PROVIDERS' NEWS

DECEMBER 2016

A publication for participating providers and their office staffs

INSIDE

Have you registered?

Arkansas Prescription Drug Monitoring Program

Any new provider coming into our Arkansas Blue Cross and Blue Shield networks must be registered with the Arkansas Prescription Drug Monitoring Program if that provider holds a DEA certificate for controlled-substances prescribing.

All current network providers have until April 1, 2017, to register. Registration is free, and it only takes a few minutes to complete the registration. Under the law, a prescriber may designate someone in the facility, such as a nurse, to be that prescriber's delegate for checking the Prescription Drug Monitoring Program database, once that delegate has also registered.

When a prescriber checks the Prescription Drug Monitoring Program, they become aware of patient issues and can begin discussions leading to safer drug use, better pain management, and treatment for addictions, when appropriate.

Arkansas Blue Cross requires contracted providers in Arkansas to register and encourages use of the Arkansas Prescription Drug Monitoring Program.

Payment policy change for individual metallic plans

The ability for providers to opt out of the provider network for individual Metallic health plans is still in place, however, the policy for how an opted-out provider is paid has been revised and needs to be clarified.

If a provider opts out of the network for individual Metallic plans, yet provides services to one of our members covered by an individual Metallic plan, the provider's claims will be adjudicated with a Medicare equivalent fee allowance. The opted-out provider will be paid directly, the member will not receive the payment.
This reimbursement policy applies to any provider considered out of network for the individual Metallic health plans. If for some reason it is not possible to verify a provider's payment address, the member will receive the payment, not the provider. If a provider opts out of the network, he or she must wait one year to rejoin.

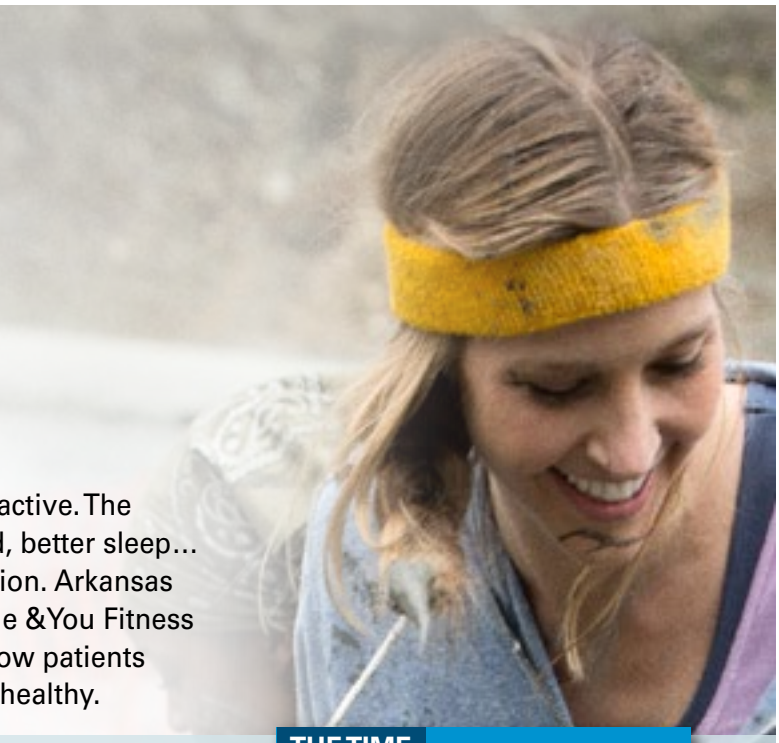
This policy becomes effective January 1, 2017. This notification through Providers' News is considered a formal policy notification and contractual amendment for all USAble Corporation True Blue PPO provider agreements.

AHIN availability for 2017 open enrollment

2017 Open Enrollment Periods began on October 1, 2016, and runs through January 31, 2017. Due to the anticipated enrollment of many new members and the renewal of current members effective on the same dates, we are expecting extremely high call volume through March 1, 2017. Arkansas Blue Cross and Blue Shield strongly encourages physician and other health care professional offices and facilities to use AHIN (Advanced Health Information Network) for verifying eligibility, benefits, and claims status.
AHIN displays information on benefits that should assist providers when scheduling appointments, checking eligibility and benefits. If a provider requires proof of coverage for their records, they may copy the screen to their files or print a paper copy. Arkansas Blue Cross is staffing to answer a higher call volume, but there may be times when call volumes spike and exceed our ability to answer every call. Because Arkansas Blue Cross recognizes how valuable our provider's time is, we want to remind our medical providers that AHIN uses the same information available to our customer service representatives and is continually updated.

Walk the talk with the 2017 Blue&You fitnessChallenge

A program of Arkansas Blue Cross and Blue Shield, Arkansas Department of Human Services and the Arkansas Department of Health



Every day, your office advises patients to be more active. The benefits are clear – improved health, happier mood, better sleep… For most people, it boils down to time and motivation. Arkansas Blue Cross and Blue Shield has a solution – the Blue &You Fitness Challenge. The Challenge is your opportunity to show patients your office's own commitment to being active and healthy.

During the contest, groups compete against similarly sized teams by performing cardiovascular exercises. When you participate, we'll provide resources in the contest kit online, including:

- A setup guide to help you get started
- Motivational emails to get your group running
- Posters you can print and display as talking points for patients
- An easy-to-use website with reporting tools to manage your team

THE TIME

From March 1 – May 31, you can earn points by exercising for as little as 15 minutes

THE MOTIVATION

Be the example for patients, challenge other groups and feel great!

HOW TO PARTICIPATE

1. Create a group of at least two people, age 13+
2. Assign a group administrator, age 18+, to register your group by mid-February at **blueandyoufitnesschallenge-ark.com**
3. Have group members register by March 1 with the admin's unique group code

MOVE, LOG AND PROMOTE

From March 1-May 31, your team simply logs exercises online. With more than 30 eligible exercises and an "other" category, too, your team can earn points for activity they're likely already doing. Your score will be added in real-time to the leaderboard – which you can also print off and display.

FREE TO JOIN

blueandyoufitnesschallenge-ark.com
info@blueandyoufitnesschallenge-ark.com | 1-800-686-2609

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Arkansas Department of Health
Keeping Your Hometown Healthy

ARKANSAS DEPARTMENT OF HUMAN SERVICES

CPT category II and Z codes aid data collection, lessen administrative work for offices

What are CPT category II and Z codes?
CPT category II codes are tracking codes, while Z codes are diagnosis codes. Certain CPT II codes and Z codes facilitate data collection for HEDIS® measures.** Used together, they can give you credit for quality care without the need for medical record review and can help you close gaps for HEDIS measures.

Here's a closer look:

- CPT category II codes describe components that are usually included in the evaluation and management process, such as A1c or blood pressure test results. They are billed in the procedure code field like CPT category I codes are.
- Z codes are diagnosis codes. To illustrate how they might be used to facilitate data collection, submitting a claim with the appropriate ICD-10 diagnosis code to indicate a patient's body mass index will alleviate the need to review the member's medical record for BMI documentation. For example, if the patient's BMI is between 24.0 and 24.9, you could submit the Z code of Z68.24. If the patient is a child, you could submit Z68.51 indicating that the child is less than the 5th percentile for her age. These are just two examples within the range of Z codes used to indicate the BMI of a patient.

Why should my practice use CPT category II and Z codes?
The use of CPT category II and Z codes on claims eases an office's administrative burden. It does this by decreasing, while not completely eliminating, the need for medical record reviews to determine if certain HEDIS measures are met. Performance on certain HEDIS measures influences the level of reimbursement providers can receive through various incentive programs.

CPT category II codes are adopted and reviewed by the Performance Measure Advisory Group, or PMAG. PMAG is made up of experts in performance measurement from organizations such as the American Medical Association, the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services and others.

For more information, download or print the following:

- CPT II quick guide for closing gaps for HEDIS measures [will link to document]
- HEDIS claim coding reference guide [will link to document]

**HEDIS®, which stands for Healthcare Effectiveness Data and Information Set, is a registered trademark of the National Committee for Quality Assurance.

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CPT® II Quick Guide

Keep this guide handy when closing gaps for HEDIS® measures.

