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

PROVIDERS' NEWS

June 2019

*Published for providers and their office staffs by Arkansas Blue Cross and Blue Shield • **Editor:** Sarah Ricard • 501-378-2105 • Fax: 501-378-2465 • ProvidersNews@arkbluecross.com*

TABLE OF CONTENTS

2018 plan year HHS ACA risk adjustment data validation (RADV) / Initial validation audit

The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health & Human Services (HHS) requires all organizations participating in the Health Insurance Marketplace/Exchange to comply with the Affordable Care Act HHS Commercial RADV Initial Validation Audit (IVA) program by submitting complete and accurate ICD-10 diagnostic data to CMS for beneficiaries enrolled in an individual and/or small-group health plan. Again, this applies to claims related to the Marketplace/Exchange.

To comply with program requirements, our partner (Cognisight) will be conducting the retrieval of randomly selected patient charts on our behalf. If you are contacted to assist in the chart-retrieval process, we appreciate your cooperation and prompt attention to fulfill these requests in a timely manner. This process will begin in June and will relate to services provided during the 2018 calendar year. If you have any questions regarding any portion of this process, contact your Arkansas Blue Cross and Blue Shield network development representative at your respective regional office.

Thank you for your ongoing partnership to improve the health of your patients and our members in compliance with CMS-HHS guidelines/regulations.

Acceptable reimbursement for Workers' Compensation medical services

In the mid-1990s, the Arkansas Workers' Compensation Commission (AWCC) adopted a managed care program for workers' compensation in an effort to reduce employers' costs for medical services involving work injuries. For Arkansas Blue Cross and Blue Shield, this program uses medical providers participating in the True Blue PPO network.

AWCC Rule 33 provides administrative guidelines for managed care in Arkansas. AWCC Rule 30 (Medical Cost Containment Program) sets guidelines for what providers must accept as payment for medical services rendered to patients falling under the rules of workers' compensation in the state. Rule 30, in reference to payment, states that "reimbursement for health care services shall be the lesser of (1) the provider's usual [normal] charge, or (2) the maximum fee calculated according to the AWCC Official Fee Schedule (and/or any amendments to that fee schedule), or (3) the MCO/PPO contracted price, where applicable." Rule 30 further states that "a licensed provider shall receive no more than the maximum allowable payment, in accordance with this rule, for appropriate health care services rendered to a person who is entitled to health care service."

As providers, you are allowed to negotiate reimbursement for workers' compensation services, so long as the accepted reimbursement is equal to or below the AWCC Official Fee Schedule. However, there are payers that inject creative pricing, using tools such as usual and customary databases or reference-based pricing. Providers should be aware that these methods of fee reduction are not condoned.

Access Only reminder

Access Only claims should be submitted directly to Arkansas Blue Cross and Blue Shield. The claims will be priced and automatically forwarded to the third-party administrator (TPA) for adjudication.

Providers should call the Customer Service number on the back of the ID card regarding payment, denial, benefits or eligibility. These questions must be directed to the appropriate group TPA responsible for adjudicating the claim. Call (501) 378-2164 if you have pricing questions.

Access Only groups effective January 2019

Group Name	PPO Network
Arkansas Department of Corrections	True Blue PPO
Ark Sheet Metal Workers	True Blue PPO
Arkansas State University Athletes	True Blue PPO
Bryce Corporation	True Blue PPO
Diocese of Little Rock	True Blue PPO
Franklin Electric	Arkansas First Source
United Food & Commercial Workers	True Blue PPO

Billing for services to provider family members prohibited

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

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

Violation of these policies and procedures and/or failure to make prompt refunds for erroneous payments will subject the offending provider to termination from the networks sponsored by Arkansas Blue Cross, Health Advantage and PPO Arkansas. Moreover, a provider's filing of claims for services rendered to immediate relatives (and receiving payment for such claims), is an abusive claims-filing practice that also may constitute fraud and could lead to permanent exclusion from the networks.

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

Previous articles regarding billings for services rendered by providers to immediate family members may be found in the June 2002, September 2003, September 2013 and June 2014 issues of *Providers' News*.

Coverage policy manual updates

Since March 2019, policies have been added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The following table highlights these additions and updates. To view entire policies, access the coverage policies located on our website at arkansasbluecross.com.

Policy ID	Policy Name
1997026	Blepharoplasty/Blepharoptosis
1997128	Leuprolide (Lupron)
1997208	Spinal Cord Neurostimulation for Treatment of Intractable Pain
1997208	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1997208	Cardiac Event Recorder, External Loop or Continuous Recorder
1997208	Vacuum Assisted Closure Device
1998061	Ultrasound in Maternity Care
1998095	Intraoperative Neurophysiologic Monitoring
1998114	Pulmonary Rehabilitation
1998158	Trastuzumab
2000041	Cryosurgical Ablation of Renal Tumors
2001012	Radiofrequency Treatment, Chronic Back Pain
2001028	Magnetic Resonance Imaging (MRI), Breast
2003011	Amevive (Alefacept)
2003046	Laser Treatment of Congenital Port Wine Stain Hemangiomas and Burn Scars
2004007	Radiofrequency Ablation, Renal Tumors
2008007	Cardiac Event Recorder, Mobile Telemetry
2008010	Certified Nurse Practitioners
2008013	Certified Nurse Midwives
2008014	Physician Assistants
2008015	Clinical Nurse Specialist
2009013	Testing for Drugs of Abuse or Drugs at Risk of Abuse Including Controlled Substances
2010013	Injection, Clostridial Collagenase for Fibroproliferative Disorders

