blue Medicare health maintenance organization (HMO) plans include a network of doctors, other healthcare providers, and hospitals. In an HMO plan, members generally must get their care and services from doctors, other healthcare providers, or hospitals in the plan's network. Exceptions include emergency care, out-of-area urgent care, or out-of-area dialysis.

The Arkansas Blue Medicare private fee-for-service (PFFS) plans include a network of doctors, other healthcare providers, and hospitals. In a PFFS plan, members can see any of the network providers who have agreed to always treat plan members. Members can also choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, but the member may pay more out-of-pocket for services provided out-of-network.

The Arkansas Blue Medicare prescription drug plans (PDPs) include a network of pharmacies. In a PDP, members must use a network pharmacy to get full benefit coverage of their prescription drugs. Members who get their Part D prescriptions at an out-of-network pharmacy may pay more. Prescriptions filled at an out-of-network pharmacy are only covered under limited circumstances. Members in a PDP get their Medicare Part A and Part B services from another source (e.g., Original Medicare).

For more detailed information about Medicare, including MA, visit www.medicare.gov.



SECTION 2

Arkansas Blue Medicare

About Arkansas Blue Medicare

Arkansas Blue Cross and Blue Shield (Arkansas Blue Cross) is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare & Medicaid Services (CMS) to offer Medicare Advantage and Part D prescription drug plans in the market. Arkansas Blue Cross markets Medicare Advantage plans under Arkansas Blue Medicare.

Offices and ArkansasBlue Welcome Centers

Main Office

601 S. Gaines St.
Little Rock, AR 72203

Northwest Corporate Center

5288 W. Don Tyson Pkwy.
Springdale, AR 72762

There are seven full-service ArkansasBlue Welcome Centers throughout the state that offer member and provider support:

- FAYETTEVILLE
- JONESBORO
- FORT SMITH
- PINE BLUFF
- HOT SPRINGS
- ROGERS
- LITTLE ROCK

For welcome center addresses and hours, visit arkansasbluecross.com/support/office-locations.

Contacting Arkansas Blue Medicare

Providers are encouraged to use Availity to inquire about member eligibility, benefits, and coordination of benefits. Log on at apps.availity.com/availity/web/public.elegant.login.

Providers can also:

- Call the Arkansas Blue Medicare provider line at **800-287-4188**. Calls to this line should be made after attempting Availity and are for Arkansas Blue Medicare inquiries only.
- Mail to:

Arkansas Blue Medicare
P. O. Box 3648
Little Rock, AR 72203-3648

Medical Directors

Office Location	Medical Director	Address	Contact Information
Main Office	Dr. Thomas Becker, Medical Director	601 S. Gaines St. Little Rock, AR 72203	tebecker@arkbluecross.com 501-294-6332
Main Office	Dr. Mark Jansen, Chief Medical Officer	601 S. Gaines St. Little Rock, AR 72203	mtjansen@arkbluecross.com 501-294-1611

Medicare Network Specialists and Network Development Representatives

The Medicare network specialists are dedicated MA provider relations representatives who assist with contracting, provider education, and overall provider support.

The network development representatives (NDRs) are the points of coordination for all other Arkansas Blue Cross lines of business and manage contracting, provider education, and overall provider support in their assigned regions.

To get contact information for a Medicare network specialist or network development representative, go to:

- arkansasbluecross.com/providers/resource-center/medicare-network-specialists
- arkansasbluecross.com/providers/resource-center/network-development-reps



SECTION 3

General Information

This Provider Manual

The Arkansas Blue Medicare Provider Manual is a tool to help providers effectively deliver covered services to Arkansas Blue Medicare members. This document will be updated periodically to reflect policy changes and to incorporate feedback intended to enhance its utility. Arkansas Blue Medicare will provide notice of any material changes through one or more of the following channels:

- Newsletter
- Email communication
- Website updates
- Explanation of payment (EOP) or remittance advice
- Other methods deemed appropriate

This manual is designed to serve as a helpful resource that supports the provider's agreement with Arkansas Blue Medicare. In the event of any inconsistency between this manual and the provider agreement, the terms of the provider agreement will take precedence.

Providers' News

Communication is an important factor in delivering quality services to members and educating providers. Providers' News is a quarterly publication designed to update providers and their office staff about changes to Arkansas Blue Medicare policies and procedures, provider workshops, and other relevant topics. The newsletter is sent to all providers who participate with Arkansas Blue Medicare.

The newsletter also covers a variety of industry topics, including:

- Current events relative to Arkansas providers
- Helpful tips for understanding health benefit plans and other coverage options
- Pertinent changes in Arkansas Blue Medicare policies and procedures
- Educational meeting schedules and updates
- General topics of interest

It is essential this publication is read by providers and their staff. A provider's network participation status could be affected by failure to keep abreast of all notices published in the Providers' News.

Provider Portal

The Arkansas Blue Medicare provider portal is powered by Availity. Using the portal is a quick and easy way to:

- Look up member eligibility and benefits
- Submit claims and view remittances
- Determine the need for an authorization
- Submit and check the status of an authorization

Register/Log in at [availity.com](https://www.availity.com).

Information Changes/Updates

Please notify Arkansas Blue Medicare's Provider Network Operations (PNO) team with any changes to provider information. Receipt of updated information will help Arkansas Blue Medicare in providing current information to members and referring physicians.

Providers must update their physical address, remittance address, network status, specialty, and affiliations via the Hub Apply Portal (powered by HealthStream and their CredentialStream tool). Continue reading for more details about the Hub Apply Portal.

If payment to a clinic or group is required, providers should use the Hub Apply Portal, as well.

Fraud, Waste, and Abuse (FWA)

Fraud is the intentional misrepresentation an individual makes that could result in some sort of unauthorized benefit to herself or himself or another person. The most frequent kind of fraud arises from a false statement or misrepresentation regarding entitlement or payment under Medicare.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

If member and/or provider fraud, waste, or abuse is suspected, contact Arkansas Blue Medicare's Special Investigations Unit (SIU) at **800-372-8321** or go to arkansasbluecross.com/report-fraud-and-abuse. All tips are kept strictly confidential and anonymous (if desired).

Anti-Fraud, Waste, and Abuse Policy Statement

As an integral part of its compliance plan, Arkansas Blue Medicare supports and maintains provisions for the prevention, detection, and correction of fraud, waste, and abuse related to all benefits of the plan, including Medicare operations. Under the direction of the Board of Directors, Chief Executive Officer (CEO), Compliance Officer and compliance committees, comprehensive written policies, procedures, and standards of conduct are implemented to comply with all applicable federal and state standards.

Provider Training

Fraud, Waste and Abuse Training

Arkansas Blue Medicare strongly encourages all providers to make every effort to detect, report, and prevent fraud, waste, and abuse. While fraud, waste, and abuse training is deemed for Medicare providers, awareness and prevention materials are made available via various mechanisms (e.g., the Arkansas Blue Medicare website, in the Provider Welcome Kit, in the Provider Directory, and in articles published periodically by Arkansas Blue Medicare). These materials contain the Arkansas Blue Medicare fraud and abuse reporting procedures, as well as potential indicators of fraud, waste, and abuse relevant to the provider setting.

Additionally, Arkansas Blue Medicare annually provides its code of conduct, along with other required CMS training (listed in the next section of this manual).

Annual Compliance Training for Providers

As a CMS contractor, and as stipulated in the Medicare Managed Care Manual (42CFR Parts 422 and 423) Chapter 21: Compliance Program Guidelines and Chapter 9: Prescription Drug Manual, Arkansas Blue Medicare is required to communicate information, including annual compliance training information, to all first-tier, downstream and related entities (FDRs). As FDRs that provide services to Arkansas Blue Medicare members, contracted providers are required to complete annual Medicare compliance training.

It is also the provider's responsibility to ensure all staff serving Arkansas Blue Medicare members complete annual compliance training. This includes front office staff, lab technicians, nurses, billing, and any other ancillary staff.

Compliance training should be completed annually, and no later than December 31, or within 90 days of hire for any new employees.

The Office of Inspector General (OIG) has issued guidance on "effective compliance programs" for specific healthcare providers, which can be found at

[cms.gov/medicare/audits-compliance/part-c-d/compliance-program-policy-and-guidance](https://www.cms.gov/medicare/audits-compliance/part-c-d/compliance-program-policy-and-guidance).

To ensure this training requirement is met, and to largely reduce the duplicative training required of FDRs by multiple organizations with whom they contract, CMS developed web-based compliance training. There are two (2) options to satisfy the general compliance and FWA training requirement as described in CMS regulations and sub-regulatory guidelines.

1. FDRs/Downstream entities (DEs) and their employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN). Once an individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be retained by all FDRs/DEs for ten (10) years.
2. FDRs/DEs may download, view, or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization's existing compliance training materials/systems. To ensure the integrity and completeness of the training, the CMS training content cannot be modified. However, an organization can add to the CMS training to cover topics specific to their organization.

Access the CMS Medicare Learning Network at

cms.gov/training-education/medicare-learning-networkr-mln/resources-training.

In accordance with CMS record retention guidelines, all training documents, including a copy of the training materials and training logs, must be retained by the provider's organization for ten (10) years. All documentation is subject to random audit by Arkansas Blue Medicare or may be requested as part of a Compliance Program Audit by CMS or CMS designees.

Reminders to complete annual training are administered through Availity and online at

arkansasbluecross.com/providers/medical-providers/providers-news.

Appointment Standards for Arkansas Blue Medicare Members

Arkansas Blue Medicare aligns with CMS' appointment standards for access and after-hours care to help ensure timely access to care for members, especially for PCP and behavioral health visits.



Arkansas Blue Medicare continuously monitors access to care and must take corrective action as necessary to ensure appointment wait times in the provider network comply with these standards.

Types of Care	Appointment Standard / Requirement
Routine and preventive	Within 30 business days
Urgent and emergency	Immediately
Services that are not emergency or urgently needed, but require medical attention	Within seven business days
After-hours	24 hours a day/seven days a week

Arkansas Blue Medicare Member Identification and Eligibility

Arkansas Blue Medicare sends all members a member identification (ID) card upon enrollment. This ID card includes important plan information such as member name, ID number, and important plan contact information.

Below is a sample of an Arkansas Blue Medicare member ID card.

		BlueMedicare Premier (HMO)	
Enrollee Name Sam Sample	Plan H6158-001	Members and Providers: www.arkbluemedicare.com	
Enrollee ID PBHAB102xxxx	RxBIN 004336	Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross Blue Shield Association.	Customer Service: 844-463-1088 TTY: 711 Pharmacy Services: 844-280-5833 Pharmacy Help Desk: 866-693-4620 Provider Inquiries: 800-287-4188
Group Number: 16158	RxPCN MEDDADV	Arkansas Providers file claims to: Arkansas Blue Cross P.O. Box 2181 Little Rock, AR 72203-2181	If you suspect fraud: 800-372-8321 Virtual Doctor Visits: MyVirtualHealth.com
	RxGROUP RX17AC	Submit prescription claims to: CVS Caremark Medicare Part D Claims Processing P.O. Box 52066 Phoenix, Arizona 85072-2066	Use of this card is subject to terms of applicable contracts, conditions and user agreements. Medicare limiting charges apply.
	Rx ID AB102xxxx	Out-of-area providers: File Claims with the local BCBS Plan	
	Issued: 01/2026		
MEDICARE ADVANTAGE HMO			

It is the responsibility of each provider to verify a member is eligible for covered services prior to rendering care. Eligibility may be confirmed by logging into the Availity portal at availity.com. Arkansas Blue Medicare is not liable for payment of services furnished to individuals who are not eligible at the time the services are provided.

To help prevent potential fraud or identity theft, providers are encouraged to request a secondary form of identification—such as a driver's license—in addition to the member ID card. Certain services require member cost sharing (e.g., copayments or coinsurance) to be paid. When applicable, the appropriate cost share should be collected from or billed to the member at the time of service.

Providers must maintain a timely process for refunding members when the cost share collected exceeds the allowable amount determined after Arkansas Blue Medicare processes the claim.

Tips to Help with Member Eligibility and Coverage Information

- When a member calls to schedule an appointment, ask for their insurance information.
- When a member arrives at the office, ask to see their Arkansas Blue Medicare (ID) card.
- Maintain a current copy of the front and back of the member's ID card in their medical file.
- When possible, collect any copayments, coinsurance, and deductibles the day services are rendered.
- File claims with Arkansas Blue Medicare within 365 days of date of service, even if MA is not the primary payer.