Medication Reconciliation Post-Discharge Measure	
1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Comprehensive Diabetes Care Measure	
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
3045F	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0%
3046F	Most recent hemoglobin A1c (HbA1c) level greater than 9.0%
3060F	Positive microalbuminuria test result documented and reviewed
3061F	Negative microalbuminuria test result documented and reviewed
3062F	Positive macroalbuminuria test result documented and reviewed
3066F	Documentation of treatment for nephropathy (includes visit to nephrologist, receiving dialysis, treatment for end stage renal disease, chronic renal failure, acute renal failure or renal insufficiency)
4010F	Angiotensin converting enzyme, or ACE, inhibitor or angiotensin receptor blocker, or ARB, therapy prescribed or currently being taken

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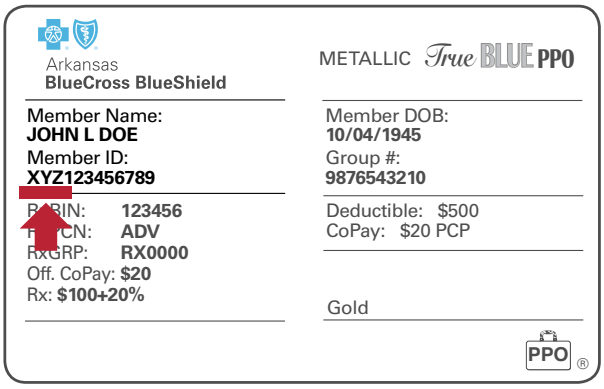
CPT® II Codes Tips

- Manage and document all acute and chronic patient conditions appropriately
- Ensure that services provided and diagnoses are documented in the medical record
- Submit accurate and timely claims for every office visit
- Report all services completed on a claim
- CPT and CPT II codes must be billed on the same date of service

Alpha Numeric Prefixes Coming in 2018

Background

The three-position alpha prefix of a Member's Identification Number (ID) is a foundational component of the BlueCard Program and Inter-Plan Teleprocessing Services (ITS). Although originally used primarily for claims routing, the functions/processes dependent on the alpha prefix have expanded along with the program.



Issue

With the potential for the current pool of alpha prefixes to run out as early as 2018, it is important to expand the pool and/or slow the rate of consumption.

Resolution

The Blue Cross and Blue Shield Association is changing the field from an alpha (only) prefix to an alpha numeric prefix. The move to an alpha numeric prefix solution increases the prefix pool and mitigates the risk of impacting the Plans business and new initiatives. The software update will be distributed in Release 17.5 which implements October 15, 2017, with utilization **effective on April 15, 2018**.

Action Needed

Arkansas Blue Cross and Blue Shield is currently assessing the impact of this system change. If any providers have hard-coded system edits that may be impacted by this change, **please contact your network development representative** as soon as possible.

Frequently Asked Questions

1. **Will the alpha numeric prefix still be three positions?**
   Yes, the change to alpha numeric allows us to keep the current three position prefix most are accustomed to.
2. **Will all positions of the prefix be allowed to be numeric?**
   No, a prefix cannot be all numeric. The system edits will be modified to allow for numeric positions.
3. **With the move to numeric, is there an impact to the Federal Employees Program (FEP)?**
   FEP ID numbers start with an R, which has been taken into consideration and will be accounted for in the requirements and design process.
4. **Are there any restrictions on the numeric character?**
   Yes, zero and one will not be used. The numeric characters will be two through nine.
5. **How many prefixes does a numeric position add to the overall prefix pool?**
   This would add about 30,000 prefix combinations.
6. **What order will the alpha numeric prefix be released?**
   There are six combinations that will be released once the current set is exhausted:

Additional Alpha Numeric Prefix Combinations					
A2A	2AA	22A	AA2	2A2	A22

Telemedicine services

Because telemedicine services are relatively new, we are seeing some claims errors. The most common problems are:

1. Q3014 should be billed by the originating site (where the patient is located), not by the provider who is performing the service via telemedicine. Q3014 and the telemedicine service (with -GT or -95 (beginning January 1, 2017) modifier) should not be billed by the same provider and should never be billed on the same claim.
2. Telemedicine is restricted to certain places of service. Please refer to the coverage policy for more detail.
3. Telemedicine for medical services is covered only when performed by physicians; mental health services are covered when performed by physicians and a few other limited provider types.
4. Complex E/M services requiring extensive history and physical exam cannot be performed adequately by telemedicine, and the highest-level E/M services (eg. 99205, 99215) are not covered by telemedicine.
5. Telemedicine is not covered for FEP members. Telemedicine coverage for self-insured groups varies depending upon the employer. The applicable coverage policy is available at http://www.arkansasbluecross.com/members/report.aspx?policyNumber=2015034

Requests for information for claims relating to unlisted codes

When claims for unlisted procedures are submitted, please include a description of the lab test, procedure or drug on the claim form. If records are requested, it is important to make clear exactly what is being billed using the unlisted code. The lab report, drug name and dosage, or procedure report should be submitted, ideally written on the fax cover sheet used in the medical record request. In many cases, we receive copious records, and even after review we cannot determine what is being billed. This often results in repeated requests for information and even denial of the claim because of failure to submit the necessary records.

Update to claims filing for habilitative services

With the passing of the Affordable Care Act in 2010, rehabilitative and habilitative services and devices became one of the ten Essential Health Benefits (EHBs) required to be covered by healthcare issuers. On January 1, 2014, EHBs were first required to be included in healthcare plans.

Beginning Jan. 1, 2017, all healthcare issuers will need to track habilitative services and rehabilitative services separately to ensure visit limits are not combined. In order to support separate tracking of habilitative services, providers need to code habilitative services on these claims with HCPCS modifier SZ = "Habilitative Services."

Care Management Portal to launch in 2017

If you are a primary care physician with patients aligned to you through Arkansas Blue Cross and Blue Shield and our family of companies, beginning January 2017, you have access to a tool through the Advanced Health Information Network (AHIN) that can help you manage your patients' care.

Overview of the Care Management Portal (CMP)

The Care Management Portal (CMP) provides clinically relevant data on three levels:

- Summary data at the practice/provider level
- Patient-level detail
- Referral data on facilities and specialists

The CMP data is updated monthly and contains a rolling year's worth of information. Nurse practitioners and physician assistants in certain value-based programs with aligned patients also can access data on their patients through the CMP.

The Care Management Portal is designed to assist primary care providers across the state in succeeding in value-based programs through the sharing of information," said David Greenwood, vice president of Enterprise Business Intelligence & Health Information Network. "We plan to continue to enhance the portal and will soon add new capabilities to AHIN to allow providers to satisfy program requirements electronically with the goal of reducing provider hassle and expense."

Objectives

The CMP can be used to help you manage your patients in a variety of ways. You can view a number of metrics concerning your aligned patients, such as:

- Care gaps
- Cost of care
- Emergency department visits
- Prescription utilization

Functions

The utilization summary screen includes PCP and emergency department visits, inpatient admissions, and pharmacy use for every aligned patient with comparisons to peers within a clinic or to the statewide averages.

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Care Management Portal to launch in 2017 (Continued from page 8)

A list of your aligned patients will be provided and you will have the ability to select a patient for additional information. On the patient detail screen, a "Find Patient" option allows you to search for an aligned patient using his/her first name, last name, date of birth or contract number.