Policy ID	Policy Name
2010046	Intravitreal Corticosteroid Implants
2011016	Preventive Services for Non-Grandfathered (PPACA) Plans: BRCA Testing; Genetic Counseling and Evaluation
2011022	Preventive Services for Non-Grandfathered (PPACA) Plans: Chlamydial Infection Screening in Women and Adolescents
2011024	Preventive Services for Non-Grandfathered (PPACA) Plans: Tobacco Use, Screening, Counseling and Interventions
2011031	Preventive Services for Non-Grandfathered (PPACA) Plans: Osteoporosis Screening in Women
2011038	Preventive Services for Non-Grandfathered (PPACA) Plans: Gonorrhea Screening in Women and Adolescents
2011039	Preventive Services for Non-Grandfathered (PPACA) Plans: Hepatitis B Virus Infection Screening in Pregnancy and Asymptomatic Adolescents and Adults
2011040	Preventive Services for Non-Grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV) Counseling and Screening
2011043	Preventive Services for Non-Grandfathered (PPACA) Plans: Depression Screening, Adults
2011044	Preventive Services for Non-Grandfathered (PPACA) Plans: Depression Screening, Adolescents
2011045	Preventive Services for Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening
2011053	Autism Spectrum Disorder, Applied Behavioral Analysis
2011066	Preventive Services for Non-Grandfathered (PPACA) Plans: Overview
2012012	Genetic Test: Uveal Melanoma, Gene Expression Profile To Predict Risk Of Metastasis
2012031	Preventive Services for Non-Grandfathered (PPACA) Plans: Well-Woman Visits for Adult Women
2012032	Preventive Services for Non-Grandfathered (PPACA) Plans: Gestational and Postpartum Diabetes Screening
2012045	Preventive Services for Non-Grandfathered (PPACA) Plans: Autism Screening
2013026	Handheld Radiofrequency Spectroscopy for Intraoperative Assessment of Surgical Margins during Breast-Conserving Surgery
2013033	Localization Devices for Nonpalpable Breast Lesions
2013049	Ocriplasmin (Jetrea®) for Symptomatic Vitreomacular Adhesion
2014014	Pertuzumab
2014017	Transcatheter Mitral Valve Repair
2015009	Genetic Test: Next-Generation Sequencing for Cancer Susceptibility Panels and the Assessment of Measurable Residual Disease
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015023	Daclatasvir (Daklinza)
2015024	Minimally Invasive Benign Prostatic Hyperplasia (BPH) Treatments
2015034	Telemedicine
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes
2016005	Anti-PD-1 (programmed death receptor-1) Therapy (Pembrolizumab) (Nivolumab) (Durvalumab)
2016008	Thermal Ablation of Peripheral Nerves to Treat Pain Associated with Plantar Fasciitis, Knee Osteoarthritis, Sacroiliitis and Other Conditions
2016010	Mepolizumab (Nucala)
2016015	Alemtuzumab (Lemtrada)
2016016	Atezolizumab (Tecentriq®)
2016018	Natalizumab (Tysabri)
2017006	Bevacizumab (Avastin™) for Oncologic Indications
2017007	Cetuximab (Erbitux™)

Policy ID	Policy Name
2017010	Pilot Policy: Balloon Ostial Dilation (Balloon Sinuplasty) for the Treatment of Chronic Sinusitis
2017011	Nusinersen (Spinraza) for the Treatment of Spinal Muscular Atrophy
2017012	Nab-Paclitaxel (Abraxane™)
2017013	Elotuzumab (Empliciti™)
2017021	Ocrelizumab (Ocrevus)
2017022	Cerliponase Alfa (Brineura™)
2017023	Bezlotoxumab (Zinplava™)
2017031	Dupilumab
2018002	Chemodenervation, Botulinum Toxins
2018003	Copanlisib (Aliqopa)
2018004	Letermovir (Prevymis)
2018005	Triamcinolone Acetonide Extended Release (Zilretta)
2018008	Reslizumab (Cinqair)
2018009	Benralizumab (Fasenra)
2019001	Myocardial Strain Imaging

Federally required annual compliance training information

Arkansas Blue Cross and Blue Shield is required by the federal government to ensure that certain individuals and entities with whom we do business (including healthcare-related professionals and organizations) complete **general compliance training and fraud, waste and abuse training** on an annual basis.

Who must complete training?

General compliance training and fraud, waste and abuse training (where applicable), should be completed annually by **all persons** who have contact (indirect or direct) with beneficiaries of the federal Centers for Medicare & Medicaid Services (CMS) and members covered by the Affordable Care Act. This includes staff in all billing, reception, lab and clinical areas.

General compliance training is required for all persons who meet the above criteria, but certain individuals and entities who participate in the Medicare program are deemed to have met the **fraud, waste and abuse training** component by virtue of satisfying Medicare's annual certification requirements. This includes entities and/or individuals who are:

- Participating healthcare providers in the federal Medicare program (Parts A and/or B).
- Accredited, Medicare-approved suppliers of durable medical equipment, prosthetics, orthotics and supplies.