If a member does not have a valid Arkansas Blue Medicare ID card, providers should access Availity to obtain member eligibility information, using the member's name, date of birth, and full Arkansas Blue Medicare member ID number (including the three-digit alpha numeric prefix).

Privacy

All providers are required to maintain the confidentiality of member information in full compliance with applicable state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations. Providers must safeguard protected health information (PHI) by:

- Adhering to internal policies and procedures.
- Limiting access to PHI to the minimum necessary to fulfill the intended purpose.

Providers who encounter any issues or have questions or concerns regarding member privacy should report them immediately to the Arkansas Blue Medicare Privacy Office.

Privacy Office

ATTN: Privacy Officer

P.O. Box 3216

Little Rock, AR 72201

Telephone: **866-254-4001**

Email: **privacyofficeinquiries@arkbluecross.com**



SECTION 4

Claims Filing Information

Availity

Availity is an industry-leading, HITRUST-certified healthcare information technology company that serves Arkansas Blue Medicare and its providers by offering a suite of dynamic products built on a powerful, intelligent platform. This portal helps to integrate and manage the clinical, administrative, and financial claims data in real-time for Arkansas Blue Medicare in coordination and collaboration with providers.

For Availity questions or concerns, call Availity at **800-AVAILITY (800-282-4548)**. Representatives are available Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern.

Claims Processing

Claims, including revisions or adjustments, that are not filed by a provider prior to the claim filing limit of 365 days from the date of service or the date of discharge will be the provider's liability. For more information, contact an Arkansas Blue Medicare Medicare network specialist or visit [NUCC.org](https://www.nucc.org).

Claims and corrected claims can be filed through one of the following methods:

- Secure file upload – directly sending claims from the provider practice management system to **Availity**.
- Through direct data entry on the Availity portal.
- Through a third-party clearinghouse.

To perform a status inquiry or submit questions about an MA claim, providers can:

- Log into **Availity**.
- Call the Arkansas Blue Medicare provider line at **800-287-4188**.

Non-Arkansas providers should contact/bill their local Blues plan, using the alpha prefix to ensure correct routing of the claim. See the Ancillary section of this manual for more information.

Ancillary Claims

The Blue Cross and Blue Shield Association has clarified its rules about how independent laboratories, durable medical equipment (DME) suppliers, and specialty pharmacies should submit claims in certain circumstances. These rules also apply to referring practitioners.

These claim submission rules include:

- Independent labs should file claims with the local Blues plan in the state in which the specimen was drawn (determined by where the referring physician is located).
- DME suppliers should file claims with the local Blues plan in the state to where the equipment or supplies were shipped (including mail-order supplies) or purchased (if purchased at a retail store).
- Specialty pharmacies should file claims with the local Blues plan in the state in which the ordering physician is located.

Rural Health Clinic Billing

If a service is performed at a rural health clinic (RHC), and the service is payable under the RHC benefit, it should be billed to Arkansas Blue Medicare on a UB claim form. If a service is performed at an RHC outside of its CMS all-inclusive rate, the service should be billed on an HCFA 1500 professional claim. Since there is not a cost settlement with Arkansas Blue Medicare, RHCs should bill the pneumococcal and influenza vaccines on an HCFA 1500 professional claim.

The place of service code should represent where the actual service was performed. The following are examples of codes RHCs may use for the place of service:

- 72 – RHC (when performed in an RHC)
- 32 – Skilled nursing facility (SNF)
- 19 or 22 – Outpatient hospital
- 21 – Inpatient hospital

Coordination of Benefits

When Arkansas Blue Medicare is the secondary carrier, the benefits will be reduced by the amount paid by the primary carrier. The allowable expense is a service that is covered in full or in part by any of the plans covering the member. Non-covered expenses are not coordinated.

When Arkansas Blue Medicare is secondary, a provider has the right to collect the deductible, copayment, or coinsurance and then coordinate benefits with the other carrier.

Please note: If Arkansas Blue Medicare is the secondary payer, providers should not submit a claim until they have received the primary payer's payment.

If the provider receives payment in excess of actual charges and has collected a deductible, copayment, or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the deductible, copayment, or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

If the provider contractually participates with other health plan(s), the privilege to collect a copayment may be affected by the agreement with the other health plan(s).

To file secondary claims electronically, please refer to the Electronic Claims section of this manual.

Corrected Claims

Arkansas Blue Medicare defines a corrected claim as a claim that has been processed, whether paid or denied, and was refiled with additional charges, a different diagnosis, or any new information that could change the way that claim was originally processed. Placing a "Corrected Claim" indication on the claim form when it has not been previously processed will cause a delay in claim adjudication.

Claims returned requesting additional information are NOT to be refiled as corrected claims. These claims have been processed; however, additional information is needed to finalize payment.

To submit an electronic corrected claim through Availity, use the following Bill and Frequency Type codes:

- **7 – Replacement of Prior Claim**

If charges have been omitted or claim information (e.g., diagnosis codes, dates of service, member information, etc.) has changed, providers should resubmit the entire claim, including all previous information and any corrected or additional information. Hospitals and facilities should include the “seven” in the third digit of the Bill Type. Physicians should submit with a Frequency Type code of “seven.”

- **8 – Void/Cancel of Prior Claim**

If a claim has been submitted to Arkansas Blue Medicare in error, providers should resubmit the entire claim. Hospitals and facilities should include the “eight” in the third digit of the Bill Type. Providers should submit with a Frequency Type code of “eight.”

UB-04 Processing Information

Arkansas Blue Medicare relies on proper coding to process provider claims and adjudicate members’ benefits. The codes providers select and enter on claims are representations to Arkansas Blue Medicare that the member’s treatment (and provider bill) was for the coded diagnosis, not others, and the provider performed the procedures as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Healthcare Procedural Coding System (HCPCS) Manual. Miscoded or improperly billed claims may constitute fraud and could result in denial of claims, termination of provider network participation, or other remedial actions.

Claims Filing Information

Information about the national uniform billing data element specifications manual, as developed by the National Uniform Billing Committee (NUBC), can be found at nubc.org.

Scanning UB 04 Claim Forms

Arkansas Blue Medicare scans UB 04 claim forms (CMS-1450). Here are some tips to avoid issues with scanned UB 04 claim forms:

- All data must be contained within its defined area.
- All dollar fields should be blank or have real values.
- Do not include a dollar sign (“\$”) or decimal points when reporting charges.

Timely Filing Requirement

Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to hospital and other Part A services and physician and other Part B services payable on a reasonable charge or fee schedule basis (including those services for which the charge is related to cost). The timely filing period for Medicare claims is one calendar year (365 days) from the date on which the services were provided.

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, federal non-workday, or legal holiday, the claim will be considered filed timely if it is filed on the next workday. Additionally, a claim received by Arkansas Blue Medicare more than one year after the service has been rendered is subject to a ten (10) percent reduction. The ten (10) percent reduction amount may not be charged to the beneficiary.

When a claim is denied for having been filed after the timely filing period, such denial does not constitute an “initial determination;” therefore, the determination that a claim was not filed timely is not subject to appeal.

Proof of Timely Filing

Documents submitted as proof of timely filing will only be accepted if electronically generated and include the following information (additional information may be required on a case-by-case basis):

- Physician or facility name
- Patient’s name and member ID number
- Date of service
- Charged amount
- CPT code
- Date claim was originally filed/resubmitted
- Insurance filed is listed as Arkansas Blue Medicare (insurance codes are not acceptable unless a memo accompanies the printout describing the code)
- If the insurance filed shows a plan other than Arkansas Blue Medicare, a memo should be attached indicating when the provider was notified that the member had other insurance and any circumstances that caused the delay in filing with the correct insurance or the delay in checking the status of the claim. These cases will be reviewed. If the member did not notify the provider of the correct insurance plan, the claim should not be filed, and the member can be billed.

If a claim correction form is attached to the claim with proof of timely filing, this can expedite the process since the scanning system should halt the claim for review.

The following will not be accepted as proof of timely filing:

- Handwritten notes indicating the date the claim was filed
- Electronic notes with incomplete information
- Insurance codes with no explanation
- Proof of timely filing with a date of service past the required filing period (extenuating circumstances may be reviewed by attaching a memo)
- Dates on the bottom of the claim submitted as proof

If Arkansas Blue Medicare is secondary, the timely filing starts from the primary carrier’s Remittance Advice date of payment or denial.



SECTION 5

Claims Payment, Refunds, & Offsets

Reimbursement Methodology

Arkansas Blue Medicare reimburses network providers at the reimbursement level stated in the provider's Provider Participation Agreement minus any member-required cost sharing, sequestration, and withhold for all medically necessary services covered by Original Medicare or a supplemental Arkansas Blue Medicare benefit.

Arkansas Blue Medicare processes claims in accordance with Original Medicare guidelines. Providers must bill Arkansas Blue Medicare in the same manner they bill Original Medicare (e.g., if an RHC or FQHC with original Medicare, providers must file Arkansas Blue Medicare as an RHC or FQHC). Arkansas Blue Medicare will not reimburse providers for services that are not covered under Original Medicare, unless such services are specifically listed as covered services under the member's particular Arkansas Blue Medicare health benefit plan.

Arkansas Blue Medicare must also comply with all applicable CMS Original Medicare manuals, instructions, directives, and guidance, including Medicare National Coverage Determinations (NCDs), Medicare Local Coverage Determinations (LCDs), general coverage guidelines, and written coverage decisions of the local Medicare administrative contractor. For example:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, providers must supply all applicable digits.
- Must include the Medicare Part B supplier number, National Provider Identifier (NPI), and federal tax identification number.
- Must include the member's member ID number, including the alpha prefix, found on the member's ID card.

National coding guidelines can be accessed [here](#).

Member Financial Obligations

In most situations, MA members will be responsible for part of a provider's bill for services; and, as the provider agreement with Arkansas Blue Medicare outlines, providers will not waive these member financial responsibilities (e.g., the member copayment, coinsurance, and deductible), as specified in the member's Evidence of Coverage (EOC).

Non-Covered Services

Members will generally be exclusively responsible for any provided non-covered services. As specified in the provider agreement, providers may not bill members for services that do not meet Medicare coverage criteria (e.g., experimental/investigational).

IMPORTANT: Except for an applicable copayment, coinsurance, or deductible, providers are not permitted to request or require payment in advance by any MA members or from anyone else as a condition of providing services to members.

Billing

Providers are not permitted to “balance bill” a member for amounts in excess of the Medicare allowance for covered services. (Member copayments, coinsurance, and deductibles are deemed part of the allowance for this purpose and should be billed to the member.) Providers are also responsible for any billing or collection service activities they may engage, or to whom a provider may assign any accounts receivable or other claims against MA members.

If Arkansas Blue Medicare finds that a provider, billing service, collection agency, or other agent engaged by a provider has improperly attempted to bill a member or collect any amounts from a member in violation of the provider agreement or the guidelines in this Provider Manual, the provider will be required to promptly take all necessary steps to halt any such activity to ensure it is not repeated and to reimburse Arkansas Blue Medicare and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency, or other agent. Providers may also be excluded or removed from the network for failure to adhere to the member “hold harmless” agreement.

Additionally, federal law prohibits MA providers from collecting Medicare Part A and Part B deductibles, coinsurance, or copayments from members enrolled in the Qualified Medicare Beneficiaries (QMB) program.

Refunds

While all parties strive for accurate claim adjudication on the first pass, adjudication mistakes are occasionally detected that result in the need to adjust the amount paid.

When these adjustments result in a lesser amount paid, and in order to “close” patient accounts timelier, Arkansas Blue Medicare will initiate the recovery process within approximately ten business days assuming the provider has claims payments to cover any, or all, of the overpaid amount.

If Arkansas Blue Medicare offsets duplicate or erroneous payments (overpayments) made to providers, providers are not allowed to pursue collection of such offset/recoupment amounts from the member against whose claims the offsets were made.