The only patients displayed in the CMP are those aligned to you. That means the member did one of the following:

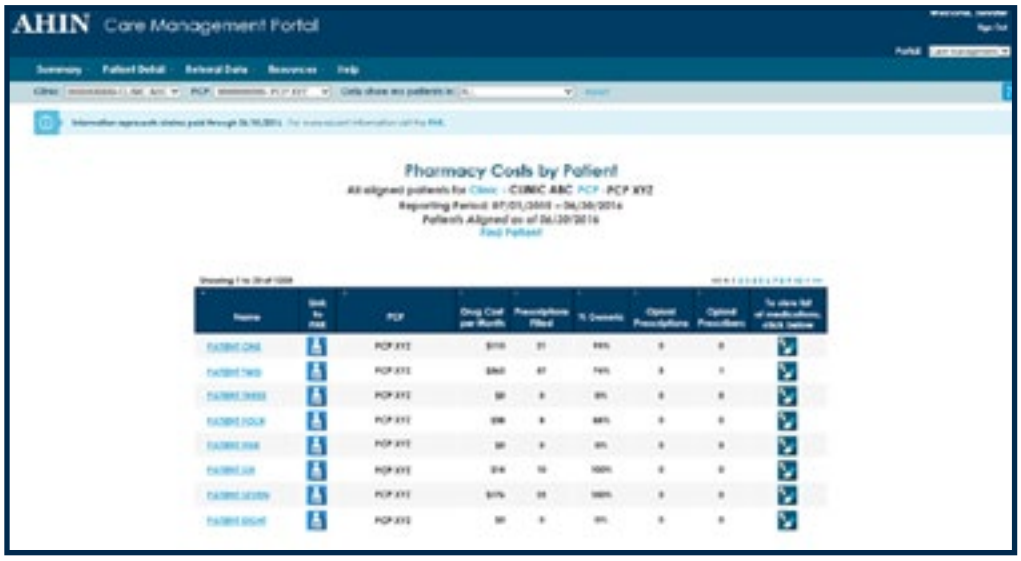
- Selected you through customer service
- Selected you through My Blueprint, our customer self-service web portal
- Had more office visits with you than any other PCP in the previous two years

Currently, Medi-Pak Advantage and Federal Employee Program patients are not included in the portal. However, A Medi-Pak Advantage portal will be available in spring 2017.

Quality metrics chosen are based on HEDIS national standards and collaboration between Arkansas Blue Cross and our provider partners.

The costs shown on the CMP include all costs incurred by your patients, regardless of which provider performed the service or where the service was performed. These costs are displayed in order to assist you in managing the total picture of your patients' care.

New information within the CMP enables practices to provide better patient care. For example, the portal provides patient-specific information to combat the prescription opioid epidemic.



The "Pharmacy Costs by Patient" screen identifies the number of opioid prescriptions filled by the patient. It also will identify the number of unique providers who prescribed opioids to the patient, which enables you to better understand the patient's patterns in obtaining opioid prescriptions.

Training on this valuable tool will begin soon to prepare for the January 2017 launch. Training will be provided both online and in the Arkansas Blue Cross regional offices. Watch for notices on AHIN to select the best training class for you and your staff. If you have questions, contact AHIN customer service at 501-378-2336 or call toll free, 855-822-AHIN.

Vision Plans

Compare
Arkansas Blue Cross and Blue Shield Vision Plans

The Silver II, Gold II, and Platinum II were added for the 2017 plan year

	SILVER	SILVER II	GOLD	GOLD II	PLATINUM	PLATINUM II
PROVIDER NETWORK	Choice Network 31,000 preferred providers; 57,000 access points					
Benefit frequency						
Exam every …	12 mo.	12 mo.	12 mo.	12 mo.	12 mo.	12 mo.
Lenses every …	12 mo.	12 mo.	12 mo.	12 mo.	12 mo.	12 mo.
Frame every …	24 mo.	24 mo.	24 mo.	12 mo.	12 mo.	12 mo.
Contacts every … (in lieu of glasses)	12 mo.	12 mo.	12 mo.	12 mo.	12 mo.	12 mo.
Copayment						
Exam	$10	$10	$10	$10	$10	$10
Materials	$25	$15	$20	$10	$10	$25
Contact lens fitting and evaluation	Member obligation not to exceed $60					
In-network allowances						
Retail frame value	$125 / 20% off overage	$130 / 20% off overage	$150 / 20% off overage	$150 / 20% off overage	$225 / 20% off overage	$200 / 20% off overage
Elective contact lenses	$100	$130	$150	$150	$150	$200
Covered lens options	Scratch coating and polycarbonate for children	Scratch coating, tint and polycarbonate for children	Scratch coating and polycarbonate for children	Scratch coating, tint and polycarbonate for children	Scratch coating, polycarbonate for children and $25 progressive lenses	Scratch coating, tint, polycarbonate for children, suncare and $25 progressive lenses
Value-added programs						
Diabetic EyeCare Plus	Included	Included	Included	Included	Included	Included
Hearing aid discounts	Included	Included	Included	Included	Included	Included
Eye health management	Included	Included	Included	Included	Included	Included
Diabetic exam reminders	Included	Included	Included	Included	Included	Included
Out-of-network allowances						
Exam (up to)	$45	$45	$45	$45	$45	$45
Single vision lenses (up to)	$30	$30	$30	$30	$30	$30
Bifocal lenses (up to)	$50	$50	$50	$50	$50	$50
Trifocal lenses (up to)	$65	$65	$65	$65	$65	$65
Lenticular lenses (up to)	$100	$100	$100	$100	$100	$100
Frame (up to)	$70	$70	$70	$70	$70	$70
Elective contact lenses (up to)	$85	$105	$105	$105	$105	$105
Necessary contact lenses (up to)	$210	$210	$210	$210	$210	$210
Extra discounts and savings						
Lens enhancements	20-25% avg. savings	20-25% avg. savings	20-25% avg. savings	20-25% avg. savings	20-25% avg. savings	20-25% avg. savings
Additional glasses	20% off	20% off	20% off	20% off	20% off	20% off
Sunglasses	20% off	20% off	20% off	20% off	20% off	20% off
Laser vision correction (LVC)	15-20% avg. discount	15-20% avg. discount	15-20% avg. discount	15-20% avg. discount	15-20% avg. discount	15-20% avg. discount

On behalf of Arkansas Blue Cross and Blue Shield, Vision Service Plan (VSP®) assists in the administration of vision benefits. VSP® is an independent company which contracts with vision care providers and provides lenses, frames and contact lenses.

Find your list of in-network vision providers at **arkansasbluecross.com.**

Questions? Contact your Arkansas Blue Cross marketing representative or agent to learn more about our vision plans.

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*Networks are comprised of independent contracted eye doctors.

VSP Vision care for life

MPI 5610 08/2016

Progress in primary care

The Centers for Medicare & Medicaid Services (CMS) recently announced shared savings results in the Comprehensive Primary Care initiative (CPCi). These results reflect the work of 481 practices that served more than 376,000 Medicare beneficiaries and more than 2.7 million patients in 2015.

According to Patrick Conway, M.D., CMS principal deputy administrator and chief medical officer, of the seven regions participating in CPCi, the states of **Arkansas** (statewide), Colorado (statewide), Oklahoma (greater Tulsa region), and Oregon (statewide) realized net savings (after accounting for the care management fees paid) and will share in those savings with CMS.

Ninety-seven percent of Arkansas CPCi practices met or exceeded the quality measure targets to achieve shared savings. Arkansas Blue Cross and Blue Shield also has experienced shared savings for the 2015 performance period, and will be distributing these soon.

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

"I'm excited to see CMS' announcement of the savings in the CPCi program," said Alicia Berkemeyer, Vice President of Enterprise Primary Care and Pharmacy Program. "We're seeing similar savings with Arkansas Blue Cross membership, and will distribute those shared savings soon. These providers are leading the nation in transforming primary care into patient-focused, innovative practices. I congratulate these providers for their commitment to the betterment of primary care in Arkansas."

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

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

The following 51 Arkansas CPCi clinics were identified by CMS as eligible for 2015 shared savings. Arkansas Blue Cross congratulates these providers on this accomplishment, as each of these CPCi providers met or exceeded the cost and quality metrics determined by CMS.