When should training be complete?

The general compliance training and/or fraud, waste and abuse training must occur within 90 days of initial hiring and annually thereafter. The

annual training may be completed at any time during a traditional calendar year. Training must be documented, and all documentation is subject to random audit by Arkansas Blue Cross or the federal government.

Methods for completing training

There are three options for satisfying these annual compliance training requirements:

1. **Web-delivered training** — Complete the web-based general compliance and/or fraud, waste and abuse training modules for Medicare (Parts C and D) located on the CMS Medicare Learning Network® (MLN), which are available through the Learning Management and Product Ordering System: https://learner.mlnlms.com/Default.aspx. Each individual must create an account. If you are not a current user, select **New user** to create an account.

    - In the Association section, if you do not see an organization with which you are associated or do not want to enter the information, select **None**.
    - When you get to the **Organization** section, choose **Select**, then **Search** and then click the **CMS-MLN Learners Domain Organization** radio button and select **Save**.
    - Select **Create**, once all required fields are complete.

Once you have logged in, proceed with the following steps:

a) From the home page, in **Browse Catalog**, type in **Medicare Parts C and D General Compliance Training**. If needed, look for **Combating Medicare Part C and D Fraud, Waste, and Abuse (January 2019)** (Contact hours: 30 min).

b) Select the title of the training you need to complete, and then select **Enroll**.

c) The enroll screen will default to **Credit** (if continuing education units are needed) or **Normal** course mode. Choose the desired mode and select **Enroll**.

d) Select **Open Item** to begin a course, or return to the training catalog to select another course by repeating the steps a) through e).

e) To return to the courses after enrolling, choose **Current Training**, select the title of the course you are completing, then select **Open Item** to begin the course.

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

For CMS Medicare Learning Network®-specific instructions and course help, go to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LMPOS-FAQs-Booklet-ICN909182.pdf.

2. **Download a PDF version to share** — Incorporate the content of the web-delivered standardized training modules from the CMS website into existing compliance training materials/systems. A PDF version is provided on the website. The PDF document is not intended to take the place of the web-based training, and no certificate is provided with the PDF download, which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf.

3. **Integrate content into other training materials** — Incorporate the content of the training modules from the CMS website into written/printed documents for providers (e.g., provider guides, participation manuals, business associate agreements, etc.). Although

training content cannot be modified, CMS will allow modification to the appearance of the content (font, color, background, format, etc.). Additionally, organizations may enhance or "wrap around" the CMS training content by adding topics specific to the organization or employees' job functions. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

***NOTE**: Should your organization provide the federally required trainings, a copy of all training documents—including a copy of the training materials and training logs—must be retained by your organization for 10 years, in accordance with the governing agencies' record-retention guidelines.*

What do we do with our training records?

Whichever method you choose to complete from the options above, no documentation should be returned to Arkansas Blue Cross. So, as noted above, retain copies (paper and/or electronic) of all documentation of federally required annual trainings for at least 10 years.

How do I show that I have completed the required training?

Arkansas Blue Cross has developed an online attestation, administered through the Advanced Health Information Network (AHIN). The AHIN user administrator (AUA) for each entity will use this reporting system to attest that all required training has been completed.

The attestation should be recorded **only after all affected staff members** have completed the applicable required trainings. Until the attestation is completed, an attestation alert will appear (beginning in June), and AHIN user administrators will be able to verify (through the end of the year) that their staff have completed required trainings. Once an organization has completed the attestation, the alert will stop.

For more information, general compliance training and Medicare Parts C and D fraud, waste and abuse training requirements may be found at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/CompliancePrograms PolicyandGuidance.html.

Direct additional questions to regulatorycompliance@arkbluecross.com.

New dental & vision ID cards

As part of an improvement to our internal systems, Arkansas Blue Cross and Blue Shield dental and vision members will receive new ID cards, potentially with new member ID numbers, for coverage beginning June 2019. No benefit changes are associated with this system update. Some members will retain their ID numbers; some ID numbers will change.

What should you do?

In June, ask your patients that have Arkansas Blue Cross member IDs whether they recently received a new member ID card. If they have, update your information to ensure your patient's claims are handled efficiently.

New prepay review of high-dollar inpatient claims

Effective January 1, 2019, Arkansas Blue Cross and Blue Shield and its family of companies implemented a new policy required by the Blue Cross Blue Shield Association. This policy requires the provision of itemized bills (from ***host*** Plans) for high-dollar claims that have a total billed amount of $250,000 or greater. Accordingly, as of July 1, 2019, we will require itemized bills for high-dollar claims from all lines of business. This process requires providers to submit an itemized bill (for review) with inpatient claims of $250,000 or more that have a payment tied to the billed charges (e.g., not paid by per diem, case rate or diagnosis-related group).

Arkansas Blue Cross uses the services of Equian to conduct this prepay review. Arkansas Blue Cross will evaluate the results of the prepay review to determine whether the billed amount that is subject to review should be adjusted.

To minimize any delays or interruption of payments of these claims, providers are asked to submit an itemized bill with any claim that meets these criteria.

Contact your network development representative for specifics on submitting itemized bills with such claims.