Minimize the Time Required to Process a Claim Refund

To minimize the time required to process a claim refund, and to ensure provider 1099 earnings are adjusted accurately:

- When sending Arkansas Blue Medicare a requested refund, follow the instructions provided in the refund request letter.
- When sending Arkansas Blue Medicare an unrequested refund, call for instructions prior to sending an unrequested refund to ensure funds are applied to the correct members(s).

If the provider is not returning the original check, a separate refund check for each line of business is preferred. A provider's 1099 earnings can only be corrected if Arkansas Blue Medicare has the specific provider name, NPI, and EIN. If a provider uses the services of a third party for these financial transactions, instruct the third-party administrator to provide this information on each refund.

Send claim refunds to:

Arkansas Blue Medicare

P.O. Box 2099

Little Rock, AR 72203

Remittance Advice

A detailed, line-by-line Remittance Advice will accompany the reimbursement from Arkansas Blue Medicare for services rendered to members. Providers using a billing service should send copies of the Remittance Advice to the billing company.



SECTION 6

Coverage Policies & Procedures

Medical Policy

Arkansas Blue Medicare medical policies identify the clinical criteria for determining when services are considered “medically reasonable and necessary.” CMS requires Arkansas Blue Medicare to provide the same medical benefits to MA members as Original Medicare. As such and when possible, Arkansas Blue Medicare medical policies are based on Medicare coverage manuals, National Coverage Determinations (NCDs), and/or Local Coverage Determinations (LCDs). If there is no applicable NCD or LCD for the service under review, other evidence-based criteria may be applied. Medical policy applies to medical services and Part B medication services requiring prior authorization.

Arkansas Blue Medicare’s medical policies may be made available to providers upon request.

Policy Hierarchy

The following hierarchy is used to determine Arkansas Blue Medicare medical policy. Some services may require references from more than one tier of the hierarchy.

- **CMS coverage manuals or other CMS-based resources**

Arkansas Blue Medicare is expected to stay apprised of new and/or changing Medicare Part A and Part B coverage policies, which include various CMS sources. An example includes the Medicare Managed Care Manual, which outlines statutory provisions governing the MA and Part D program requirements.

- **National Coverage Determinations (NCD)**

For some services, procedures, and technologies, CMS has developed an NCD, which is to be applied on a national basis for all Medicare beneficiaries. NCDs are binding on all MA plans.

- **Local Coverage Determinations (LCD)**

When there is no NCD or other coverage provision outlining medical necessity criteria within a Medicare manual, or when there is a need to further define an NCD, the Medicare Administrative Contractor (MAC) for a service area may develop a policy (LCD) or article (LCA).

Arkansas Blue Medicare uses Novitas Solutions, Inc., (Novitas) as the MAC, Jurisdiction H (JH), which spans Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, and includes Indian Health Service (IHS) and Veterans Affairs (VA) nationally.

Novitas may provide coverage or non-coverage guidance in a Part B news article published at [novitas-solutions.com/webcenter/portal/NovitasSolutions](https://www.novitas-solutions.com/webcenter/portal/NovitasSolutions). These articles may be used in MA medical policy development, even though they are not in the form of an LCD or LCA.

Medicare Part B Step Therapy

The Arkansas Blue Medicare Preferred Drug List (PDL) encourages utilization of clinically appropriate and lower net cost products within certain therapeutic drug classes. The PDL applies to the listed products only, and other products may be available under the medical benefit. The PDL can be found [here](#).

Step Therapy Prior Authorization Process

The step therapy prior authorization process evaluates if the drug is appropriate for the individual member and considers:

- Applicable Medicare coverage determination guidance
- Dosage recommendation from the FDA-approved labeling
- Terms of the member's health benefit plan
- Trial and failure of preferred products
- The member's treatment history

For Medical Non-Oncology Indications or for Non-EviCore Delegated Oncology Reviews

Providers can request pre-certification or step therapy review by:

- Going to arkansasbluecross.com/providers.
- Clicking the Forms tab.
- Scrolling down to the Medicare Advantage Prior Authorization section for the PA form.
- Faxing the completed form to the appropriate fax number listed on the form.

For Medical Oncology Indications or for EviCore Delegated Reviews

Providers can request pre-certification or step therapy review by:

- Accessing the pre-certification list at evicore.com/resources/healthplan/arkbluecross.
- Submitting a request via the Providers' Hub at evicore.com/provider or by calling **800-646-0418** (option 4) (encouraged for urgent treatment requests)

Determination and Review Timeline

Arkansas Blue Medicare will review prior authorization or pre-service coverage determination requests for Part B drugs within:

- 24 hours for expedited requests
- 72 hours for standard requests

Notifications of the case determination, including appeal rights when applicable, will be provided within the required time frame.

Arkansas Blue Medicare will issue a denial decision if sufficient clinical information to complete the review isn't received. To prevent denials due to a lack of information, submit all relevant clinical information with the Part B drug prior authorization request.



SECTION 7

Hospital & Inpatient Information

Critical Access Hospitals

Reimbursement for inpatient and outpatient services will be based on the critical access hospital's most recent interim rate letter from their A/B Medicare Administrative contractors. To ensure appropriate reimbursement, Arkansas Blue Medicare requires a copy of the rate letter to be provided.

Member Discharge Appeal Rights

As required by Medicare, hospitals must notify Medicare beneficiaries, including Arkansas Blue Medicare HMO and PFFS members who are hospital inpatients, about their discharge appeal rights by providing them with the **Important Message from Medicare (IM)** document within a specified timeframe. This document and additional information are available at cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

More information about this is in Section 8.



SECTION 8

Medical Records

Medical Records

Patient medical records and health information shall be maintained in accordance with current federal and state regulations.

Arkansas Blue Medicare providers must maintain timely and accurate medical, financial, and administrative records related to services rendered to MA members. Providers shall maintain such records and any related contracts for ten (10) years from date of service, unless a longer time period is required by applicable statutes or regulations.

Consistent with all federal, state, and local laws, a provider shall allow without limitation Arkansas Blue Medicare, the U.S. Department of Health and Human Services, the U.S. General Accounting Office, or their designees to audit, evaluate, and inspect all books, contracts, medical records, and patient care documentation maintained by the provider. Such records will be used by CMS and Arkansas Blue Medicare to assess compliance with standards, including but not limited to:

- Complaints from members and/or providers
- HEDIS, Star Ratings, and other reviews, quality studies/audits, or medical record review audits
- CMS and Arkansas Blue Medicare reviews of risk adjustment data
- Post-pay reviews to determine if services are reasonable and medically necessary and billed correctly to the plan
- Pre-service organization determinations and appeals decisions
- Medical, disease, and utilization management-specific medical record reviews
- Suspicion of fraud, waste, and/or abuse
- Periodic office visits for contracting purposes
- Other reviews deemed appropriate and/or necessary

Medical record content and requirements for all practitioners include but may not be limited to the following.

Clinical Record

- Patient name and member ID number (name and ID number must be on each page)
- Address
- Date of birth or age
- Sex
- Marital status
- Home and work telephone numbers
- Emergency contact telephone number
- Guardianship information (if relevant)
- Signed informed consent for immunization or invasive procedures
- Documentation of discussion about advance directives (18 and older) and a copy of the advance directives

Medical Documentation

- History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services, and other risk screening.
- Documentation of the offering or performance of a health maintenance exam within the first twelve (12) months of membership. The exam includes:
 - Past medical, surgical and behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age and sex specific risk screening exam, relevant review of systems, including depression and alcohol screening.
- Documentation of patient education (age and condition specific), if applicable – injury prevention, appropriate dietary instructions, lifestyle factors, and self-exams.

Clinical Record – Progress Notes

- Identification of all providers participating in the member’s care and information on services furnished by these providers
- Reason for the visit or chief complaint
- Documentation of clinical findings and evaluation for each visit
- Diagnosis
- Treatment/diagnostic tests/referrals
- Specific follow-up plans
- Follow-up plans from previous visits that have been addressed
- Follow-up report to referring practitioner (if applicable)

Clinical Record – Reports Content

- Labs
- X-rays
- Referrals
- Consultations
- Discharge summaries, consultations, and summary reports from healthcare delivery organizations such as SNFs, home health agencies, free-standing surgical centers, and urgent care centers (all reviewed, signed, and dated within 30 days of the service or event)

For Behavioral Health Practitioners

- Chief complaint, review of systems, and complete history of present illness
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history
- Past medical history
- A medication list, including dosages of each prescription, the dates of the initial prescription, and refills
- At least one complete mental status examination, usually done at the time of initial evaluation and containing each of the items below:
 - Description of speech
 - Description of thought processes
 - Description of associations (such as loose, tangential, circumstantial, or intact)
 - Description of abnormal or psychotic thoughts
 - Description of the patient’s judgment
- Complete mental status examination
- Subsequent mental status examinations documented at each visit and contain a description of orientation, speech, thought process, thought content (including any thoughts of harm), mood, affect, and other information relevant to the case
- A DSM-IV diagnosis, consistent with the presenting problems, history, mental status examination, and other assessment data
- Thorough assessment of risk of harm to self or others
- Informed consent indicating the member’s acceptance of the treatment goals (formal signed consent is not required except where required by law)
- To ensure coordination of the member’s care, the treatment records shall reflect continuity and coordination of care with the member’s primary care practitioner and, as applicable, consultants, ancillary practitioners, and healthcare institutions involved in the member’s care –
 - Where required by law, obtained proper, documented, written, and signed consent for any release of information to outside entities
 - Progress notes that describe the member’s strengths and limitations in achieving the treatment goals and objectives
 - Evidence that members who become homicidal, suicidal, or unable to conduct activities of daily living were promptly referred to the appropriate level of care

Other Medical Record Requirements

The provider of service for all face-to-face and telemedicine encounters must be identified on the medical record, and it must include a signature and credentials (can be located anywhere on the record, including stationery) for each date of service. Documentation of telemedicine visits require identification of audio-only or audio-visual encounter.

Stamped signatures are not acceptable. Acceptable signatures include handwritten (initials can be used if the full name and credentials appear somewhere in the record or on stationery) or an electronic signature on electronic records if authenticated at the end of each note in accordance with CMS authentication requirements (e.g., “electronically signed by,” “authenticated by,” “approved by,” “completed by,” “finalized by,” or “validated by” and includes the practitioner’s name, credentials, date, and signature).

Claims Processing When Medical Records Are Required

When medical records are required to make a determination for a claim, providers are sent a letter requesting the necessary documents. If medical records are not received within 30 days, claims will be denied as medical records not received. Providers should submit the medical record request letter, along with the documents, to the following address. If records are received after the 30-day period, the claim will be reviewed as a redetermination.

Arkansas Blue Medicare
Claims and Medical Records Department
P.O. Box 3648
Little Rock, AR 72203-3648

The following are recommendations to help expedite processing and ensure a prompt and accurate response:

- Use the Arkansas Blue Medicare records coversheet for all submissions
- Include the member’s ID number on all correspondence
- Include provider information such as provider name, address, and NPI on all correspondence
- Document the claim number related to the records
- Distinguish between records if submitting for multiple members in the same mailing, using the published Arkansas Blue Medicare records coversheet

To access the Arkansas Blue Medicare records coversheet, [click here](#). The appropriate form should be attached as the coversheet to expedite the review process and prevent delays in claim adjudication.

Confidentiality of Member Information

In accordance with the highest standards of professionalism, and as a requirement of each provider's contract with Arkansas Blue Medicare, providers are obligated to protect the personal health information of their MA members from unauthorized or inappropriate use. All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements with Arkansas Blue Medicare.

Routine Needs for Member Information

At the time of enrollment, Arkansas Blue Medicare members who enroll electronically or by paper permit Arkansas Blue Medicare to use and disclose their personal health information for routine purposes such as:

- Bonafide research purposes
- Claims processing (payment, denial, and investigation)
- Post-service pre-pay review for medical necessity
- Coordination of care
- Customer service
- Data processing
- Fraud/Abuse investigations or reports
- Healthcare operations
- Medical management
- Performance measurement
- Provider credentialing or quality evaluation
- Quality assessment and measurement
- Regulatory audits or inquiries, subpoenas, or other court or law enforcement procedures
- Required regulatory reports
- Risk adjustment and HEDIS
- Routine audits
- Utilization review

If Information Is Needed for Other Reasons

If member-specific and identifiable information is needed for reasons other than those listed above under "routine purposes," the member must sign specific authorization to release the information. If a member is unable to personally give preauthorization, Arkansas Blue Medicare has a process to obtain this consent through a parent's or legal guardian's signature, signature by next of kin, or attorney-in-fact. While specific authorizations are issued, the member has the right to limit the purposes for which the information can be used, and all concerned parties are obligated to respect that expressed limitation.