Clinic Name	City
John E Alexander Jr	Magnolia
Autumn Road Family Practice PA	Little Rock
AHEC Family Practice	Jonesboro
Beebe Family Clinic	Beebe
UAMS AHEC Family Medical Center	Fayetteville

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Progress in primary care (Continued from page 11)

Clinic Name	City
Sherwood Family Medical Center	Sherwood
Baptist Health Family Clinic Maumelle	Maumelle
UAMS AHEC Family Med Center	Fort Smith
Hamilton West Family Medicine	Hot Springs
Family Clinic Of Ashley Co.	Crossett
No. Central AR Medical Association	Mountain Home
Glenwood Family Medicine	Glenwood
SW Family Practice Residency and Clinic	Texarkana
Baptist Health Family Clinic Cabot	Cabot
Baptist Health Family Clinic Lakewood	North Little Rock
Benton Family Clinic	Benton
Baptist Health Family Clinic Bryant	Bryant
Baptist Health Family Clinic Malvern	Malvern
Baptist Health Family Clinic Perryville	Perryville
West Shores Medical Clinic	Hot Springs
West Washington County Clinic	Lincoln
Arkansas Family Care Network	North Little Rock
Main Street Medical Clinic	Harrison
Ouachita Valley Family Clinic	Camden
UAMS Family Medical Center Springdale	Springdale
Baptist Health Family Clinic Baptist Health Drive	Little Rock
Community Physicians Group	Siloam Springs
SAMA Healthcare Services Pa	El Dorado
Batesville Family Practice Clinic	Batesville
Internal Medicine Diagnostics	Cherokee Village
Barry V Thompson MD PA	Crossett
Ozark Internal Medicine And Pediatrics	Clinton
Cowherd Family Medical Center PA	Heber Springs
St Vincent Physician Clinics LLC	Little Rock
Fountain Lake Family Medicine	Hot Springs
Alliance Senior Health PLLC	West Memphis
Saline Med Pediatrics Group Inc	Benton
Washington Regional Senior Clinic	Fayetteville
Garner Family Medical Clinic	Highland
Verona Brown Bebow MD PA	Batesville
Freeman Family Medicine	Conway
Leslie Clinic PA	Harrison
Bryant Medical Clinic	Bryant
Bradley Bibb MD PLLC	Ash Flat

(Continued on page 13)

Progress in primary care (Continued from page 12)

Clinic Name	City
Greenbrier Family Clinic	Greenbrier
Lofton Family Clinic MD PA	De Queen
Baptist Health Family Clinic Hillcrest	Little Rock
Shipley And Sills Family Doctors	Fort Smith
Clopton Clinic Of Jonesboro Inc	Jonesboro
Harrison Family Practice Clinic Washington Regional	Harrison
B Brooks Lawrence MD PA	Conway
Baptist Health Family Clinic West	Little Rock
Randy D Walker	De Queen
Harriet J Alexander	Magnolia

CPCi is scheduled to end December 2016; however, a new model will take its place on January 1, 2017. Arkansas was selected as one of 14 regions for the Comprehensive Primary Care Plus (CPC+) initiative. While there will be similarities, CPC+ is an expanded version, with more regions, more participating clinics, two track options, and an enhanced payment methodology. CMS has announced that CPC+ is an eligible Advanced Payment Model (APM) in MACRA, CMS's new Quality Payment Program.

Pre-Service, Admission, and Discharge (PAD) Messages

As part of the Blue Cross and Blue Shield Association's national healthcare initiative known as Blue Distinction Total Care (BDTC), Advanced Health Information Network (AHIN) will provide access to pre-service, admission, and discharge (PAD) messages. BDTC is an initiative that recognizes physicians, group practices and hospitals participating in locally tailored programs designed to improve quality of care and lower cost trends through better coordinated care and performance-based payment.

AHIN PAD messages display informational messages to primary care providers (PCPs) about inpatient pre-services, admissions, and discharges for their attributed members. The primary purpose is to keep PCPs informed when their patients are admitted to a local or out-of-state hospital, and to enable the PCP to effectively manage and coordinate their member's care in support of the care coordination component of the BDTC/Payment Innovation initiative.

Facilities must agree to participate in the process. Arkansas Blue Cross and Blue Shield is working with local facilities to coordinate this activity and display this information via AHIN. As of the time that this newsletter was published, the following in-state hospitals are participating:

- Mercy Hospital Berryville
- Mercy Hospital Booneville
- Mercy Hospital Fort Smith

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Pre-Service, Admission, and Discharge (PAD) Messages (Continued from page 13)

- Mercy Hospital Ozark
- Mercy Hospital Paris
- Mercy Hospital Rogers
- Mercy Hospital Waldron
- St Bernard's Medical Center
- University Hospital of Arkansas (UAMS)
- Washington Regional Medical Center
- White River Medical Center

PCPs and appropriate staff may grant access to PAD messages through their AHIN user administrator.

Future enhancements of this system will include notifications that a provider's attributed membership is participating in a disease management or care management program.

Updates to the network credentialing standards – DEA certificate standard

Effective October 1, 2016, the network credentialing standards applicable to all individual network participants and applicants for the Preferred Payment Plan, Medi-Pak® Advantage PFFS, Medi-Pak® Advantage LPPO, Medi-Pak® Advantage HMO, Arkansas' FirstSource® PPO, True Blue PPO, and Health Advantage HMO Networks will be updated in section C, Drug Enforcement Agency (DEA) to effect the following significant changes in the DEA certificate standard:

- Recognition that primary care physicians (PCPs), and advanced practice registered nurses and physicians assistants who collaborate with PCPs, but who do not prescribe or intend to prescribe controlled substances no longer have to obtain a DEA certificate as a condition of network credentialing and participation.
- Clarification that any practitioner who does prescribe or intends to prescribe controlled substances must maintain a DEA certificate in good standing as a condition of network credentialing and participation.
- A new requirement that practitioners who hold a DEA certificate must enroll in the Arkansas Prescription Monitoring Program (AR PMP).
- New provisions detailing the ineligibility period applicable to any practitioner whose DEA certificate is subject to a disciplinary action.

Special Note on the Prescription Monitoring Program procedures and extended compliance deadline:
Registration for the Prescription Monitoring Program is free and takes about five minutes. The registration page can be found at: arkansaspmp.com/practitioner-/-pharmacist/.

Current participating providers will have until April 1, 2017, to complete enrollment in the AR PMP in order to be in compliance with the network credentialing standards. Non-compliance with the revised DEA Certificate Standard could prompt the networks to take additional action, up to and including network termination.

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The following is revised language for the DEA Certificate Standard, effective October 1, 2016:

DEA and Arkansas Prescription Monitoring Program

All practitioners are responsible for complying with all applicable state and federal laws and regulations related to the prescribing and administration of medications. This includes a network requirement (consistent with applicable law) that applicants or current network participants who prescribe or intend to prescribe controlled medications must hold an active Drug Enforcement Agency certificate in good standing. In addition, applicants and current network participating practitioners who hold an active DEA certificate must be registered with the Arkansas Prescription Monitoring Program as a condition of network participation.
A practitioner whose DEA certificate is subject to any action (as hereinafter defined) shall lose eligibility to participate in the networks for the longer of (a) 365 days or (b) the date that the networks determine, in their sole discretion, that the conditions leading to any action have been appropriately alleviated or redressed by the practitioner and any applicable disciplinary board oversight or monitoring program.

For purposes of this standard, "action" means any voluntary or involuntary surrender, restriction, limitation, suspension or revocation of a DEA certificate, including but not limited to any arrangement whereby the practitioner agrees to a surrender, restriction, limitation, suspension or revocation of the DEA certificate, or any arrangement whereby practitioner's use of the DEA certificate is limited or restricted (voluntarily or involuntarily) in terms of the scope or classifications of medications that may be prescribed, the location(s) or conditions under which the DEA certificate may be utilized to legally prescribe medications, or the length of time that the DEA certificate may be utilized without further review or approval from any government agency or disciplinary board or program.

Any practitioner whose DEA certificate is subject to any action must give written notice of the same to the networks not later than three business days following the action, and failure to promptly provide such notice shall, in itself, constitute separate grounds upon which network participation may be denied or terminated.

The preceding notwithstanding, the networks recognize one exception under which a practitioner who has been subject to an action may, in the judgment of the networks, remain eligible for network participation and not be excluded from the networks as provided in subpart (b), above: if the practitioner is actively enrolled in and fully compliant with all terms of a practitioner health/rehabilitation program that is officially sanctioned and overseen by the practitioner's applicable disciplinary board or agency and such practitioner is (i) otherwise in good standing with the practitioner's applicable disciplinary board or agency; and (ii) otherwise in good standing with all regulatory authorities and state and federal agencies and programs, including but not limited to Medicaid and Medicare; and (iii) otherwise in good standing with the networks and in compliance with all other terms and conditions of the practitioner's network participation agreement and network terms and conditions; and (iv) practicing with competence and quality and in a manner that does not pose a risk of harm to the networks' members, as determined in the networks' sole discretion.

Preventive vs. diagnostic screenings

In an effort to ensure our members to maximize their available benefits, Arkansas Blue Cross and Blue Shield has communicated with members through Blue & You magazine regarding the difference between preventive and diagnostic screenings.