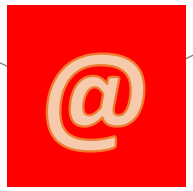
Outpatient hospital billing: Revenue codes require CPT or HCPCS codes

In October, a change is coming on how electronic and paper UB04 claims must be filed. All such claims (with dates of service of October 1, 2019 or later) that are submitted by an outpatient hospital facility must include a supporting Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code with each revenue code except Emergency Room 45X (see footnote below). Revenue code and procedure code combinations that are submitted should reflect the services that were provided to the patient on that date of service. The revenue code and respective CPT/HCPCS code should be submitted on the same line for accurate claims processing. If more than one CPT or HCPCS code is needed for a revenue code, repeat the revenue code on a separate line, along with the additional CPT/HCPCS code.

Outpatient hospital claims that do not have the required corresponding CPT/HCPCS codes will be rejected. This requirement applies to all outpatient UB04 claims with bill type 13X and 14X submitted to Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage.

(Important note: *Emergency Room 45X is a temporary exception to this requirement. Emergency Room will not be required to have the corresponding CPT/HCPCS until April 1, 2020. Much more information about this change will be presented in future newsletters and by other means.)*

Prefer to receive the newsletter via email?



Send your name, the affiliate provider's name, and your email address to mprovidersnews@arkbluecross.com

Federal Employee Program

Surgical Treatment for Morbid Obesity

Prior approval is required for inpatient and outpatient surgery for morbid obesity. In addition, surgery for morbid obesity performed on an inpatient basis ***also*** requires precertification. Contact FEP Customer Service at **1-800-482-6655** and follow the prompts for both Prior Approval and Pre-certification. Visit www.fepblue.org to view the Service Benefit Plan brochure for the additional pre-surgical requirements.

Health Advantage

Health Advantage Coding Changes

Be advised that all Health Advantage claims should include the appropriate service facility location and National Provider Identifier (NPI) in CMS-1500 claim form box 32a (see sample below) and its equivalent on electronic claim form 837-P.

This information is required for proper claims and benefit adjudication for all Arkansas Blue Cross and Blue Shield lines of business but is especially important for the Health Advantage HMO and HMO Plus networks.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

BOX 32a Service Location NPI

HEDIS® News

I. Changes to the Controlling High Blood Pressure HEDIS® measure reduces the need for medical record reviews

The Controlling High Blood Pressure (CBP) Healthcare Effectiveness Data and Information Set (HEDIS®) measure has been updated to assess patients ages 18-85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the last reading of the year.

Previous CBP HEDIS specifications required medical record reviews to determine if a patient's blood pressure was under control. Now, billing blood pressure Current Procedural Terminology (CPT®) Category II codes on each office visit claim along with a hypertensive condition will determine compliance.

When you add the correct CPT Category II and ICD-10 codes to your claims, medical records will not need to be collected for confirmation. This optimizes time and lessens the need for record keeping for providers. To learn more about claims coding to reduce medical record reviews and other measure changes, click here to view the CBP tip sheet.

II. Gain insights about your patients from CAHPS research on improving the patient experience

The Centers for Medicare & Medicaid Services (CMS) can help providers better understand their Medicare patients' needs and expectations through research from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS annually compiles findings about improving the patient experience and understanding health outcomes.

You can access reports, articles and case studies through the Agency for Healthcare Research and Quality (AHRQ): Research on Improving the Patient Experience. To learn more about why this annual survey is important, how it's conducted, what questions are asked and ways you can successfully address care opportunities for patients, click here to view the CAHPS survey tip sheet.

III. Two star measures support importance of statin therapy for cardiovascular disease and diabetes

The Centers for Disease Control and Prevention (CDC) estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes. Additionally, almost two out of five people with diabetes who could benefit from statin therapy to lower their risk of future heart attack, stroke and related deaths were not prescribed one, according to the Journal of the American College of Cardiology.

To support the importance of statin therapy, the Centers for Medicare & Medicaid Services includes two star measures aimed at the use of statin therapy. Please consider prescribing statins for your patients diagnosed with atherosclerotic cardiovascular disease and diabetes.

To learn more about the use of statin therapy, Click the links below to view the tip sheets.

- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Use in Persons with Diabetes (SUPD)

IV. Risk adjustment & HEDIS® records requirements

The Blue Cross Blue Shield Association requires its licensees and their participating healthcare providers to comply with procedures that support Healthcare Effectiveness Data and Information Set (HEDIS®), risk adjustment and government-required activities around HEDIS and risk adjustment. The Association has employed third-party vendors to coordinate medical records requests in support of risk adjustment and HEDIS activities. These activities include:

- Performing risk-adjustment audits
- Reporting HEDIS measures
- Communicating coding gaps identified in patient records
- Monitoring compliance with government-required activities

All providers participating in the Arkansas Blue Cross and Blue Shield Preferred Payment Plan, PPO Arkansas' True Blue PPO and Arkansas' FirstSource® PPO, Health Advantage HMO and Medi-Pak® Advantage's Patient Fee-for-Service (PFFS) and HMO provider networks must follow the needed processes for medical record audits and record requests within the required timeframe.

This notice should be considered a provider contract amendment to the provider network participation agreements of the entities listed in the preceding paragraph. This policy has been in effect since January 1, 2014.

A previous article related to this topic appeared in the March 2015 issue of Providers' News. This information also is located in the Arkansas Blue Cross and Health Advantage provider manuals.