Members Rights to Medical Records

Members have the right to access their medical records; therefore, each practitioner must have a mechanism in place to provide this access.

Members must not be interviewed about medical, financial, or other private matters within the hearing range of other patients.

Practitioners must have procedures in place for informed consent, storage, and protection of medical records. Arkansas Blue Medicare may verify that these policies/procedures are in place as part of an on-site review process.

MA Employees

As a condition of employment, all MA employees must sign a statement agreeing to hold member information in strict confidence. Physicians and all other Arkansas Blue Medicare participating providers are also bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information.



SECTION 9

Network Terms & Conditions

Network Participation Guidelines

Practitioners requesting participation in the Arkansas Blue Medicare network must agree to follow CMS regulations and Arkansas Blue Medicare network policies and procedures and terms and conditions, as well as meet applicable credentialing standards.

Providers with questions about Arkansas Blue Medicare network participation should contact a regional Medicare network specialist, network development representative, or the Provider Network Operations team.

Provider Network Operations

P.O. Box 2181

Little Rock, AR 72203-2181

Telephone: **501-210-7050**

Fax: **501-378-2465**

E-mail: providernetwork@arkbluecross.com

Provider Qualifications and Requirements

To be paid by Arkansas Blue Medicare for services rendered to a member, providers must:

- Have a National Provider Identifier (NPI) to submit electronic transactions to Arkansas Blue Medicare, in accordance with HIPAA requirements.
- Submit all claims electronically to Arkansas Blue Medicare.
- Furnish services to an MA member within the scope of their licensure or certification.
- Provide only Arkansas Blue Medicare covered services that are medically necessary (as defined by Medicare).
- Meet applicable Medicare certification requirements.
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General (OIG) excluded and sanctioned provider list and not on the CMS Preclusion List.
- Not be a federal healthcare provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other federal healthcare program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Arkansas Blue Medicare to resolve any member grievance that is provider-related within the time frame required by CMS.
- For hospitals, home health agencies, SNFs, or comprehensive outpatient rehabilitation facilities (CORFs) – provide applicable beneficiary appeals notices (see Section 8 for specific requirements).
- Not charge a member in excess of the appropriate cost-sharing amount allowed under these terms and conditions under any condition, including in the event of plan bankruptcy.

Payment to Providers

Plan Payment

- For claims for medically necessary services covered by Original Medicare, Arkansas Blue Medicare reimburses providers at the amount paid under Original Medicare for Medicare-covered services, minus any member required cost-sharing amount.
- Arkansas Blue Medicare will process and pay clean claims within 30 calendar days of receipt. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. View the Payment Methodology for more detailed information.
- Services covered under MA that are not covered under Original Medicare are reimbursed using the Arkansas Blue Medicare fee schedule. Contact a Medicare network specialist to receive information on Arkansas Blue Medicare's fee schedule.

Access Availability to obtain more information about covered benefits, plan payment rates, and member cost-sharing amounts under MA.

All Arkansas Blue Medicare plans follow Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Arkansas Blue Medicare unless specified by the plan.

Information on obtaining a pre-service coverage determination can be found in Section 15.

IMPORTANT: Arkansas Blue Medicare PFFS plans do not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage.

Note: Medicare Supplemental policies, commonly referred to as Medigap policies, cannot cover cost-sharing amounts for MA plans, including Arkansas Blue Medicare PFFS plans. All cost sharing is the member's responsibility.

Balance Billing

If a provider is deemed and a non-participating provider under Original Medicare rules, balance billing is permitted up to fifteen percent (15%). However, the plan – **not the beneficiary** – must pay the fifteen percent (15%).

Participating/In-network providers who furnish covered services to Arkansas Blue Medicare members are prohibited from balance billing members.

Hold Harmless Requirements

In no event, including but not limited to non-payment, insolvency, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, copayments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, providers must make a timely refund of that amount to the member.



Getting an Advanced Organization Determination

Providers may choose to obtain a written advance coverage determination (known as an organization determination) from Arkansas Blue Medicare before furnishing a service to confirm the service is medically necessary and will be covered by Arkansas Blue Medicare. To obtain an advanced organization determination, call **800-287-4188** or fax **816-313-3014**.

Arkansas Blue Medicare will make a decision and notify the provider and member within 14 calendar days of receiving the request. A 14-day extension may be given either at the member's request or if Arkansas Blue Medicare has justification the delay is in the member's best interest. In cases where a provider believes waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, an expedited determination can be requested. Expedited determinations can be requested by calling **800-287-4188** or faxing **816-313-3013**. Arkansas Blue Medicare will notify the provider and member of the decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request, unless a 14-day extension is invoked at the member's request or Arkansas Blue Medicare believes the extension is in the member's best interest.

In the absence of an advanced organization determination, Arkansas Blue Medicare can retroactively deny payment for a service furnished to a member if it's determined the service was not covered by the plan or was not medically necessary.

Treating providers acting on behalf of the member have the right to dispute Arkansas Blue Medicare's decision by exercising the member's appeals rights (see the federal regulations at 42 CFR Part 422, subpart M, or Chapter 13 of the Medicare Managed Care Manual).

Member and Provider Appeals and Grievances and Contracting Provider Dispute Resolution

Member and Provider Appeals and Grievances Under Member Appeal Process

Arkansas Blue Medicare members have the right to file appeals and grievances with Arkansas Blue Medicare when they have concerns or problems related to coverage or care. Members may appeal a decision made by Arkansas Blue Medicare to partially or fully deny coverage or payment for a service or benefit they believe should be covered or paid. Members should file a grievance when they are dissatisfied with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested.

Providers and/or physicians also have certain appeal opportunities under the member appeal process. These opportunities are set forth below.

Pre-Service Appeal Request

A physician who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan on behalf of the member without submitting an Appointment of Representative Form or Waiver of Liability Form. Arkansas Blue Medicare is required by Medicare to verify the member has been notified and approves of the physician's appeal request. If it is not evident the member is aware of the appeal request, Arkansas Blue Medicare will contact the physician to gather this information. If Arkansas Blue

Medicare verifies the member's knowledge of the physician's appeal request, it will be processed according to the MA five-level member appeal process.

Arkansas Blue Medicare automatically grants an expedited appeal if any physician or other provider, whether participating with Arkansas Blue Medicare or not, asks for one on the grounds that waiting for a standard appeal could seriously jeopardize the member's life, health, or ability to regain maximum function or, in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment being requested. An expedited appeal will not be granted for a service that has already been provided.

Post-Service Appeal Request

A contracting physician or provider may request a review of a post-service organization determination denial using the contracted provider payment dispute process.

A non-contracting physician or provider may appeal a post-service organization determination by signing and submitting a Waiver of Liability Form. This form can be found at arkansasbluecross.com/providers/resource-center/provider-forms. When the physician or other provider signs the form, she or he agrees not to bill the member, regardless of the outcome of the appeal. **Important:** The Waiver of Liability Form must be included with the appeal submission.

Medicare regulations prohibit Arkansas Blue Medicare from considering the appeal until the signed Waiver of Liability Form is received. When Arkansas Blue Medicare receives the appeal request and signed form, the appeal is processed according to the MA five-level appeal process.

If a physician or provider uses the appeals process, the provider agrees to abide by the status, regulations, standards, and guidelines applicable to the Medicare appeals processes. Included in these regulations is the requirement that the appeal and Waiver of Liability Form be submitted within 60 days from the date on the Remittance Advice notice.

The physician or provider should consider including the following documentation with the appeal submission:

- Provider or supplier contact information, including name, address, e-mail address, fax number, and phone number
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where the services were rendered, and physician specialty
- Reason for the dispute and a description of the specific issue being appealed
- Documentation of any correspondence and/or records that supports the provider's position that the plan's denial was incorrect (including clinical rationale, LCD, and/or NCD documentation)
- Appointment of Representative Form or Waiver of Liability Form, as applicable
- Name and signature of the provider or provider's representative

The Arkansas Blue Medicare member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. All current plan year Arkansas Blue Medicare EOCs are posted at arkbluemedicare.com/medicare-forms.

Contracted Provider Claim Adjudication Review Request (Non-Member Appeal Review Requests)

Contracted providers with Arkansas Blue Medicare have dispute resolution rights separate from the member appeal process. Specifically, a contracted physician or contracted provider may request a review of a post-service denial related to medical necessity or medical appropriateness. A contracted physician or provider may also request a review of administrative denials.

Administrative denials are determinations made by Arkansas Blue Medicare in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness. Examples of administrative denials include, but are not limited to:

- Provider non-compliance with clinical review requirements for elective procedures requiring Arkansas Blue Medicare approval.
- Provider non-compliance with providing clinical information needed to render a decision for inpatient admissions within 48 hours of Arkansas Blue Medicare's request.

Finally, a contracting provider may request a review when she or he believes the payment amount made by Arkansas Blue Medicare to the contracted provider is less than the payment amount that would have been paid under the Original Medicare fee schedule.

Arkansas Blue Medicare assumes the physician or provider is acting on his or her own behalf. Submission of an Appointment of Representative Form is not required for these review requests as they are not considered a part of the CMS-regulated member appeal process.

These post-service review requests will be reviewed based on:

- Pertinent medical information
- Member's benefit coverage
- Information from the attending physician and primary care physician
- Clinical judgment of the medical director, when applicable/appropriate

A single level of review will be provided. This review process is designed to be objective, thorough, fair, and timely.

At any step in the review process, a plan medical director may obtain the opinion of a same specialty, board-certified physician or an external review board.

When a provider claim adjudication review request is received and a member appeal is in process, the member appeal takes precedence.

The request must be submitted to Arkansas Blue Medicare within 60 calendar days of the date noted on the written remittance advice notification. If the review request is received by Arkansas Blue Medicare outside the designated time frame, Arkansas Blue Medicare is not obligated to review the case. A letter will be sent to the requesting provider either advising the request was not reviewed or notifying the provider of the outcome of the request if the plan has chosen to review the case.

Requests are to be submitted in writing, must include any additional clarifying clinical information to support the request, and be identified as a provider claim adjudication review request. Appropriate documentation needed for a medical necessity review includes:

- Provider or supplier contact information, including name, address, e-mail, and fax number
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers)
- ZIP code where the services were rendered
- Physician specialty
- Reason for dispute
- Documentation and any correspondence that supports the provider's position that the plan's denial was incorrect (including clinical rationale, LCD, and/or NCD documentation), when appropriate
- Documentation and any correspondence that supports the provider's position that the plan's reimbursement was incorrect (including interim rate letters), when appropriate
- Name and signature of the provider or provider's representative

Requests should be submitted to:

Arkansas Blue Medicare Legal Appeals Department

Attn: Contracting Provider Claim Adjudication Review Request

P.O. Box 2181

Little Rock, AR 72203

Fax: **501-378-3366**

E-mail: appealscoordinator@arkbluecross.com

Arkansas Blue Medicare will notify the provider of the decision within 30 calendar days of receiving all necessary information.

Providing Members with Notice of Their Appeal Rights – Requirements for Hospitals, SNFs, HHAs, and CORFs

CMS requires hospitals to notify Medicare beneficiaries, including MA beneficiaries, who are hospital inpatients about their discharge appeal rights by providing the *Important Message from Medicare (IM)*.

CMS also requires skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) to notify Medicare beneficiaries, including MA beneficiaries, about their right to appeal a termination of services decision by providing the *Notice of Medicare Non-Coverage (NOMNC)*.

The *Important Message from Medicare (IM)* and *Notice of Medicare Non-Coverage (NOMNC)*, along with more information about both notices, can be found at cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Hospitals, SNFs, HHAs, and CORFs must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that she/he wishes to appeal a decision regarding a hospital discharge (*Detailed Notice of Discharge*) or termination of SNF, HHA, or CORF services (*Detailed Explanation of Non-Coverage*) within certain time frames specified by law. (These time frames are explained later in this section.)

Quality Improvement Organization – Acentra

A Quality Improvement Organization (QIO) consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness, and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan like Arkansas Blue Medicare. The QIO for Arkansas is Acentra.