We encourage that providers take the time to support our initiative to improve our members overall health. Often our members believe that all screenings are to be preventive, however it is important that we educate them on the differences. Screenings to check cholesterol and blood glucose levels are examples of preventive screenings.

Diagnostic screenings include tests to check the member's thyroid or other illnesses where symptoms are present. Your input and effort can go a long way to ensure that each of our members get the appropriate and recommended screenings that can lead to a healthier life. You can check a member's preventive benefits in AHIN.

This communication may cause an influx of calls or appointments by our members. Please refer them to check their benefits in the My Blueprint, the online member self-service portal, or call the customer service telephone number on their member ID card.

Coverage policy changes

Policy ID #	Policy Name
2005030	Intrauterine Systems, Progesterone or Progestogen-Releasing
2010023	Orthopedic Applications of Stem Cell Therapy
2011066	Preventive Services for Non-Granfathered (PPACA) Plans: Overview
2012009	Skin and Soft Tissue Substitutes, Bio-Engineered Products
2013048	Repository Corticotropin Injection
2014008	Infertility Services
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients with Non-Small-Cell Lung Cancer
2015008	Genetic Test: Miscellaneous Genetic and Molecular Diagnostic Tests
2015034	Telemedicine
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab)
2016021	Paliperidone Palmitate (Long-acting Injectables Invega Sustenna® & Invega Trinza)
2016022	PET or PET/CT for Uterine Cancer
2016023	Eteplirsen (Exondys-51)

New drug prior authorization requirement effective January 2, 2017

Blue Cross and Blue Shield of Minnesota is changing its prior authorization* list within its medical drug policy, which may affect about 2,700 members treated by Arkansas Blue Cross and Blue Shield network providers. The medical policy change requires prior authorization for several biologics treating autoimmune disorders, including Crohn's disease, psoriasis, rheumatoid arthritis and ulcerative colitis.

Effective January 2, 2017, Blue Cross Blue Shield of Minnesota will start performing in-house medical necessity reviews for commercial lines of business for following services:

Prior Authorization Required for the Following Drugs Effective January 2, 2017	
Botulinum Toxin ▪ Botox ▪ Dysport ▪ Myobloc ▪ Xeomin	Biologic Immunomodulators ▪ Abatacept (Orencia) ▪ Certolizumab Pegol (Cimzia) ▪ Golimumab (Simponi Aria) ▪ Tocilizumab (Actemra) ▪ Ustekinumab (Stelara) ▪ Vendolizumab (Entyvio)
Infliximab ▪ Remicade	
Rituximab ▪ Rituxan	

If the services listed above are not submitted for prior authorization by contracted providers for BCBSMN members, as of January 2, 2017, the claims may be denied and patients may be held responsible for payment. In addition, if a pre-service review is submitted and not approved before service is provided, the member may be held liable for service charges determined to be not medically necessary.

Please note, this prior authorization program requirement does not impact members who have coverage through the Federal Employee Program or Platinum Blue (Medicare Cost Plan), as those lines of business have separate prior authorization requirements.

*Prior authorization of healthcare services and medications allows the review for medical necessity as a cost-effective measure and ensures coverage of what is prescribed.

Changes to pharmacy coverage in 2017

Did you know about 25 percent of the cost of healthcare nationally is for prescription drugs? Our job at Arkansas Blue Cross and Blue Shield is to make sure members get safe drugs that work at the lowest cost. Almost every year, we have to ask some of our members to change drugs because of costs. The tables below show some of the medications that will not be covered in our formularies (covered drug lists) **starting January 1, 2017.** The good news is that there are other drugs just as effective that can save you money. **You can keep your patients' costs lower by prescribing a preferred or generic drug (*listed as a covered alternative*).**

New Standard Formulary Drugs Not Covered in 2017

The Standard Formulary is used by Arkansas Blue Cross and Blue Shield, Health Advantage and some BlueAdvantage Administrators of Arkansas health plans. Call the customer service number on your patient's member ID card to verify which formulary their health plan uses.

DRUGS NOT COVERED	COVERED ALTERNATIVES
ABSTRAL	fentanyl transmucosal lozenge, FENTORA, SUBSYS
ALCORTIN A	hydrocortisone
ALOQUIN	hydrocortisone
butalbital-acetaminophen-caffeine 50-300-40 mg	naratriptan, rizatriptan, sumatriptan, zolmitriptan, RELPAX, ZOMIG
butalbital-acetaminophen-caffeine 50-325-40 mg	naratriptan, rizatriptan, sumatriptan, zolmitriptan, RELPAX, ZOMIG
CARNITOR	levocamitine
CARNITOR SF	levocamitine
CRESTOR	atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin, VYTORIN
DAKLINZA	EPCLUSA, HARVONI
DEXPAX	dexamethasone, methylprednisolone, prednisone
DICLOFENAC SODIUM 3% *(Generic Solaraze)*	fluorouracil cream/ soln 5%/ soln 2%, imiquimod (Zyclara), ingenol (Picato)
DUEXIS	naproxen, meloxicam or diclofenac WITH lansoprazole omeparazole or pantoprazole
DUTOPROL	metroprolol succinate ext-rel with hydrochlorothiazide
ENABLEX	darifenacin, oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium ext-rel, MYRBETRUQ, TOVIAZ, VESICARE
EVZIO	NARCAN NASAL SPRAY
FIORICET	naratriptan, rizatriptan, sumatriptan, zolmitriptan, RELPAX, ZOMIG
GELNIQUE	oxybutynin ext-rel, tolterodine, tolterodine ext-rel, trospium ext-rel, MYRBETRUQ, TOVIAZ, VESICARE
GLEEVEC	imatinib mesylate, BOSULIF, SPRYCEL
HELIXATE FS	KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
insulin pen needles that are not BD brand	BD PEN NEEDLES
insulin syringes that are not BD brand	BD INSULIN SYRINGES
KLOR-CON/25	potassium chloride liquid
LANTUS	BASAGLAR, LEVEMIR, TRESIBA
METFORMIN HCL ER *(Generic Glumetza and Generic Fortamet)*	metformin, metformin extended-release 500mg (generic Glucophage XR 500mg)
MILLIPRED	dexamethasone, methylprednisolone, prednisone
NAPROXEN SODIUM ER	naproxen (generic Naprosyn or Anaprox), meloxicam, diclofenac
NEUPOGEN	ZARXIO
NEXIUM	esomeprazole, lansoprazole, omeprazole, omeprazole-sodium bicarbonate capsule, pantoprazole, DEXILANT
NILANDRON	bicalutamide, ZYTIGA

(Continued on page 19)

Changes to pharmacy coverage in 2017 (Continued from page 18)

DRUGS NOT COVERED	COVERED ALTERNATIVES
NOVACORT	hydrocortisone
OLYSIO	EPCLUSA, HARVONI
OPSUMIT	LETAIRIS, TRACLEER
PRADAXA	warfarin, ELIQUIS, XARELTO
PROVENTIL HFA	PROAIR HFA, PROAIR RESPICLICK
QUDEXY XR	topiramate IR
TASIGNA	imatinib mesylate, BOSULIF, SPRYCEL
TECHNIVIE	EPCLUSA, HARVONI
TOBI	tobramycin inhalation solution, BETHKIS
TOBI PODHALER	tobramycin inhalation solution, BETHKIS
TOPIRAMATE ER	topiramate IR
TOUJEO	BASAGLAR, LEVEMIR, TRESIBA
TREXIMET	sumatriptan WITH naproxen
TROKENDI XR	topiramate IR
venlafaxine ext-rel tablet *(except 225 mg)*	duloxetine, venlafaxine, venlafaxine ext-rel capsule, PRISTIQ
VENTOLIN HFA	PROAIR HFA, PROAIR RESPICLICK
VIMOVO	naproxen, meloxicam or diclofenac WITH lansoprazole omeparazole or pantoprazole
XENAZINE	tetrabenazine
XTANDI	bicalutamide, ZYTIGA
ZEGERID	esomeprazole, lansoprazole, omeprazole, omeprazole-sodium bicarbonate capsule, pantoprazole, DEXILANT
ZEPATIER	EPCLUSA, HARVONI

New Metallic Formulary Drugs Not Covered in 2017

The Metallic Formulary is used by Arkansas Blue Cross and Blue Shield members with Metallic, ACA-compliant health plans.