Medi-Pak® Advantage

I. HMO Plan Referrals

Effective January 1, 2020, Health Advantage Medi-Pak® Advantage HMO plans will require a physician referral prior to the member receiving services from a specialist. Primary care physicians are the "quarterbacks" of the member's care, and the referral process will allow them greater ability to manage the care of the patients they serve.

More details will be shared throughout the year, but generally, this process will mirror the current prior-approval process. Referrals submitted prior to claims submissions will generate overrides in the claims processing system, which will allow for specialists' claims to be processed. If a referral is not in place prior to services being rendered, the claim will pend for manual review. If a determination is made that no referral is on record, the claim will be denied. Watch for additional updates in future newsletters.

II. Provider Portal Notice: Be Healthy Member Open Gap Letter and Chart

We are partnering with a third-party vendor to conduct a mail campaign to select Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage Patient Fee for Service (PFFS) or Health Advantage Medi-Pak® Advantage Health Maintenance Organization (HMO) members. Members who have not completed recommended preventive and other health services will receive a personalized services letter and chart in the summer and fall.

The chart will show members which screenings and tests they have completed to date and which ones they should still have performed by the end of 2019. Educational flyers about the importance of breast cancer screenings, colorectal cancer screenings and services related to diabetes management will be included for members who are due to complete those services. We appreciate your encouraging members to schedule these preventive screenings.

III. Wellness Codes

The Centers for Medicare & Medicaid Services (CMS) have deemed Initial Wellness Visit (G0438) to be a "once in a lifetime" code. This code should be billed only once during the member's entire lifetime – not merely once during the time the member is the patient of the billing provider. **It is the belief of CMS that the member would receive this exam in their second year of Medicare eligibility.** Each annual wellness visit afterward should be billed as the Subsequent Annual Wellness Visit (G0439). All claims billed with G0438 will be denied automatically, indicating "once in a lifetime," for members who already have this code in their history.

Happy Independence Day

Our offices will be closed Thursday, July 4.

2019 Star quality measure tips

Arkansas BlueCross BlueShield
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Make the most of Medicare

One in a series of tip sheets that look at key 2019 Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Controlling High Blood Pressure (CBP)

Effectiveness of Care HEDIS® Measure

HEDIS measure definition

Patients ages 18-85 in the measurement year who had a diagnosis of hypertension (HTN) reported on an outpatient claim and whose blood pressure was adequately controlled (<140/90 mm Hg) as of December 31 of the measurement year.

Exclusions from the HEDIS measure

Patients are excluded if they:

- Have evidence of end-stage renal disease (ESRD) or had a kidney transplant or dialysis in the measurement year.
- Have a diagnosis of pregnancy during the measurement year.
- Are a patient in hospice or living in a long-term institutional setting any time in the measurement year.
- Have an advanced illness and frailty:
  - Medicare members ages 66-80 with advanced illness in the measurement year or the year prior to the measurement year AND frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes.
  - Medicare members ages 81 and older with a frailty claim in the measurement year are also excluded.
  - See the Advanced Illness and Frailty Guide for more information.

Information patient medical records should include

- All blood pressure readings and the dates they were obtained. If there's more than one reading at a single visit, use the lowest systolic and diastolic readings.
- Exact readings; do not round up blood pressure readings.
- The blood pressure reading must be from the provider managing the patient for hypertension (HTN).
- The controlled reading must be the last one of the year to meet the HEDIS definition.
- Blood pressure may be taken and documented by any practitioner (e.g., R.N., M.A.) during any visit type.

continued

Information patient claims should include

- You can use the ICD-10 code R03.0 when the patient has an elevated blood pressure reading, but has no diagnosis of hypertension (such as with "white coat syndrome" or transient hypertension).
- Bill blood pressure CPT® II codes on each office visit claim, along with a hypertensive condition:

CPT® II code	Most recent systolic blood pressure
3074F	<130 mm Hg
3075F	130 -139 mm Hg
3077F	≥ 140 mm Hg
CPT® II code	**Most recent diastolic blood pressure**
3078F	<80 mm Hg
3079F	80 - 89 mm Hg
3080F	≥ 90 mm Hg

Tips for taking blood pressure readings in the office

- Make sure the proper cuff size is used.
- Ensure patients do not cross their legs and have their feet flat on the floor during the reading. Crossing legs can raise the systolic pressure by 2-8 mm Hg.
- Make sure the elbow is at the same level as the heart. If the patient's arm is hanging below heart level and unsupported, this position can elevate the measured blood pressure by 10-12 mm Hg.
- Take it twice: If the patient has a high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit. Consider switching arms for subsequent readings.

General tips

- Educate patients about the risks of uncontrolled blood pressure.
- Reinforce the importance of medication adherence and encourage patients to report side effects.
- If patients have an abnormal reading, schedule follow-up appointments for blood pressure readings until their blood pressure is controlled.

2019 Star quality measure tips

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Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Member Perception Star Measure

Why is the survey important?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, developed by the U.S. Agency for Healthcare Research and Quality, measures the patient experience with healthcare services. The results contribute to the Centers for Medicare & Medicaid Services star rating.

Providing a positive patient experience improves patient outcomes and makes good business sense, according to recent studies. Research shows that a good patient experience is associated with positive clinical outcomes.

Also, improvement in patient experience correlates with key financial indicators such as lower medical malpractice risk and less employee turnover.[1]

Survey questions and provider opportunities

Review the survey questions to find out which areas of the patient experience are being measured and see recommendations for improvement, where applicable.