Contacting the QIO

Members may request a QIO review from Acentra if they disagree with the decision of a hospital, SNF, HHA, or CORF to discharge them.

To appeal, members may contact Acentra at:

5201 West Kennedy Blvd.

Suite 900

Tampa, FL 33609

ATTN: Records Department

Phone: **888-315-0636** (TTY: **711**)

Fax: **844-878-7921**

Hours: 9:00 a.m. to 5:00 p.m., Monday through Friday, and 11:00 a.m. to 5:00 p.m., weekends and holidays

Member Appeal Rights for Hospital Discharge

Members who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe coverage of their hospital stay is ending too soon.

Hospitals are required to notify all Arkansas Blue Medicare members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the *An Important Message from Medicare* twice – the

first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the member or of her/his representative and provide a copy.

Arkansas Blue Medicare members have the right to appeal to the QIO for immediate review when a hospital and Arkansas Blue Medicare, with physician concurrence, determine inpatient care is no longer necessary.

Hospital Discharge Appeal Process

If a member is dissatisfied with the discharge plan and wishes to appeal for an immediate review by the QIO:

1. She/He must submit a request to the QIO, following the instructions on the *An Important Message from Medicare* notice.
2. The QIO will notify Arkansas Blue Medicare the member has requested an immediate review.
3. Arkansas Blue Medicare or the facility will deliver a Detailed Notice of Discharge to the member as soon as possible, but no later than noon of the day after the QIO's notification. The notice will explain why services are no longer reasonable and necessary or no longer covered.
4. Arkansas Blue Medicare or the facility must supply any other information the QIO needs to make its determination as soon as possible, but no later than the close of business on the day the request for information is received. This additional information may include copies of the *An Important Message from Medicare* and *Detailed Notice of Discharge* and documentation of any information provided by phone.
5. The QIO will make a determination and notify Arkansas Blue Medicare, the member, hospital, and physician of the determination within one calendar day after it receives the requested information.
6. Arkansas Blue Medicare will continue to be responsible for paying the costs of the member's stay until noon of the next calendar day following the day the QIO notifies the member of the determination.
7. If the member is late or misses the noon deadline to file a QIO immediate review, she/he may still request an expedited appeal from Arkansas Blue Medicare.

Member Responsibilities Related to Hospital Discharges

If...	Then...
The QIO agrees with the doctor's discharge decision:	The member is responsible for paying the cost of her/his hospital stay beginning at noon of the calendar day following the day the QIO notifies the member of the coverage determination.
The QIO disagrees with the doctor's discharge decision:	The member is not responsible for paying the cost of additional hospital days, except for certain convenience services or items not covered by Arkansas Blue Medicare.

Circumstances in Which the Immediate Review Process Does Not Apply

The immediate review process does not apply in these circumstances:

- To care provided in a physician clinic
- To observation care
- To inpatient-to-inpatient transfers
- To admissions for services that Medicare never covers
- When the member has exhausted all her/his Medicare days

QIO Immediate Review of SNF, HHA, and CORF Discharges

Arkansas Blue Medicare members have special appeal rights that allow an expedited review if they disagree with the decision to end SNF, HHA, or CORF covered services.

SNF, HHA, or CORF services providers must deliver a *Notice of Medicare Non-Coverage (NOMNC)* to Arkansas Blue Medicare members:

- When medical necessity criteria are no longer met, and no additional days are authorized by Arkansas Blue Medicare or the facility/provider.
- At least two days prior to a scheduled discharge date.

The *NOMNC* provides detailed instructions on how members may request an immediate appeal directly to the QIO if they disagree with the decision to end SNF, HHA, or CORF services.

The NOMNC Appeal Process

Medicare regulations require the provider to deliver the standard *NOMNC* to all members when covered services are ending whether the member agrees with the plan to end services.

1. The provider will deliver the *NOMNC* to the member at least two calendar days before coverage ends. If the member is receiving home health agency services and the span of time between services exceeds two days, the provider may deliver the *NOMNC* at the next-to-last time that services are furnished. Some considerations for the provider when delivering the *NOMNC*:

- a. As noted in the instructions, the NOMNC should include Arkansas Blue Medicare's contact information somewhere on the form (ideally in the *Additional Information* section on page two).
 - b. Arkansas Blue Medicare encourages providers to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.
 - c. If services are expected to be less than two days in duration, the provider may deliver the NOMNC at the start of service. A member who receives the NOMNC and agrees with the determination of services before the end of the two days may waive the right to request the continuation of services.
 - d. If a member is not mentally competent to receive the notice, the provider must deliver it to the member's authorized representative.
2. The member should sign and date the NOMNC, acknowledging receipt of her/his appeal rights. If the member refuses to sign it, the provider must record the date and time it was delivered to the member.
 3. The provider must fax the signed NOMNC for SNF services only back to Arkansas Blue Medicare's Care Management team at **816-313-3013** (Attn: Medical Records).
 4. The provider is expected to retain a signed copy of the NOMNC form with the member's medical record. The member is responsible for contacting the QIO by noon of the day before services end if she/he wishes to initiate an expedited review. The NOMNC has detailed instructions for the member.
 5. When the member initiates an expedited review, a *Detailed Explanation of Non-Coverage (DENC)* is delivered to the member by the close of business on the same day the QIO is notified of the member's request for appeal. The DENC provides specific and detailed information why the member's SNF, HHA, or CORF services are ending.
 - a. The DENC must be completed and submitted by the entity that determines the covered services are ending, whether it is Arkansas Blue Medicare or the SNF, HHA, or CORF provider.
 - b. Arkansas Blue Medicare may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.
 6. A copy of the DENC is also sent to the QIO.
 7. The expedited review process conducted by the QIO is usually completed within 48 hours. The provider, member, and Arkansas Blue Medicare are notified of the decision by the QIO.
 8. If the member is late or misses the noon deadline to file for an immediate review by the QIO, she/he may still request an expedited appeal from Arkansas Blue Medicare.

Other Considerations in the NOMNC Process

Providers should also be aware of the following when notifying a member her/his services are ending:

- Contracted facilities should use the appropriate NOMNC forms. Providers should insert their name, address, and phone number in the spaces provided at the top of the form.
- Arkansas Blue Medicare may issue a next review date when authorizing SNF services. The next review date does not mean Arkansas Blue Medicare is denying further coverage.
 - Providers should submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, Arkansas Blue Medicare will allow two additional days for the provider to supply.

- The member must be notified with the NOMNC form. The form should only be given to members when SNF criteria are no longer met, and no further days are authorized by Arkansas Blue Medicare, or two days prior to a scheduled discharge date.
- If there is a change in the member's condition after the NOMNC is issued, both Arkansas Blue Medicare and the provider should consider the new clinical information.
- If there is a change to the date coverage ends, the provider must inform the member that services will continue. The provider must then inform the member of the new coverage end date by delivery of a new or amended NOMNC at least two days before the services end.

Member Responsibilities When Appealing SNF, CORF, or HHA Discharges

If...	Then...
The QIO agrees with the doctor's decision to end covered services:	The member is financially responsible for services on the date indicated on the NOMNC.
The QIO disagrees with the doctor's decision to end covered services:	Arkansas Blue Medicare will continue to cover the services.



SECTION 10

Pharmacy

Medicare Part D Prescriber Requirements

CMS has requirements for any physician or other eligible provider who prescribes MA (Part D) covered drugs. Providers must either enroll in the Original Medicare program or “opt out” to prescribe covered medications to their patients who have a Part D prescription drug benefit plan. Providers who are not enrolled must do this to allow for the processing of applications and to ensure members will continue to receive their Part D covered prescriptions.

Note: Part D benefit plans will not be allowed to cover drugs that are prescribed by providers who have not enrolled with or have not opted out of the Medicare program.

Arkansas Blue Medicare requires all providers to be enrolled in Original Medicare before they can be considered for participation in any of its MA networks.

Utilization Management

Certain drugs must undergo a criteria-based approval process prior to a coverage decision. These requirements and limits, which ensure members can use these drugs in the most effective way and help to control drug costs, include the following.

Prior authorization (PA)	Providers need to get approval from Arkansas Blue Medicare before a member fills her/his prescription. If a PA request isn't approved, Arkansas Blue Medicare may not cover the drug.
Quantity limits (QL)	Arkansas Blue Medicare limits the amount of certain drugs that are covered. For example, rosuvastatin calcium may be limited to 30 tablets per prescription. This may be in addition to a standard one-month or three-month supply.
Step therapy (ST)	In some cases, Arkansas Blue Medicare may require a member to first try certain drugs to treat their medical condition before another drug for that condition will be covered. For example, if Drug A and Drug B both treat a medical condition, Arkansas Blue Medicare may not cover Drug B unless the member tries Drug A first. If Drug A does not work, then Drug B will be covered.

Arkansas Blue Medicare's utilization management program is managed by CVS Caremark. The CVS Caremark Pharmacy and Therapeutics (P&T) Committee reviews medications based on safety, efficacy, and clinical benefit and may make additions or deletions to the list of drugs requiring prior authorization and to the list of drugs that have quantity limits.

For information on utilization management and to view specific prescription drug criteria, navigate to covermy meds.health/prior-authorization-forms/caremark.

Generic Substitution

When a generic equivalent of a brand-name drug is available, Arkansas Blue Medicare's network pharmacies will dispense the generic version by default, unless the brand-name drug is specifically requested. If the requested brand-name drug is not included on the Arkansas Blue Medicare Formulary, the member and/or prescriber must submit a formulary exception request to seek approval for coverage of the non-formulary drug. If the exception request is approved, Arkansas Blue Medicare will provide coverage for the drug; however, the member may be responsible for a higher cost share for the brand-name drug.

Transition Fill Policy

Arkansas Blue Medicare strives to avoid disruption to members' drug therapy. Under Arkansas Blue Medicare's transition fill policy, members can get a one-time temporary supply of a drug they are taking that is not on the Formulary or is restricted in some way. This temporary supply provides the member and her/his prescriber time to change to another covered drug or to file an exception request to have the drug covered.

Eligibility for Arkansas Blue Medicare's Transition Policy

To be eligible for this one-time supply, a member must meet the following two requirements:

1. The drug that is being taken is no longer on the Arkansas Blue Medicare Formulary or the drug is newly restricted in some way.
2. One of the following situations applies to the member – she/he is/has:
 - a. New to the plan.
 - b. A current member affected by formulary changes.
 - c. Been in the plan for more than 90 days and resides in a long-term care (LTC) facility and needs an emergency supply.

Transition Supply at a Retail Pharmacy (Non-LTC Members)

Arkansas Blue Medicare will cover a one-time, 30-day supply of a covered Part D drug during the first 90 days of the member's enrollment. If the prescription is written for fewer than 30 days, Arkansas Blue Medicare will allow multiple fills to provide up to a total of 30 days.

Transition Supply for Residents of LTC Facilities

For long-term care residents, Arkansas Blue Medicare will cover a 31-day supply during the first 90 days of enrollment. If the prescription is written for fewer than 31 days, Arkansas Blue Medicare will allow multiple fills to provide up to a total of 31 days. After the transition period has ended or the days supply is exhausted, the plan will allow up to a 31-day emergency supply while an exception request or prior authorization determination is pending.

Transition Supply for Level-of-Care Changes

For members encountering a level-of-care change, Arkansas Blue Medicare will cover a 31-day transition supply within a 90-day window. If the prescription is written for fewer than 31 days, the plan will allow multiple fills to provide up to a total of 31 days.

Transition Fill Notices

A transition policy notification letter explaining the transition supply will be mailed to the member within three days of her/him receiving the transition supply. The letter will advise the member to talk to her/his prescriber about changing to another drug that is on Arkansas Blue Medicare's Formulary OR requesting an exception.

Transition Fill Cost Share

If the member is a low-income subsidy (LIS) beneficiary, her/his cost share for transition supplies will not exceed her/his LIS limit. For non-LIS beneficiaries, the cost share will be on the same cost-sharing tier as if a non-formulary exception was applied (generally Tier 4).

Drugs Excluded from Part D Transition Fills

Certain drugs are excluded from this transition fill policy:

- Drugs excluded from Medicare Part D coverage
- Drugs that need a determination if they are covered under Medicare Part B or Part D
- Drugs that have safety concerns (e.g., opioids, benzodiazepines, or other pain management medications, drug interactions, etc.)