DRUGS NOT COVERED	COVERED ALTERNATIVES
CHLORD/CLIDI	dicyclomine and hyoscyamine
COPAXONE 20 MG/ML	Copaxone 40 MG
CORDRAN	flurandrenolide cream
CRESTOR	rosuvastatin
DAKLINZA	Epclusa or Harvoni
EDECRIN	ethacrynic acid
FROVA	frovatriptan succinate
GELNIQUE	darifenacin, oxybutynin, tolterodine, trospium
GLYSET	miglitol
INVEGA	Aristada
LANTUS	Tresiba, Levemir or Basaglar
LOMUSTINE	Gleostine
NEUPOGEN	Zarxio
NEXIUM	Pediatric formulation no longer covered. Try omeprazole, lansoprazole, pantoprazole, rabeprazole or Dexilant
NITROGLYCERIN	isosorbide mononitrate, isosorbide dinitrate, Nitro-Dur patches
NUVIGIL	armodafinil
OMEPRAZOLE/BICARBONATE	omeprazole, lansoprazole, pantoprazole, rabeprazole or Dexilant.
PROVENTIL	ProAir HFA or ProAir RespiClick
RISPERDAL CONSTA	Product no longer covered, Try Aristada
TEGRETOL-XR	carbamazepine
TIKOSYN	dofetilide
VENTOLIN	ProAir HFA or ProAir RespiClick
VOLTAREN	diclofenac sodium gel 1%

Encourage your patients to use the Wire®

A powerful new way to communicate

With nearly two-thirds of Americans owning smartphones, we've opened a new channel of communication that harnesses the power already in your hands.

This year Arkansas Blue Cross and Blue Shield's corporate marketing team expanded its purview of the digital experience to mobile messaging. Known as the Wire®, the free* member service offers a secure, HIPAA-compliant, cloud-based message board where personalized messages are stored. Users access it through unique links sent via text message.

Members who sign up for messages through the Wire will receive tips and reminders about things like:

- Preventive care
- Member-only services
- Coverage and benefits information
- Finding the most cost-effective, quality care

Marketing is pairing with other departments to create a communications strategy that is tailored right down to the individual. According to Eric Paczewitcz, vice president of Corporate Marketing, "With so many people using smartphones, it's the fastest way for us to put valuable information in the hands of people who want it."

Ultimately the Wire will support someone on a very personal level by reminding him or her of specific, unused benefits, managing chronic health conditions, and even providing resources during specific health episodes.

Considering the Pew Institute reports that 62 percent of smartphone users used their phone to get health information, mobile messages from someone who has information on their health history will help reduce confusion and add peace of mind.

How to Opt In

Members can opt in by editing their notification preferences within their online self-service portal, My Blueprint, or calling their health plan's customer service phone number.

*No download is required to use the free service. Standard message and data rates may apply depending on the mobile carrier. Arkansas State and Public School Employees cannot participate in the Wire.

IMAGES & VIDEO

How it works

See how the Wire works in this video: https://www.youtube.com/watch?v=K9cGXWVIwV0

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Did you know you can receive correspondence, including the *Providers' News,* by email? It's faster, saves trees and is easy to share with other staff members.

As we transition to an electronic communications platform, we invite you to email us at **ProvidersNews@arkbluecross.com**.

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Reminder: Annual compliance training requirements must be completed by December 31, 2016

Arkansas Blue Cross and Blue Shield is required by the Centers for Medicare and Medicaid Services to develop and maintain a compliance program and ensure annual compliance training is satisfied by our first-tier, downstream and related entities (FDRs) and delegated entities (DEs). General compliance training must occur within 90 days of initial hiring and annually thereafter. The annual training can be completed any time between January 1-December 31 in the contract year. CMS training courses are available, at no charge, on the CMS Medicare Learning Network® (MLN): http://www.cms.gov/MLNProducts.

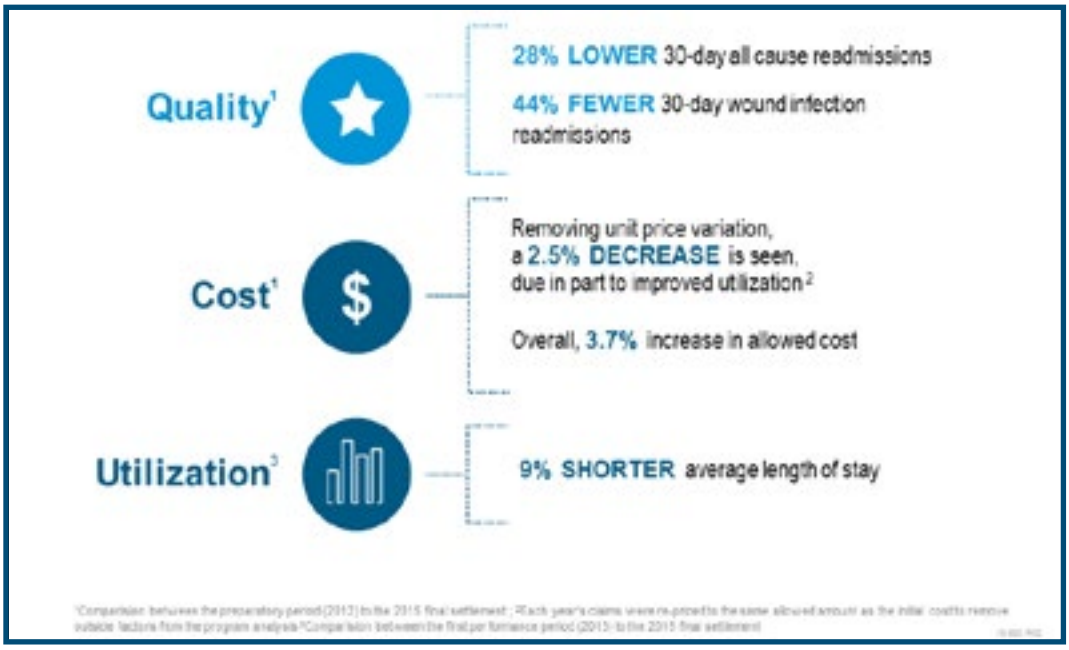
AHCPII episode of care celebrates success

Since its implementation in January 2013, Arkansas Blue Cross and Blue Shield's hip and knee replacement episode of care in the Arkansas Health Care Payment Improvement Initiative (AHCPII) has added great value to the healthcare system of our state.

The overall goals of this program are to improve the health of the population, improve patient experience, of care (quality and access) and to reduce, or at least control, the cost of healthcare. Simply, episode-based care delivery aims to reward coordinated, team-based care for a patient. This multi-payer initiative includes Arkansas Blue Cross, Arkansas Medicaid and QualChoice.

We're excited to share the results of a recent analysis of the program's impact since its implementation in 2013 through the 2015 final settlement data. By re-pricing each year's claims to the same allowed amount as the initial cost to remove outside factors from the program analysis, we discovered the following program successes.

Proven Results | Total Joint Replacement



In its third year of performance, the majority of total joint replacement principal accountable providers (PAPs) kept costs within or below the acceptable cost thresholds. Specifically, the 2015 annual settlement process identified a total of 41 PAPs that reached the Acceptable and Commendable levels in the total joint replacement episode of care model. Each of these physicians demonstrated a strong commitment to the AHCPII by controlling costs, and, in many cases, meeting the pre-defined quality metrics.

(Continued on page 23)

AHCPII episode of care celebrates success (Continued from page 22)

Success in these programs couldn't be achieved without partnerships with the PAPs throughout the state. The PAPs in the chart below reached the commendable level in cost and met all quality metrics in the 2015 performance period.