Measure	Sample survey questions	Tips for providers
Annual flu vaccine	Have you had a flu shot since July 1?	Administer flu shot when available each fall.
Getting appointments and care quickly	In the last six months: • How often did you see the person you came to see within 15 minutes of your appointment time? • When you needed care right away, how often did you get care as soon as you needed? • How often did you get an appointment for routine care as soon as you needed?	• Patients are more tolerant of appointment delays if they know the reasons for the delay. When the provider is behind schedule: – Front-office staff should update patients often and explain the cause for the schedule delay. – Staff members interacting with the patient should acknowledge the delay with the patient. • Leave a few appointment slots open each day for urgent visits, including post-inpatient discharge visits. • Offer appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice. • Ask patients to make routine checkups and follow-up appointments in advance.

continued

Measure	Sample survey questions	Tips for providers
Overall rating of healthcare quality	Using any number between zero and 10, where zero is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last six months?	Ask patients how you can help improve their healthcare experience.
Care coordination	In the last six months: • When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results? • When your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them? • How often did you and your personal doctor talk about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about the care you got from specialists?	• Before walking in the exam room, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits. • Implement a system in your office to ensure timely notifications of test results and communicate clearly with patients on when and how they'll receive test results. • Ask your patients if they have seen another provider since you last saw them. If you know patients received specialty care, discuss their visit and the treatment plan they received, including any newly prescribed medication.

[1]https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality_improvement/improvement_guide/cahps_ambulatory_care_guide_full.pdf

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One in a series of tip sheets that look at key 2019 Healthcare Effectiveness Data and Information Set measures, commonly referred to as HEDIS® measures.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Effectiveness of Care HEDIS® Measure

HEDIS measure definition

This measure examines the percentage of males ages 21-75 and females ages 40-75 in the measurement year who are identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who:

- Were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year, and
- Remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period.

Exclusions from the HEDIS measure

Patients are also excluded if they:

- Are a patient in hospice or living in a long-term institutional setting any time in the measurement year.
- Have a diagnosis of pregnancy, dispensed clomiphene or underwent in vitro fertilization in the measurement year or the year prior to the measurement year.
- Have end-stage renal disease (ESRD) during the measurement year or the year prior to the measurement year.
- Have cirrhosis during the measurement year or the year prior to the measurement year.
- Have myalgia, myositis, myopathy or rhabdomyolysis during the measurement year.
- Have an advanced illness and frailty:
  - Medicare members ages 66 and older with advanced illness in the measurement year or the year prior to the measurement year AND frailty in the measurement year are excluded when claims are received with advanced illness (includes dispensed dementia medication) and frailty codes. See the Advanced Illness and Frailty Guide for more information.

continued

Information patient claims should include

When patients are not able to tolerate statin medications, they are excluded from the measure. Document their condition in their medical record and submit a claim using the appropriate code:

Condition	ICD-10 code
Myalgia	M79.1-M79.18
Myositis	M60.80-M60.819; M60.821-M60.829; M60.831- M60.839; M60.841-M60.849; M60.851- M60.859; M60.861-M60.869; M60.871-M60.9
Myopathy	G72.0, G72.2, G72.9
Rhabdomyolysis	M62.82

General tips

Prescribe at least one high-intensity or moderate-intensity statin medication during the measurement year to patients diagnosed with ASCVD. This must be a pharmacy claim. Medication samples, when given, could interfere with pharmacy claims and produce false nonadherence results.

Statin therapy	
High-intensity statin therapy	Atorvastatin 40-80 mg Amlodipine-atorvastatin 40-80 mg Rosuvastatin 20-40 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg Atorvastatin 10-20 mg Ezetimibe-simvastatin 20-40 mg Fluvastatin 40 mg bid Fluvastatin XL 80 mg Lovastatin 40 mg Pitavastatin 2-4 mg Pravastatin 40-80 mg Rosuvastatin 5-10 mg Simvastatin 20-40 mg

You also can:

- Educate your patients on the importance of statin medication adherence.
- Remind them to contact you if they think they are experiencing adverse effects.
- Encourage them to obtain 90-day supplies at their pharmacy to ensure a claim is received, once patients demonstrate they tolerate statin therapy.

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2019 Star quality measure tips

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Statin Use in Persons with Diabetes (SUPD)

The Centers for Medicare & Medicaid Services (CMS) Drug Safety and Accuracy of Drug Pricing Measure

To lower their risk of developing heart disease, most people with diabetes should take cholesterol medication.[1] The American Diabetes Association (ADA) recommends the following statin intensities for patients ages 40 and older who have been diagnosed with diabetes.[2]*

Presence of atherosclerotic cardiovascular disease (ASCVD)	Recommended statin intensity
No	Moderate-intensity statin^
Yes	High-intensity statin
ASCVD with LDL ≥ 70 mg/dL, despite maximally tolerated statin dose	Maximally tolerated statin dose, plus ezetimibe or PCSK9 inhibitor

*Lifestyle modifications should be incorporated into all treatments.

^High-intensity statin may be considered, based on risk-benefit profile and presence of ASCVD risk factors such as LDL cholesterol ≥100 mg/dL, high blood pressure, smoking, chronic kidney disease, albuminuria and family history of premature ASCVD.