Medication Therapy Management

Arkansas Blue Medicare's medication therapy management (MTM) program is a no-cost program designed to help eligible members ensure their medications are appropriate to treat their medical conditions and to help identify potential medication errors.

To be eligible for the MTM program, a member must meet all three of the following criteria:

- Have multiple chronic conditions (e.g., asthma, diabetes, hypertension, etc.).
- Take at least a certain number of unique Part D Drugs.
- Be likely to incur a specific annual amount for covered Part D drugs.

To learn more about Arkansas Blue Medicare's MTM program, visit arkbluemedicare.com/medication-therapy-management.

Excluded Medications

Arkansas Blue Medicare does not cover all prescription drugs.

Arkansas Blue Medicare will not cover the following drugs under the Part D benefit:

- Drugs covered under Medicare Part A or Part B.
- Drugs purchased outside the United States and its territories.
- Off-label use of drugs.
 - Off-label use is any use of a drug other than those indicated on a drug's label as approved by the Food and Drug Administration (FDA).

- Coverage for off-label use is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, Arkansas Blue Medicare cannot cover the off-label use.

Also, by Medicare law, Arkansas Blue Medicare does not cover the following drugs:

- Non-prescription drugs
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for the treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Pharmacy Directory & Formulary (Drug List)

Providers can search the Arkansas Blue Medicare Pharmacy Directories and Formularies (Drug Lists) at arkbluemedicare.com/pharmacy-resources.

For More Information

For more information about an Arkansas Blue Medicare member's prescription drug coverage, call the CVS Caremark Pharmacy Help Desk at **844-280-5833**.



SECTION 11

Medicare HEDIS and Star Ratings

Healthcare Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. MA follows HEDIS reporting requirements established by the National Committee for Quality Assurance (NCQA) and CMS. Audited HEDIS reports are used to identify quality improvement opportunities and develop quality-related initiatives.

The 2026 HEDIS measures for MA include, but are not limited to:

- Breast cancer screening
- Colorectal cancer screening
- Osteoporosis management in women who had a fracture
- Diabetes care – eye exam
- Glycemic status assessment for patients with diabetes (A1c \leq 9%)
- Kidney health evaluation for patients with diabetes
- Controlling blood pressure
- Statin therapy for patients with cardiovascular disease
- Transitions of care
- Follow up after ER visits for people with multiple high-risk chronic conditions
- Plan all-cause readmissions

Additionally, the MA program focuses on several pharmacy-based measures developed by the Pharmacy Quality Alliance (PQA). These measures are used in the CMS Star Ratings program and include:

- Medication adherence for hypertension (RAS antagonists)
- Medication adherence for cholesterol (statins)
- Medication adherence for diabetes medications
- Statin use in persons with diabetes
- Concurrent use of opioids and benzodiazepines, and polypharmacy
- Use of multiple anticholinergic medications in older adults

MA Star Ratings Program (Quality)

CMS evaluates health plans and issues Star Ratings each year; these ratings may change from year to year. CMS Star Ratings use quality measurements widely recognized within the healthcare and health insurance industries to provide an objective method for evaluating health plan quality. Arkansas Blue Medicare's overall Star Rating combines scores for the types of services Arkansas Blue Medicare offers. CMS compiles its overall score for the quality of services based on measures such as:

- How Arkansas Blue Medicare helps members stay healthy through preventive screenings, tests, and vaccines
- How Arkansas Blue Medicare helps members manage chronic conditions and clinical care
- Members' satisfaction with Arkansas Blue Medicare and their provider experience
- How well Arkansas Blue Medicare handles calls from members, and how long they remain enrolled in the plan

In addition, because Arkansas Blue Medicare offers prescription drug coverage, CMS also evaluates Arkansas Blue Medicare’s prescription drug plans for the quality of services based on:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Members’ experience with their drug plan
- Drug pricing and patient safety

More about CMS Star Ratings

CMS developed a set of quality performance ratings for health plans that includes specific clinical, member perception, and operational measures. The 2026 Star Ratings (based upon the 2024 measurement year [MY]) include 42 measures in six domains of care. Each of the 42 measures has a defined “weight” used in calculating the Star Ratings. These measures are adjusted each year and finalized by CMS.

CMS established Star Rating thresholds at a measure level, which are based on certain specifications – one Star through five Stars, where five Stars indicate higher performance. This rating system applies to MA and prescription drug plans (PDPs).

Star Ratings are posted on the CMS consumer website, [medicare.gov](https://www.medicare.gov), to help beneficiaries choose an MA plan offered in their area.

How Star Ratings Are Derived

A health plan’s Star Rating is based on measures in five categories:

Data Source	Description	# of Metrics*
HEDIS (Part C)	Subset of broad HEDIS data used to measure a health plan’s ability to drive compliance with preventive care guidelines and evidence-based medical treatment guidelines related to clinical measures	13
PQA (Part D)	Subset of PQA medication use measures designed to measure a health plan’s ability to drive appropriate medication use based upon evidence-based medical treatment guidelines and adherence to medications	6
CAHPS	Survey of randomly selected members focusing on member perception of their ability to access quality medical care	13
HOS	Survey of randomly selected members focusing on member perception of their own health and recollection of specific provider care delivered	5
CMS	Administrative data collected by CMS related to a health plan’s service capabilities and performance	5
Independent review entity	Timeliness and fairness of decisions associated with appeals	2

*The metrics indicate current proposal from CMS for MY2025.

The methodology used by CMS is subject to change and final guidelines are released each fall.



The Star Ratings methodology was developed to:

- Help consumers choose plans on [medicare.gov](https://www.medicare.gov)
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D
- Penalize consistently poor performing health plans
- Strengthen beneficiary protections

Star Measurement Timeline

As mentioned, CMS created the Part C and D Star Ratings to provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug services during the annual fall open enrollment period.

Arkansas Blue Medicare is accountable for the care provided by physicians, hospitals, and other providers to its members.

The measure categories in the Star Ratings measurement timeline illustrate when the clinical, perception, and operations data are collected, as well as when CMS publishes the Star Ratings.

2026 Star Rating Calendar

Measure Categories	2022	2023	2024	2025	2026
HOS	Survey		Follow-up survey		
HEDIS			Services incurred	Records retrieved	
Patient Safety			Claims incurred		
IRE			Appeals		
CMS			Complaints, membership, retention, price accuracy	Enterprise TTY services	
CMS Data Publication				★	
CMS Plan Year					
CAHPS				Member surveys	

Benefits of Star Ratings

In most instances, the value of improving performance is well worth the investment for the health plan, members, and provider community.

Member Benefits	Provider Benefits	Arkansas Blue Medicare Benefits
Quality care that leads to positive health outcome	Improved care quality and health outcomes	Improved care quality and health outcomes
Greater focus on access to care	Improved patient relations	Improved provider relations
Improved relations with doctors	Improved health plan relations	Improved member relations
Increased levels of customer service	Increased awareness of patient safety issues	Process improvement
Early detection of disease and health care that matches individual needs	Greater focus on preventive medicine, early disease detection, and chronic condition management	Key component in financing healthcare benefits for MA plan members
Improved plan benefits		

Tips for Improving Quality Care

- Encourage patients to get their preventive screenings annually or when recommended.
- Create office practices to identify non-compliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Understand the metrics included in the CMS Star Ratings system.
- Ensure documentation includes assessment of advanced illnesses, frailty, and cognitive and functional statuses.
- Identify opportunities for you or your office to have an impact.

To access more tools to help improve quality care, visit arkansasbluecross.com/providers/resource-center/hedis-measures.

For More Information:

To learn more about the HOS, visit cms.gov/data-research/files-for-order/limited-data-set-lds-files/health-outcomes-survey-hos.

To learn more about the CAHPS survey, visit cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems.

To learn more about HEDIS, visit ncqa.org/hedis/.



SECTION 12

Care Management

Overview of Arkansas Blue Medicare Care Management

Arkansas Blue Medicare's care management program promotes cost-effective and medically appropriate care and services. Components include clinical review of selected services, case management, transitional care coordination and chronic condition management programs.

Care management programs are available to the following Arkansas Blue Medicare products:

- **BlueMedicare HMO** – Utilization and case/chronic condition management program
- **BlueMedicare FFS** – Case/chronic condition management programs

While the PFFS plans are not subject to utilization management/prior authorization, a pre-service organization determination request can be submitted to determine if Arkansas Blue Medicare will pay for/cover a medical service or care.

Care Management Services

Utilization Management (only for Arkansas Blue Medicare HMO plans)

- Conduct clinical review of certain services and maintenance of medical review criteria
- Ensure medical services are medically necessary, appropriate, and provided in the most cost-effective setting
- Facilitate communication and collaboration between members, providers, and Arkansas Blue Medicare to support cooperation and appropriate utilization of healthcare services
- Provide information to practitioners about utilization management updates and activities
- Render timely determinations and issue timely notifications
- Assist with hospital discharge planning and transition of care needs
- Perform peer-to-peer reviews
- Ensure continuity of care

Transitional Care Coordination/Chronic Condition Management

- Coordinate healthcare services through chronic condition management programs
- Coordinate care between medical providers, as well as between medical and behavioral health providers
- Conduct member health education
- Assist with discharge planning
- Coordinate transitional care
- Perform health risk assessments
- Ensure compliance with accrediting and regulatory governing bodies
- Implement/Manage quality improvement initiatives

Contacting Care Management

The Arkansas Blue Medicare Care Management team is available Monday through Friday, 8:00 a.m. to 5:00 p.m. Central, at the following numbers.

Utilization Management: **800-287-4188**

Case Management (transition care coordination and complex case management): **800-817-7784**



SECTION 13

Utilization Management

Monitoring Utilization

Arkansas Blue Medicare uses various mechanisms to ensure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization such as overutilization, underutilization, and inefficient or inappropriate uses of resources. This helps ensure Arkansas Blue Medicare members receive the medical services required for health promotion, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of healthcare effectiveness data and information set data
- Results of member satisfaction surveys
- Rate of inpatient admissions
- Rate of emergency services
- Review of alternative levels of care such as observation
- High-dollar claim triggers
- Chronic condition identification
- Transitions care – to a facility or within the community
- Review of prior authorization rates for required services
- Monitor plan-directed care referrals for out-of-network utilization
- Observation care

Affirmation Statement

Arkansas Blue Medicare bases its utilization decisions about care and service solely on appropriateness in relation to each member's specific medical condition. Arkansas Blue Medicare's review staff has no compensatory arrangements that encourage denial of coverage or service. Clinicians employed by Arkansas Blue Medicare do not receive bonuses or incentives based on their authorization review decisions. Arkansas Blue Medicare bases all clinical review decisions on medical necessity by applying approved clinical criteria and ensures thorough and consistent utilization management decision-making within the limits of the member's plan coverage.

Appropriate Professionals

Arkansas Blue Medicare continues to demonstrate its commitment to a thorough and consistent utilization decision process by working collaboratively with its participating physicians. A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by care management nurses. It may be necessary for the plan medical director to contact physicians for additional information about their patients to assist in making a determination.

Peer-to-Peer

The peer-to-peer process is intended to facilitate discussion between a provider and a plan medical director. The peer-to-peer process should be used to explain or clarify something that a clinical record cannot convey. It should not be used as a means to provide additional clinical information. A peer-to-peer review may be initiated by the requesting provider any time prior to a pre-service written determination being rendered. A peer-to-peer discussion may be requested at any time for a concurrent review determination if the member has not been discharged from the facility.

Providers who wish to discuss an authorization with a plan medical director may do so by contacting Arkansas Blue Medicare Care Management at **800-287-4188**, Monday through Friday, 8:00 a.m. to 5:00 p.m. Central.