PAP	City	PAP	City
Russell B Allison, MD	Russellville	Kenneth A Martin, MD	Little Rock
Christopher A Arnold, MD	Fayetteville	Gregg L Massanelli, MD	
John F Ball, MD	Jonesboro	Samuel A Moore, DO	Little Rock
C Lowry Barnes, MD	Little Rock	David G Newbern, MD	Little Rock
William S Bowen, MD	Little Rock	Larry Nguyen, MD	Little Rock
Dylan P Carpenter, MD	Batesville	Richard A Nix, MD	Little Rock
Roy E Cooper, MD	Jonesboro	Tad C Pruitt, MD	Little Rock
Brian G Dickson, MD	Jonesboro	Ron D Schechter, MD	Paragould
Paul K Edwards, MD	Little Rock	Jason G Stewart, MD	North Little Rock
Kenneth G Gati	El Dorado	Henry C Wallace, MD	Heber Springs
William F Hefley	Little Rock	Donald S Walsh, MD	Benton
Thomas E Knox	Mountain Home	David L Wassell	Little Rock
Jay M Lipke, MD	Little Rock	Michael J Weber, MD	North Little Rock
Jerry J Lorio, MD	Benton	John H Yocum, MD	Little Rock

"I'd like to thank and congratulate the physicians who have shown that high quality can be provided to patients in an efficient way," said Steve Spaulding, senior vice president of Enterprise Networks for Arkansas Blue Cross. "These physicians not only provided great care for their patients, but coordinated the total care of the patient for services that they did not directly provide. The choices made for the delivery of all of the care for an episode, whether through the facility where the care was provided, or through other care providers, are important. The work these physicians have done benefits everyone involved in team-based care."

AHCPII episode of care updates

The Arkansas Healthcare Payment Improvement Initiative (AHCPII) has been fully operational for almost four years for many physicians and hospitals participating in Arkansas Blue Cross and Blue Shield's Preferred Payment Plan (PPP), Health Advantage's HMO network, USAble Corporation's Arkansas' FirstSource® PPO and True Blue PPO networks. We have seen improvements in quality as well as cost effectiveness. As we begin the next year, we have researched the data and are making the following modifications for 2017.

Colonoscopy episode of care reinstated
The colonoscopy episode of care was on hold for the 2016 performance period, and will resume January 2017.

Congestive heart failure (CHF) episode of care suspended for 2017
The congestive heart failure (CHF) episode of care is being suspended for the 2017 performance period. This is not a complete suspension of the congestive heart failure episode program; we will evaluate the volume and impact on an annual basis to determine program necessity.

Episodes now include individual metallic members
Effective January 1, 2017, the Arkansas Blue Cross AHCPII payment system will have financial and quality targets for the individual metallic business sold through the Arkansas Marketplace (also known as Qualified Health Plans (QHP)). These services are reimbursed at different fee rates than usual commercial business, thus the need for separate financial targets.

Providers must have five or more eligible cases of an episode to be considered principal accountable providers (PAPs). Individual metallic members (QHP members) will not count toward a provider's count for regular commercial members (non-QHP members). The following chart demonstrates that five or more eligible cases must be present for both membership for a provider to qualify as a PAP in both. It is possible, based on patient mix, for a provider to be a PAP for one group, but not for another.

Eligible Episodes of Care		PAP Eligibility for Gain/Risk Sharing
QHP Members	Non-QHP Members	
4 or less	4 or less	Not eligible for either
4 or less	5 or more	Non-QHP Members ONLY
5 or more	4 or less	QHP Members ONLY
5 or more	5 or more	Eligible for both

Principal accountable providers (PAPs) have preparatory reporting available in 2016 for this membership available on the AHIN "APII Portal" under "Episodes."

The provider manual at www.arkansasbluecross.com (under Doctors & Hospitals) contains detailed information for each active episode; including individual episode details and algorithms, gain and risk share requirements, appeal process, and the report glossary.

Have you moved? Expanded your staff or services?

Let us know so we can update our provider directory to accurately refer members to you and ensure payments arrive in a timely fashion.

Please visit **arkbluecross.com/providers/forms.aspx** to download a Provider Change of Data Form.

Mail or **fax** the completed form with supporting documents to:

Provider Enrollment
PO Box 2181
Little Rock, AR 72203

Fax: 501-378-2465

Please note:

- Completing this form does not create any network participation.
- If payment to a clinic or group is required, please complete an Authorization for Clinic Billing form.
- Practitioners wishing to use an Employer Identification Number (EIN) for payment must submit verification of EIN (Letter 147C, CP 575 E, or tax coupon 8109-C).

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MPI 5241 6/16

What to look for when hiring a care coordinator

The care coordinator position is fairly new to the world of family practice, and some clinics aren't sure what the job entails. We believe once you have one, however, you'll wonder how you functioned without one.

What exactly is a care coordinator? Very simply put, a care coordinator is exactly how it sounds. A person in this position assists patients through the different components of the health care system. Some common job duties of a care coordinator include: hospital follow-up calls, referral management, chronic disease management and education, medication reconciliation and assistance navigating health plans. The role of this position can vary from practitioner, clinic, and even medical system.

Many job postings for care coordinators include the request for social workers, registered nurses, licensed practical nurses, and recently a few registered dietitians. The idea is to staff this position with an expert in the field, who is trained to engage the patient, has knowledge of chronic disease treatment, and honestly, who can practice at the top of their license; therefore, reducing the work load of the practitioner for a reasonable cost.

How the clinic plans to utilize this position will determine the ratio of full-time employee care coordinators per provider. A common model is one coordinator for two to four practitioners. Some clinics hire from within, while others seek out experienced qualities in new staff members that may enhance the current team within the practice. Regardless, there are several education and training opportunities within the state for those who are new to the position. For example, Arkansas Blue Cross and Blue Shield and the State Medicaid patient-centered medical home programs provide webinars and learning sessions to staff of clinics enrolled in their value-based programs. Do you need CME for your staff? Arkansas Blue Cross and Blue Shield also offers four-hour care coordination training with CME credit.

Holiday closings

Arkansas Blue Cross and Blue Shield offices will be closed for Christmas on Friday, December 23, and Monday, December 26.

Our offices will also be closed on Friday, December 30, in observance of New Year's Day.

Please note that some of our offices will be open on December 30, 2016, due to service level agreements with the State of Arkansas (Arkansas State and Public School Employees) and the Federal Employee Program.

Arkansas Blue Cross offices will reopen on January 2, 2017.

FEP Wellness Incentive Program

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

The attached information covering self-measured blood pressure monitoring, a component of the Improving Health Outcomes: Blood Pressure Program developed by the AMA, is designed to help you and your office staff engage your patients in the self-measurement of their own blood pressure. The Community Preventive Services Task Force found "there is strong evidence of effectiveness for these interventions when combined with additional support (i.e., patient counseling, education, or web-based support). The economic evidence indicates that self-measured blood pressure monitoring interventions are cost-effective when they are used with additional support or within team-based care." (http://www.thecommunityguide.org/cvd/RRSMBP.html)

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

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

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

BlueCross BlueShield
Federal Employee Program.

FEP benefit changes for 2017

The following benefit changes apply to Federal Employee Program (FEP) members for 2017.

Changes for the Standard Option:

- Preventive dental care benefits will be limited for the topical application of fluoride or fluoride varnish, from no limit, to up to two per person, per calendar year.
- Dental benefits have been revised for extra-oral diagnostic images to provide a fee schedule for each extra-oral image.

Changes for Basic Option:

- Copayment for sleep studies performed in a member's home has been reduced from $100 to $40 when billed by a Preferred professional provider.

Changes for both the Standard and Basic Options:

- FEP now provides benefits for applied behavior analysis (ABA) for the treatment of autism spectrum disorder. Prior approval is required for ABA and related services, including assessments, evaluations and treatment.
- FEP now provides benefits for gender reassignment surgery, limited to once per lifetime, for adult members age 18 or older. Prior approval is required.
- The eligibility criteria for BRCA-related testing for members with a first- or second-degree relative diagnosed with pancreatic or prostate cancer has been expanded. Members must receive genetic counseling, evaluation services and obtain prior approval before receiving preventive BRCA testing.
- FEP now provides annual preventive care benefits for screening mammography using digital technology.
- FEP now provides benefits for children from birth through age 21 for nonsurgical treatment of amblyopia and strabismus. Previously, benefits were provided from birth through age 18.
- Prior approval is now required for sleep studies rendered outside a member's home.
- Certain FDA-approved drugs that have multiple generic equivalent/alternative medications may be excluded from the formulary. Previously, all FDA-approved drugs were covered under prescription drug benefits, with the exception of some lifestyle drugs.
- Benefits for self-administered injectable drugs will be limited to once per lifetime when the drugs are dispensed/provided by a physician, healthcare professional or hospital.