Measure definition

Patients ages 40-75 in the measurement year who were dispensed at least two diabetes medication fills and who received a statin medication fill in the current measurement year.[1]

Exclusions from the measure

Patients are excluded if they:

- Are diagnosed with end-stage renal disease (ESRD).
- Are a patient in hospice any time in the measurement year.

continued

Information patient medical records should include

The statin prescribed and the date it was prescribed.

Moderate-intensity and high-intensity statins
Amlodipine-atorvastatin
Atorvastatin
Ezetimibe-atorvastatin
Fluvastatin
Fluvastatin XL
Lovastatin
Pitavastatin
Pravastatin
Rosuvastatin

Tips to overcome barriers

There are many reasons why statins are not being prescribed. Here are some solutions:

Barrier	Solution
Patient has type 1 diabetes	The American Diabetes Association and the American College of Cardiology/American Heart Association guidelines recommend statin therapy for primary prevention of ASCVD events for both type 1 and type 2 diabetes.[2,3]
Patient's LDL is within normal range	Statins should be considered for all patients diagnosed with diabetes (ages 40 and older) regardless of LDL levels, according to current ADA guidelines.[2] LDL levels should still be monitored, since an elevated LDL is a risk factor for CVD and monitoring can help assess patient adherence to treatment.
Myalgia	Myalgias are common and may not be medication-related. Try a brief period of discontinuation. Consider a rechallenge with a reduced dose of the same or a different statin if myalgia resolves.[3] Try a different statin that is more hydrophilic, such as pravastatin, rosuvastatin or fluvastatin.[4,5] These statins may be less likely to cause myalgia. Try lower or less-frequent dosing. Evidence supports the use of a very low dose or less-than-daily regimen, such as simvastatin every other day or rosuvastatin once weekly.[6,7,8,9] Consider the maximally-tolerated statin dose for patients with ASCVD.[2]
ACC/AHA ASCVD risk calculator estimates a <7.5% 10-year atherosclerotic ASCVD risk	This tool has limited use in patients with diabetes, since diabetes itself confers an increased risk for ASCVD and all diabetics over the age of 40 should be taking a statin.[2]
Drug interaction with concomitant medication	Simvastatin, lovastatin and atorvastatin are susceptible to the most drug interactions.[10] If initiating a medication that interacts, consider switching to a different statin with less potential for drug interactions such as rosuvastatin, pravastatin or fluvastatin.[10]

continued

Barrier	Solution
Patient believes that red yeast rice is superior to statins	Red yeast rice may contain a chemical identical to the active ingredient in lovastatin, but, as a supplement, it can only contain trace amounts.[11] Furthermore, the FDA has issued warnings against taking this supplement due to the lack of standardized preparation and efficacy or safety data.[11,12,13]
Elevated liver enzymes	Elevated liver enzymes in diabetes often are due to nonalcoholic fatty liver, which may improve with better glycemic control. It is reasonable to reinitiate the same statin at a lower dose or try a different statin, once liver function returns to normal.[14] This can be safely done with routine liver function test monitoring.
Patient is at high risk for myopathy	Risk factors include: female gender, advanced age, low body mass index, hepatic dysfunction, kidney dysfunction, human immunodeficiency virus, preexisting myopathy, Asian ancestry, excess alcohol intake, high levels of physical activity, trauma and drug interactions.[15,16,17] To minimize the risk of myopathy, a lower dose of a hydrophilic statin (e.g., pravastatin, rosuvastatin, fluvastatin) may be considered in patients with multiple risk factors.[17]
Statins increase HgbA1c	Increased HgbA1c and fasting serum glucose have been reported with statin use.[18,19,20] This risk is considered minimal compared to the cardiovascular benefits seen with statin therapy.[2] The ADA recommends performing the HgbA1c test at least two times per year in patients who are meeting their treatment goals and have stable glycemic control and performed quarterly in patients whose therapy has changed or who are not meeting glycemic goals.[1]
Statins cause dementia	There is no definitive data to support the claim that statins cause dementia. Conversely, statin use may even be associated with a reduction in incidence of dementia.[21,22,23] There have been some rare post-marketing reports of cognitive impairment associated with statin use. These events weren't serious and reversed upon statin discontinuation.[24] The evidence associating statins with cognitive impairment is not well-established, and healthcare providers should note whether a patient is taking another medication that can cause cognitive impairment, such as OTC antihistamines, sedative-hypnotics, antipsychotics and pain medications.[25]

Sources:

1. Medicare 2019 Part C & D Star Ratings Technical Notes (Centers for Medicare & Medicaid Services), 82-84

2. American Diabetes Association. Standards of Medical Care in Diabetes 2018. *Diabetes Care*. 2018; 40 Suppl 86-104

3. Stone NJ, Robinson JG, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* 2014; 129 (25 Suppl 2): S1-45. doi: 10.1016/j.jacc.2013.11.002.

4. Bitzur R, Cohen H, Kamari Y, et al. Intolerance to Statins: Mechanisms and Management. *Diabetes Care*. 2013; 36(Supplement 2): S325- S330. doi: 10.2337/dcS13-2038.