SECTION 14

Clinical Review Requirements

Overview of Clinical Review

The MA clinical review process was established to do the following:

- Ensure uniformity in the provision of medical care.
- Ensure the medical appropriateness and cost effectiveness of certain services.
- Improve the overall quality of care Arkansas Blue Medicare members receive.
- Lower the cost of coverage for MA members.
- Render timely determinations and issue timely notifications specific to CMS regulation:
 - Medical
 - Standard determinations within seven calendar days
 - Expedited determinations within 72 hours
 - Part B Pharmacy
 - Standard determinations within 72 hours
 - Expedited determinations within 24 hours

Arkansas Blue Medicare determines which services are subject to clinical review by analyzing the plan's utilization data and comparing it with the following:

- Internal goals
- External benchmarks such as HEDIS
- Medical policies and other evidenced-based criteria

Other factors are also taken into consideration:

- Procedures high in cost or volume
- Trends toward increasing use of a procedure or service
- Evidence of or reason to suspect actual or potential misuse
- Variations in practice patterns

In deciding which services require clinical review, Arkansas Blue Medicare also carefully examines:

- The negative impact the proposed review program might have on providers
- The acceptability of any existing criteria, such as InterQual criteria, Medicare guidelines or information from the medical literature
- Administrative impacts to the health plan and providers
- Market analysis or benchmarking, to determine whether the procedure is within the range of reasonable or accepted practice
- Net cost savings, considering any possible administrative cost offset

Criteria and Guidelines for Decisions

The criteria adopted by the plan are updated annually and include CMS Medicare guidelines and the following:

Criteria	Application
CMS guidelines <ul style="list-style-type: none"> ▪ NCDs ▪ LCDs ▪ Medicare articles ▪ Other CMS coverage manuals/guidance 	<ul style="list-style-type: none"> ▪ Inpatient admissions ▪ Continued stay ▪ Discharge readiness
InterQual	LOC – acute criteria LOC – post-acute inpatient criteria LOC – post-acute outpatient criteria Ambulatory care criteria, including Medicare content <ul style="list-style-type: none"> ▪ DME ▪ Part B drugs (non-oncology) ▪ Procedures
eviCore (uses InterQual review criteria at evicore.com/provider)	<ul style="list-style-type: none"> ▪ Radiology ▪ Radiation therapy ▪ DME ▪ Medical drug oncology
Lucet Health (online medical policy available at lucethealth.com/)	<ul style="list-style-type: none"> ▪ Inpatient services ▪ Outpatient services ▪ Residential services ▪ Behavioral health case management

Obtaining Criteria

The review criteria related to a specific decision are available to physicians upon request by calling Arkansas Blue Medicare Care Management at **800-287-4188**.

Clinical Review Determination

In addition to reviewing clinical information, Arkansas Blue Medicare evaluates the following:

- Member eligibility, coverage, and benefits
- Medical need for the service
- Appropriateness of the service and setting
- Continuity of care

If additional clinical information is required to approve the service, a Medicare Advantage Care Management representative will call and/or fax the provider to ensure that all needed information is received in a timely manner.

Clinical Review Required

Arkansas Blue Medicare must review and approve select services before they are provided. The primary reason for clinical review is to determine if the service is medically necessary, it is performed in the appropriate setting, and it is a benefit covered by the member's plan. Clinical information is necessary for all services that require clinical review to determine medical necessity.

A complete list of the clinical criteria and required information that apply to each requested service is as follows:

- **Acute hospital admissions** – notification is required the next business day
- **30-day bundling for readmissions** – notification is required the next business day
- **SNF admissions** – notification is required prior to admission and prior to exhausted days for concurrent review
- **Long-term acute care hospital admissions** – notification is required prior to admission and prior to exhausted days for concurrent review
- **Inpatient rehabilitation** – notification is required prior to admission and prior to exhausted days for concurrent review

More information is available online

- Arkansas Blue Medicare prior authorization list: arkansasbluecross.com/providers/medical-providers/medicare
- Arkansas Blue Medicare forms: arkansasbluecross.com/providers/resource-center/provider-forms

Submit the Required Clinical Information with the Initial Review Request

Providers are encouraged to fax the required clinical information with the initial request for clinical review.

- Clinical information for acute and post-acute hospital admissions and expedited pre-service authorizations should be faxed to **816-313-3013**.
- Standard authorizations should be faxed to **816-313-3014**.
- Part B pharmacy authorizations should be faxed to **816-313-3015**.

Arkansas Blue Medicare is required by regulatory agencies and Medicare to notify members about the clinical information needed to process a clinical review request. When providers submit the necessary clinical information with the initial request, it decreases the number of letters Arkansas Blue Medicare is required to send to members, thus reducing member abrasion.

Guidelines for Observations and Inpatient Hospital Admissions

Contracted facilities must notify Arkansas Blue Medicare of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure Arkansas Blue Medicare members receive care in the most appropriate setting, Arkansas Blue Medicare is involved in the evaluation and coordination of discharge planning, and there are appropriate referrals to case management for members who need those services, including those managing active disease processes, demonstrating high use of health resources, or are at high risk for health complications.

Providers should notify Arkansas Blue Medicare of admissions by telephone or fax.

- Telephone: **800-287-4188**
- Fax: **816-313-3013**

Arkansas Blue Medicare nurses conduct admission reviews via telephone or fax by obtaining information from the hospital's utilization review staff and talking with attending physicians (when necessary).

Clinical information includes relevant information about the member:

- Health history
- Physical assessment
- Test and laboratory results
- Consultations
- Emergency room treatment and response
- Admitting orders

Once authorization is approved, the facility will be provided with an authorization number that is valid for the entire length of stay for the acute care admission.

Emergency Admissions

When an admission occurs through the emergency room, Arkansas Blue Medicare will ask the facility to contact the primary care physician prior to admission to discuss the member's medical condition and coordinate care.

Elective Admissions

Prior authorization is required for elective admissions, and the primary care and specialist physicians are required to notify Arkansas Blue Medicare at least 14 days before arranging the service, when possible.

Arkansas Blue Medicare will review the request to determine appropriateness of the setting and, if required, meets criteria. Arkansas Blue Medicare will then notify the member, primary care physician, attending physician, and facility of the determination.

Obstetrical Admissions

Arkansas Blue Medicare requires facilities to provide admission and discharge information on deliveries via fax or phone to the Care Management Department. For all deliveries, the facility should notify Arkansas Blue Medicare one day after discharge. The following information must be provided:

- Admission date, delivery date, and discharge date
- Type of delivery
- If the baby was born alive
- If both mother and baby were discharged alive

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services that:

- Include ongoing short-term treatment, assessment, and reassessment.
- Are furnished while a decision is being made about whether a member requires further treatment as a hospital inpatient or can be discharged from the observation bed.

Observation stays of up to 48 hours for Arkansas Blue Medicare members may be eligible for reimbursement when providers need more time to evaluate and assess a member's needs to determine the appropriate level of care. Examples of diagnoses that may be treated in an observation setting include, but are not limited to:

- Chest pain
- Syncope
- Cellulitis
- Pneumonia
- Bronchitis
- Pain or back pain
- Abdominal pain
- Pyelonephritis
- Dehydration (gastroenteritis)
- Overdose or alcohol intoxication
- Close head injury without loss of consciousness

Options Available Beyond the Observation Period

The following options are available when members require care beyond the observation period:

- Contact Arkansas Blue Medicare care management clinical staff to discuss alternate treatment options such as home care or home infusion therapy.
- Request an inpatient admission.

Note: If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should reevaluate the member's need for inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.

Medical Necessity Considerations: Inpatient vs. Observation Stays

When Arkansas Blue Medicare members are admitted for inpatient care, the process used to determine if their stay is medically necessary is different than the Original Medicare process.

Here are some guidelines on how Arkansas Blue Medicare determines medical necessity:

- Arkansas Blue Medicare uses InterQual criteria to make determinations of medical necessity for all members.
- Arkansas Blue Medicare does not require physician certification of inpatient status to ensure a member's inpatient admission is reasonable and necessary. (For Original Medicare patients, however, this certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B and 42 CFR 412.3.)
- When the application of InterQual criteria results in an Arkansas Blue Medicare member's inpatient admission being changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- The Arkansas Blue Medicare clinical review process takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient versus observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures, and the "two midnight" rule.

Review of Readmissions that Occur Within 30 Days of Discharge

Arkansas Blue Medicare reviews inpatient readmissions that occur within 30 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member has the same or a similar diagnosis. Arkansas Blue Medicare reviews each readmission to determine if it resulted from one or more of the following:

- Premature discharge or a continuity of care issue
- Lack of or inadequate discharge planning
- Planned readmission
- Surgical complications

In some instances, Arkansas Blue Medicare combines the two admissions into one for purposes of the DRG reimbursement. Arkansas Blue Medicare guidelines for bundling a readmission with the initial admission are available at arkansasbluecross.com/providers/resource-center/provider-forms.

Skilled Nursing, Long-Term Acute Care, and Inpatient Rehabilitation Facility Admission Guidelines

Facilities must notify Arkansas Blue Medicare of all post-acute admissions and provide clinical information prior to the admission for initial requests, and prior to the expiration of approved days for continued stay review requests. Timely notification helps ensure Arkansas Blue Medicare members receive care in the most appropriate setting, Arkansas Blue Medicare is involved in the evaluation and coordination of discharge planning, and there are appropriate referrals to case management for members who need those services, including those managing active disease processes, demonstrating high use of health resources, or are at high risk for health complications.

Providers should notify Arkansas Blue Medicare of admissions by telephone or fax.

- Telephone: **800-287-4188**
- Fax: **816-313-3013**

Arkansas Blue Medicare requires requests for transitional or discharge planning services be handled during business hours.

Arkansas Blue Medicare nurses conduct admission and discharge planning via telephone or fax by obtaining information from the hospital's utilization review staff and talking with attending physicians (when necessary).

Clinical information includes relevant information about the member:

- Health history
- Prior level of functioning
- Clinical assessment
- Therapy evaluations
- Admitting orders
- Discharge plans

Outpatient and Professional Services Requiring Authorization

Outpatient and professional services prior authorization requirements apply to providers who participate with Arkansas Blue Medicare HMO plans.

When prior authorization is required, primary care and specialist physicians must notify Arkansas Blue Medicare prior to rendering services. Arkansas Blue Medicare will review the request to determine if the services meet the medical necessity criteria. The member, referring physician, and rendering physician will then be notified of the clinical determination.

Some services that require prior authorization. This is not the full list – for the full list, go to arkansasbluecross.com/providers/medical-providers/medicare.

- DME
- Diagnostic testing
- Genetic testing
- Surgical procedures
- Medical procedures
- Professionally administered Part B drugs

Per CMS regulation, prior authorization requests are classified in two ways and should be submitted accordingly to Arkansas Blue Medicare.

- **Expedited** – to be requested when care is deemed to be of priority need. Responses are given within 72 hours of the request.
- **Standard** – to be requested when routine care is being provided or scheduled. Responses are given within seven days of the request.

Note:

- Prior authorization is not required for emergency room and urgent care visits.
- Arkansas Blue Medicare contracted providers should use appropriate in-network providers, labs, and imaging centers whenever possible and in accordance with the participating provider’s contract. If the provider fails to inform the member of a referral or admission to an out-of-network entity or provider, such action shall constitute a material breach of the agreement, which may lead to contract termination.

Decision Criteria and Guidelines

Arkansas Blue Medicare criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan, or a combination of both. Individual circumstances of a member are taken into consideration when applying the criteria, as are characteristics of the local delivery system such as:

- Availability of SNFs, sub-acute care facilities, or home care in the network to support the member after discharge.
- Member’s benefit coverage for SNFs, sub-acute care facilities, or home care, where needed.
- Ability of network hospital(s) to provide all recommended services within the established length of stay.

The review criteria are available to physicians upon request by calling **800-287-4188**.

Discharge Planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member
- Family members
- Primary care physician
- Specialist
- Hospital discharge planning staff
- Ancillary providers, as necessary

Arkansas Blue Medicare monitors all hospitalized members to assess their readiness for discharge and assist with post-hospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay.

Arkansas Blue Medicare nurses work in conjunction with members’ primary care physicians to authorize and coordinate post-hospital needs such as home health care, DME, and skilled nursing placement. For these members, providers should follow the processes described in the “Guidelines for Transitional Care” section of this chapter.

Note: Only acute care, skilled nursing, long-term acute care, and inpatient rehabilitation facilities require prior authorization.