Access Only: Current PPO groups

Group Name	PPO Network
Alternative Opportunities	True Blue Access Only
AR Sheet Metal Workers	True Blue Access Only
Arvest Bank	True Blue Access Only
Brentwood Industries, Inc	True Blue Access Only
Bryce Corporation	True Blue Access Only
Diocese of Little Rock	True Blue Access Only
Franklin Electric	First Source Access Only
Harps Food Stores	True Blue Access Only
Hickory Springs	True Blue Access Only
Razorback Concrete Co	True Blue Access Only
United Food & Commercial Workers	True Blue Access Only

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): *Quality Payment Program*

The Medicare Access and CHIP Reauthorization Act (MACRA), which became law in April 2015 after receiving bipartisan support, sets forth a plan that will make the final push toward quality-based care. In the simplest possible terms, MACRA repeals the sustainable growth rate (SGR) formula that has determined Medicare Part B reimbursement rates for physicians and replaces it with new ways of paying for care. Under MACRA, participating providers will be paid based on the quality and effectiveness of the care they provide. Through MACRA, Medicare aims to tie 85 percent of payments to quality by 2018.

According to the Centers for Medicare & Medicaid Services, MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries.

- Ending the SGR formula for determining Medicare payments for healthcare providers' services.
- Making a new framework for rewarding healthcare providers for giving better care.
- Combining our existing quality reporting programs into one new system.

Rather than continuing a fee-for-service model of reimbursement, MACRA introduces two new payment paths.

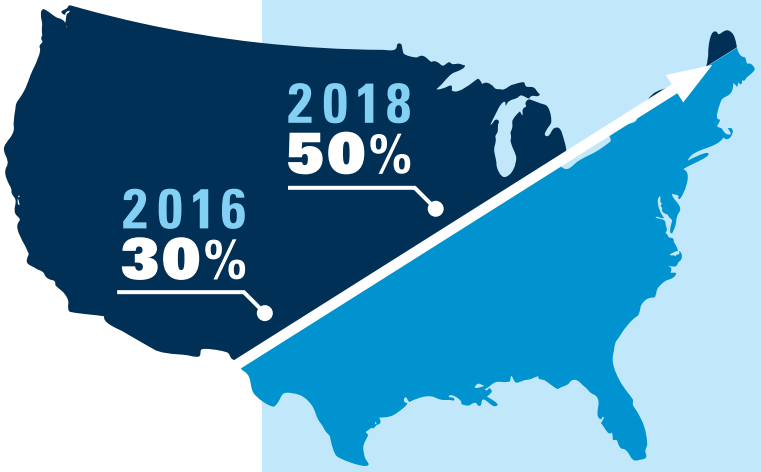
- The first is the Merit-based Incentive Payment System (MIPS), which bundles three preexisting quality programs: meaningful use (MU), the Physician Quality Reporting System (PQRS) and the Value-based Modifier (VBM).
- The second option is to participate in eligible alternative payment models (APMs). By choosing this track, providers are exempt from MIPS and receive more favorable financial incentives, including a 5 percent lump sum bonus payment for years 2019 through 2024 based on the prior year's benchmarked costs.

2016
30%

In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

2018
50%

In 2018, at least 50% of U.S. health care payments are so linked.



CPT II billing guidelines for blood sugar monitoring lab services

When performing blood sugar monitoring lab services (HgbA1c) for Arkansas Medi-Pak® Advantage members, please note the following information regarding CPT II codes.

Importance of CPT II Codes

Current Procedural Terminology (CPT) Category II codes are tracking codes utilized by CMS to facilitate performance measurements. These codes ease the administrative burden of chart reviews for many Healthcare Effectiveness Data and Information Set (HEDIS*) and CMS Star rating performance measures. They also can support organizational quality improvement efforts and care management for your diabetic patients.

Arkansas Blue Cross understands that our providers are one of the most important factors in achieving improved quality performance goals. Accurate coding of blood sugar claims is a great opportunity to reduce the administrative burden on the provider office by eliminating manual requests to provide lab values from health plans.

Blood sugar monitoring billing guidelines

Beginning January 1, 2017, when billing the HgbA1c lab test CPT code 83036 and 83037, providers must also bill the associated CPT Category II codes which represent results of the tests in the form of a range of values. Arkansas Blue Cross will not reimburse physician offices for lab services performed for Arkansas Medi-Pak® Advantage members without submission of the appropriate CPT II code.

The following table lists the selected lab test, the billable CPT Category I code, the correlated CPT Category II codes and the associated value range.

Test	CPT Code	CPT II Code	Associated Value Range
HbA1c sceening	83036, 83037	3044F	Less than 7.0%
HbA1c sceening		3045F	Between 7.0% and 9.0%
HbA1c sceening		3046F	Greater than 9.0%

Taxonomy codes for Medi-Pak® Advantage

We have noticed a significant increase in Medi-Pak® Advantage claims denials due to the improper use of taxonomy codes. Taxonomy codes are not required for claims processing, however, if a taxonomy code is submitted, it must be accurate for the service being billed. If the taxonomy field is left blank, the system will automatically search for the appropriate taxonomy code. However, if the taxonomy code field is populated, the system will check to validate that the code is accurate and any mismatches will result in a claims denial.

Corrected claims for Medi-Pak® Advantage

You have the ability to submit corrected claims electronically through AHIN for services in 2016 and later. Please use this method for submitting corrected claims to ensure timely processing. You need to provide the original ICN information along with the required REF segment and qualifier in Loop ID 2300. The Claim Frequency Code should be 7. Please see example below:

Claim Frequency Code
CLM*12345678*500***11:B:7*Y*A*Y*I*P~

REF*F8*(Enter the Claim Original Reference Number)

Medi-Pak® Advantage HMO service area expansion effective January 1, 2017

We are pleased to announce that the service area for the Medi-Pak® Advantage HMO product offered by Arkansas Blue Cross and Blue Shield will be expanded to include White and Pope counties effective January 1, 2017. Enrollment is now open to Medicare beneficiaries residing within those counties for the 2017 plan year. As a reminder, the service area for Medi-Pak® Advantage HMO currently includes the following counties: Benton, Carroll, Madison, Washington, Franklin, Logan, Scott, Sebastian, Cleburne, Lonoke, Jefferson, and Pulaski.

2015 claims filing deadline for Medi-Pak® Advantage

All original claims for 2015 dates of service **must** be filed by December 31, 2016, to ensure processing. Failure to do so may result in timely filing denials and claim rejections.

Medi-Pak® Advantage coverage change for licensed professional counselors and licensed psychological examiners

Coverage of the services of licensed professional counselors and licensed psychological examiners for the Medi-Pak® Advantage networks sponsored by Arkansas Blue Cross and Blue Shield will end effective January 1, 2017. This supplements the official correspondence mailed in late October providing advance notice of this change, which was sent to each individual LPC and LPE who are currently network participants in the Medi-Pak® Advantage networks.

This notice only impacts coverage and participation in the Medi-Pak® Advantage networks and does not include the other provider networks sponsored by Arkansas Blue Cross and Blue Shield or its affiliated companies, USAble Corporation and Health Advantage.

Medi-Pak® Advantage Inpatient DRG changes effective January 1, 2017

October 1, 2015, Medicare converted from ICD-9 to ICD-10 diagnosis and procedure codes. To reduce filing issues for providers during this conversion, Arkansas Blue Cross and Blue Shield recognized the date Medicare used to change from ICD 9 to ICD 10 diagnosis and procedure codes for coding of inpatient claims. This change also included using the DRGs and weights that were effective for Medicare on that date. The transition to ICD 10 has been successfully completed.

Please note that for the fiscal year starting January 1, 2017, ABCBS will once again begin using January 1st of each calendar year to begin using the DRGs and corresponding weights effective for Medicare the previous October 1st. (Example: The DRG's and weights effective January 1, 2017 are equal to the F.Y. 2017 DRG case weights that are effective for Medicare on October 1, 2016)

CMS issues a reminder for hospice providers

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

Reminder to hospice providers – CMS is encouraging hospice providers to use the first page of the standardized form (Information for Medicare Part D Plans; OMB 0938-1269) to immediately notify the appropriate Medicare Advantage or Part D sponsor of the election. In order to prevent inappropriate payment of drugs by Medicare Advantage or Part D sponsors, the form should be faxed to the sponsor as soon as possible. Arkansas Blue Cross and Blue Shield will use all information included on the form to properly administer this benefit.

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

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

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

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PLEASE NOTE

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

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