5. McTaggart F, Buckett L, Davidson R, et al. Preclinical and clinical pharmacology of rosuvastatin, a new 3-hydroxy- 3-methylglutaryl coenzyme A reductase inhibitor. *Am J Cardiol*. 2001; 87(suppl): 28B–32B. doi: 10.1016/S0002-9149(01)01454-0

6. Backes JM, Venero CV, Gibson CA, et al. Effectiveness and tolerability of every-other-day rosuvastatin dosing in patients with prior statin intolerance. *Ann Pharmacother*. 2008; 42(3): 341. doi: 10.1345/aph.1K604.

7. Meek C, Wierzbicki AS, Jewkes C, et al. Daily and intermittent rosuvastatin 5 mg therapy in statin intolerant patients: an observational study. *Curr Med Res Opin*. 2012; 28: 371–378. doi: 10.1185/03007995.2012.657302.

continued

8. Ruisinger JF - Once-a-week rosuvastatin (2.5 to 20 mg) in patients with a previous statin intolerance. *Am J Cardiol*. 2009; 103: 393-4. doi: 10.1016/j.amjcard.2008.09.095.

9. Degreef LE, Opdam FL, Teepe-Twiss IM, et al. The tolerability and efficacy of low-dose simvastatin in statin-intolerant patients. *Eur J Intern Med*. 2010; 21(4): 293-6. doi: 10.1016/j.ejim.2010.03.015.

10. Zhelyazkova-Savova M, Gancheva S, Sirakova V. Potential statin-drug interactions: prevalence and clinical significance. *SpringerPlus*. 2014; 3:168. doi: 10.1186/2193-1801-3-168.

11. Klimek M, Wang S, Ogunkanmi A. Safety and efficacy of red yeast rice (Monascus purpureus) as an alternative therapy for hyperlipidemia.P&T: *A Peer-Reviewed Journal for Formulary Management*. 2009; 34(6): 313–327.

12. Dujovne CA. Red Yeast Rice Preparations: Are They Suitable Substitutions for Statins? *Am J Med*. 2017 Jun 7. pii: S0002-9343(17)30591-0. doi: 10.1016/j.amjmed.2017.05.013.

13. Gordon RY, Cooperman T, Obermeyer W, et al. Marked variability of monacolin levels in commercial red yeast rice products: buyer beware! *Archives of Internal Medicine*. 2010; 170(19): 1722–1727.

14. Calderon RM, Cubeddu LX, Goldberg RB, Schiff ER. Statins in the Treatment of Dyslipidemia in the Presence of Elevated Liver Aminotransferase Levels: A Therapeutic Dilemma. *Mayo Clinic Proceedings*. 2010; 85(4): 349-356. doi:10.4065/mcp.2009.0365

15. Feng Q, Wilke RA, Baye TM. Individualized risk for statin-induced myopathy: Current knowledge, emerging challenges, and potential solutions. *Pharmacogenomics*. 2012; 13(5): 579-594. doi:10.2217/pgs.12.11.

16. Mancini GB, Tashakkor AY, Baker S, Bergeron J, Fitchett D, Frohlich J, Genest J, Gupta M, Hegele RA, Ng DS, Pearson GJ, Pope J. Diagnosis, prevention, and management of statin adverse effects and intolerance: Canadian Working Group Consensus update. *Can J Cardiol*. 2013 Dec; 29(12): 1553-68. Epub 2013 Sep 29.

17. Husband A. Managing statin-induced myopathy. *Clinical Pharmacist*. http://www.pharmaceutical-journal.com/learning/learning-article/ managing-statin-induced-myopathy/10970792.article. Published July 14, 2009. Accessed August 29, 2017.

18. Rajpathak SN, Kumbhani DJ, Crandall J, Barzilai N, Alderman M, Ridker PM. Statin therapy and risk of developing type 2 diabetes: a meta- analysis. *Diabetes Care*. 2009; 32: 1924–1929

19. Sattar N, Preiss D, Murray HM, et al. Statins and risk of incident diabetes: a collaborative meta-analysis of randomised statin trials. *Lancet*. 2010; 375: 735–742

20. Ridker PM, Pradhan A, MacFadyen JG, Libby P, Glynn RJ. Cardiovascular Benefits and Diabetes Risks of Statin Therapy in Primary Prevention. *Lancet*. 2012; 380(9841): 565-571. doi:10.1016/S0140-6736(12)61190-8.

21. Cramer C, Haan M N, Galea S, et al. Use of statins and incidence of dementia and cognitive impairment without dementia in a cohort study. *Neurology*. 2008 Jul 29; 71(5): 344–350. doi: 10.1212/01.wnl.0000319647.15752.7b.

22. Jick H, Zomberg G L, Jick S S, et al. Statins and the risk of dementia. *Lancet*. 2000 Nov 11; 365: 1627-1631.

23. Wanamaker, B. L., Swiger, K. J., Blumenthal, R. S. and Martin, S. S. (2015), Cholesterol, Statins, and Dementia: What the Cardiologist Should Know. *Clin Cardiol*, 38: 243–250. doi:10.1002/clc.22361.

24. Lipitor (atorvastatin) package insert. NY, NY. *Pfizer Inc*; 2017 Jul.

25. Rojas-Fernandez C, Goldstein L, Levey A, et al. An assessment by the Statin Cognitive Safety Task Force: 2014 update. *Journal of Clinical Lipidology*. 2014; 8, S5–S16. doi:10.1016/j.jacl.2014.02.013.

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