Standard Timeframes for Pre-Service Decisions

The care management staff conducts timely reviews of all requests according to the type of service requested. Decisions are made according to the following standard timeframes:

Request Type	Decision	Initial Notification	Written Notification	Service Type
Pre-service urgent/ concurrent	Within 72 hours of request receipt	Within 72 hours of request receipt	Within three days of initial notification	Acute and post-acute admissions
Pre-service non-urgent	Within seven days of request receipt	Within seven days of request receipt	Within seven days of request receipt	Surgery

Requests for More Information for Pre-Service Requests

An extension of up to 14 calendar days is allowed if a member asks for the extension or if Arkansas Blue Medicare needs more information to make a decision about the request. The member can request an extension by phone or in writing.

Expedited Decision

Either a physician or member may request an expedited decision if they believe waiting for a standard decision could or would do one of the following:

- Seriously harm the life or health of the member.
- Seriously compromise the ability of the member to regain maximum function.
- Subject the member to severe pain that cannot be adequately managed with the care or treatment that is being requested.

Arkansas Blue Medicare relies on the physician to determine conditions that warrant expedited decisions.

- If the physician requests an expedited decision, the decision is made according to pre-service time frames.
- If the member requests an expedited decision, Arkansas Blue Medicare will call the physician to determine if the member's medical condition requires a fast decision.
 - If the physician agrees, Arkansas Blue Medicare will make a decision to approve or deny the request according to the pre-service expedited time frame (see table above).
 - If the physician disagrees, Arkansas Blue Medicare will make a decision according to the standard time frame (see table above) and notify the member of the decision not to make an expedited decision.
- Arkansas Blue Medicare will not make an expedited decision about payment for care the member has already received.

How a Physician May Request an Expedited Decision

Per CMS expedited definitions, the provider certifies that applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to recover or result in serious impairment or permanent disability. A request submitted as expedited that does not meet the above criteria will be changed to a standard request.

- For imaging, therapeutic radiation, or DME, contact eviCore by calling **800-646-0418** or logging in at [evicore.com/provider](https://www.evicore.com/provider).
- For behavioral health, contact Lucet Health by calling **888-611-6285** or via their website at [lucethealth.com/](https://www.lucethealth.com/).
- For all other medical services, call Arkansas Blue Medicare at **800-287-4188**, 8:00 a.m. to 5:00 p.m. (expedited telephonic medical requests can only be processed during these hours). Or fax to **816-313-3013**.

Steps to Take Before Rendering Services that Are Not or May Not Be Covered

It is recognized that a member may consent to get services that are not or may not be covered by Arkansas Blue Medicare and, therefore, may be payable by the member. Providers are encouraged to verify member benefits prior to service.

To verify member benefits, call one of the following numbers.

- Medical services and Part B drugs: **800-287-4188**
- Part D drugs: **844-280-5833**

General Medical Necessity Considerations

As an MA organization, Arkansas Blue Medicare is required by CMS to provide coverage to members for all Medicare Part A and Part B covered services. However, CMS does not require MA organizations to follow the same payment determination rules or processes as Original Medicare does for providers.

While Arkansas Blue Medicare applies medical necessity criteria to determine coverage, the criteria do not have to be applied in the same manner as is required under Original Medicare.

- **Benefits:** Arkansas Blue Medicare plans must provide or pay for medically necessary covered items and services under Part A (for those entitled) and Part B.
- **Access:** Arkansas Blue Medicare members must have access to all medically necessary Part A and Part B services. However, Arkansas Blue Medicare is not required to provide members the same access to providers given under Original Medicare.
- **Billing and payment:** Arkansas Blue Medicare does not follow Original Medicare claims processing procedures. Arkansas Blue Medicare may create its own billing and payment procedures as long as providers, contracted or non-contracted, are compensated accurately, timely, and with an audit trail.

When determining medical necessity, both Arkansas Blue Medicare and Original Medicare coverage and payment are contingent upon a determination that the following conditions are met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member or is a covered preventive service.

Members Held Harmless

In accordance with their Arkansas Blue Medicare provider agreement, providers may not seek payment from members for elective services that have not been approved by Arkansas Blue Medicare unless the member is informed in advance about her or his payment responsibility. Some of the circumstances in which members are held harmless for denied covered services include:

- Urgent/emergent admission denials.
- Partial denial of a hospital stay.
- Requests for elective services provided by contracted providers that require clinical review but were not forwarded to Arkansas Blue Medicare prior to the service being rendered.
- Denials issued for post-service requests for services provided by contracted providers when the information submitted is not substantiated in the medical record.

Members at Risk

In certain instances, members are held at financial risk for denied services. These instances occur when:

- The member's plan was not in effect on the date of service.
- The member refuses to leave an inpatient setting after the attending physician has discharged the member.
- A denial has been issued for pre-certified services.
- Services that are not a covered benefit under the member's plan are rendered.
- Services are rendered at a non-contracted facility.

Medical Records Requests

Medical records may be requested to render a medical management decision or to investigate potential quality concerns. The member's plan allows Arkansas Blue Medicare to review all medical records.

Arkansas Blue Medicare must receive all records within five to six days of the request. Urgent requests may be made in accordance with CMS expedited request rules. Providers cannot charge a copying fee for medical records requested by Arkansas Blue Medicare

Emergency Room and Urgent Care Services

Emergent Care Defined

Arkansas Blue Medicare provides members with coverage for emergency and urgent care services necessary to screen and stabilize their condition without precertification.

Emergency care definitions:

- **Medical emergency** – The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a member's health or pregnancy (in the case of a pregnant woman), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- **Accidental injury** – A traumatic injury that, if not immediately diagnosed and treated, could be expected to result in permanent damage to the member's health.

Arkansas Blue Medicare members should not be referred to emergency rooms or urgent care centers for services that can be performed in the primary care physician's office during regular business hours or that do not meet emergency or urgent care definitions.

Coordination of Emergent and Urgent Care Services

Members are encouraged to contact their primary care physician to assist in arranging urgent care services required after hours. Emergency and urgent care providers should send a written summary of the services provided and the treatment plan to the primary care physician within 30 days of the date of service.

Excessive Use of Emergency Services

All Arkansas Blue Medicare members receive information on the appropriate use of emergency room services, as well as guidelines to follow when a situation does not require emergency care.

Case managers address the unique needs of the high-volume ER user. The member is assessed and interventions are employed, including interaction with the Pharmacy Department, as well as the member and primary care physician. Members are educated about appropriate ER usage and follow up with the primary care physician is arranged as appropriate. In addition, members identified for case management services are sent a document with tips for appropriate ER usage.

Additionally, the case manager provides written communication to the physician about opportunities to assist the member and coordinate an appropriate plan of care

Part B Medications (Outpatient/Office Administered Drugs)

Submitting the Required Clinical Information with the Initial Review Request

Arkansas Blue Medicare uses InterQual Specialty Medication Criteria for Part B non-oncology drugs administered in an outpatient or office setting.

Providers are strongly encouraged to submit the required clinical information with the initial request for clinical review, including:

- Drug name, J code, dose, and quantity requested
- Pertinent test and laboratory results
- Documentation of failed therapies

The request form can be found at arkansasbluecross.com/providers/resource-center/provider-forms. The completed form and supporting clinical information should be faxed to **816-313-3015**.

Note: For oncology or chemotherapy drug requests, contact eviCore at **800-646-0418**.

CMS-Regulated Decision Timeframes for Part B Medication Requests

- Standard determinations: Within 72 hours
- Expedited determinations: Within 24 hours
 - Expedited determinations are considered when a member is in direct health harm if the drug is not administered urgently.

Administrative Denials

Administrative denials are determinations made by Arkansas Blue Medicare in accordance with administrative policies and procedures and/or contract language. These determinations are not based on medical necessity or appropriateness.

Administrative denials can be issued by Arkansas Blue Medicare with or without review by a plan medical director. Examples of situations likely to result in administrative denials include, but are not limited to:

- Authorization submissions for non-covered benefits
- Out-of-network exception requests when care is available in-network

The administrative determination appeal process affords providers and practitioners one level of appeal for determinations related to administrative denials.



SECTION 15

Health Education & Chronic Condition Management

Health Education and Management Program

Arkansas Blue Medicare has developed a chronic condition management program to help members manage chronic diseases through a partnership among physicians, members, and the plan.

Arkansas Blue Medicare's healthcare management strategies include education about staying healthy and living with an illness. The objective of this strategy is to improve clinical outcomes, reduce costs, and improve member and physician satisfaction.

Goals for Chronic Condition Management

Arkansas Blue Medicare identifies members with chronic conditions who may benefit from chronic condition management interventions designed to:

- Promote early diagnosis and appropriate treatment according to recognized clinical practice guidelines.
- Provide tools to simplify member self-management efforts.
- Improve member adherence to a treatment plan.
- Provide continuity of care through specialty case management, when indicated.
- Integrate health promotion and wellness initiatives across the continuum of care.
- Educate members about the purpose and importance of advance directives.

Arkansas Blue Medicare's role in chronic condition management includes:

- Analyzing plan data and targeting conditions appropriate for program development.
- Researching, developing, and distributing clinical practice guidelines.
- Developing and implementing comprehensive chronic condition management programs.
- Using predictive modeling to determine individual member interventions.
- Mailing educational materials to members about self-management, preventive health issues, relevant medical tests, lifestyle issues, and medication compliance.
- Offering registered nurse chronic condition managers who make outreach calls to identified members.
- Providing educational resources to physicians.
- Studying outcomes to determine the impact of chronic condition management programs.

Member Participation

Members identified as eligible for specific chronic condition management programs are automatically enrolled (member identification criteria are consistent with Arkansas Blue Medicare's clinical practice guidelines).

Members can decline participation in a program at any time.

Quality Management

All MA organizations are required to have a quality improvement (QI) program as described in the federal regulations at 42 CFR §422.152, "Quality improvement program." The requirements for a prescription drug plan quality assurance program are based in regulation as per 42 Code of the Federal Regulations § 423.153(c).

The primary goal of the QI program is to effect sustained improvement in patient health outcomes. As provided under 42 CFR §422.152(c) and §422.152(d), Arkansas Blue Medicare's QI program must include at least one chronic care improvement program (CCIP) for one chronic condition and a quality improvement project (QIP) that measures and demonstrates improvement in health outcomes and member satisfaction.



SECTION 16

Pre-Service Organization Determinations for Services

Obtaining a Pre-Service Organization Determination (not related to services or items requiring pre-authorization/certification)

Providers may choose to obtain a written pre-service organization determination from Arkansas Blue Medicare before rendering a service or item.

All Arkansas Blue Medicare plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets Original Medicare medical necessity criteria, it will be covered by Arkansas Blue Medicare and subject to the member's cost share and terms and conditions of the member's particular health plan.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To request a pre-service organization determination:

1. Go to arkansasbluecross.com/providers/resource-center/provider-forms.
2. Complete the *Arkansas Blue Medicare Organizational Determination Form*.
3. Fax the completed form to **816-313- 3014**.

The following information should be included with a pre-service organization determination request:

- Provider or supplier contact information, including name and address
- Anticipated date of service, if applicable
- Procedure/HCPCS and diagnosis codes
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where the services will be rendered, and physician specialty
- Documentation and any correspondence that supports the position that the plan should cover the service or item (including clinical rationale, LCD, and/or NCD documentation)
- Name and signature of the provider or provider's representative

Arkansas Blue Medicare will make a decision and notify the provider within seven days of receiving the request, with a possible 14-day extension if either the member requests an extension or Arkansas Blue Medicare believes taking more time is in the member's best interest.

If a provider believes waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, an expedited determination can be requested by indicating "Urgent" or "Expedite" on the first page of the request. Arkansas Blue Medicare will render a decision within 72 hours unless a 14-day extension is requested by the member or Arkansas Blue Medicare believes taking more time is in the member's best interest.

Network Exceptions

Arkansas Blue Medicare HMO members do not have out-of-network benefits.* However, Arkansas Blue Medicare PFFS members do have out-of-network benefits, but they may have a higher cost share for services or items received from an out-of-network provider.

Non-contracted providers can request a network exception for members who need specialized services when there are no or limited access to appropriate providers in the Arkansas Blue Medicare network.

Providers can request a network exception by completing a *Medicare Out-of-Network Exception Form* (arkansasbluecross.com/providers/resource-center/provider-forms) and faxing it to:

- Standard requests: **816-313-3014**
- Expedited requests: **816-313-3013**

***Exceptions:** Emergency care, urgently needed services when the network is not available, and out-of-area dialysis services.



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