PROVIDERS' NEWS
A publication for participating providers and their office staffs
JUNE 2015

INSIDE

ICD-10 testing

Only 3 months left

for ICD-10 testing with Arkansas Blue Cross and Blue Shield!
Last date for testing is

August 31, 2015.

Sign up is required for ICD-10 testing.

Have you signed up?

ICD Assist

Did you know that Arkansas Blue Cross and Blue Shield is offering a free* tool to help providers with ICD-10? Get comfortable with the new world of ICD-10 by creating an account today!

Website: http://icdassist.com

*This tool is free for Arkansas Blue Cross providers only. Your NPI number will be asked during registration for verification. The free account is valid for one user per facility. Additional users from the same provider will be available upon payment.

LIVE FEARLESS℠
Arkansas BlueCross BlueShield

ICD-10 compliance date is October 1, 2015

The U.S. Department of Health and Human Services (HHS) has issued a rule finalizing October 1, 2015, as the new compliance date for health care providers, health plans and health care clearinghouses to transition to ICD-10. This new deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

Arkansas Blue Cross and Blue Shield is actively performing ICD-10 end-to-end testing with providers. See frequently asked questions to get started. Arkansas Blue Cross encourages providers to initiate ICD-10 testing as soon as possible.

Original article located in the March 2015 issue of *Providers' News*.

Claims without ICD-10 codes will not be paid

By federal mandate, the ICD-10 compliance date is October 1, 2015. As a result, all claims submitted to the Arkansas Blue Cross and Blue Shield family of companies for dates of service on and after October 1, 2015, must utilize ICD-10 codes in place of ICD-9 codes. Claims not billed with ICD-10 codes will be rejected. Claims effected by this change include Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, Health Advantage, Medi-Pak, Medi-Pak Advantage, Federal Employees Program and Metallic Plans on the Arkansas Exchange.

Arkansas Medicaid is also planning to do the same and has published a similar update on their site. Arkansas Blue Cross will monitor federal guidelines regarding compliance and make changes to this policy as needed.

Feel free to contact Arkansas Blue Cross for assistance. Arkansas Blue Shield has opened up ICD-10 testing with providers for some time now and is ready to test with more providers. Sign-up for your testing slot now! Please contact us at icd10@arkbluecross.com for anything related to ICD-10. Please see other ICD-10 articles in this newsletter for more details.

Revenue codes requiring CPT or HCPCS codes

Beginning July 1, 2015, outpatient institutional claims (UB04) containing revenue codes 0480, 0481, 0482, 0483 and 0489 will require CPT/HCPCS codes in conjunction with these revenue codes. The additional CPT/HCPCS codes will be required on both electronic and paper claims. Claims submitted without the appropriate CPT/HCPCS codes will be rejected and the member will not be held responsible. This revision applies to all outpatient UB04 claims submitted to Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators of Arkansas and Health Advantage.

Original article located in the March 2015 issue of *Providers' News*.

ICD-10 testing – frequently asked questions

Why should providers test with Arkansas Blue Cross and Blue Shield?

- To resolve problems early and avoid possible delays in submission, processing and payments.
- To help ensure your internal systems and teams are equipped to handle ICD-10.
- ICD-10 compliance is the law. CMS is firm on the October 1, 2015 implementation date.

Do providers need to be involved with testing?

- ICD-10 may impact payments and/or benefits for institutional, professional, outpatient and dental (medical) claims.
- Providers should test equivalency of benefits and payments under ICD-9 and ICD-10.
- Testing objective for providers will be different than that for clearinghouses and vendors.
- Providers can avoid major issues by choosing test scenarios that are most important to them.

What resources are provided by Arkansas Blue Cross?

- ICD Assist (http://icdassist.com) Arkansas Blue Cross is offering a free tool for providers to help with mapping, code search and lookup. The free tool provides customized listing of top frequency ICD-9 codes for each provider.
- ICD-10 Resource Center at http://www.arkansasbluecross.com/providers/ICD10ResourceCenter.aspx

Who should providers contact for questions regarding ICD-10?

- Email: icd10@arkbluecross.com or call Sharon Stone at 501-378-3623 or Jignesh Borad at 501-399-3876.

How should providers start?

Step 1: Registration

- Registration is required.
- Email provider name, address, NPI and requested testing date.
- Receive confirmation and testing guide.

Step 2: Create test claims

- Can your software (or vendors) support ICD-10?
- Select original ICD-9 claims (20-25).
- Code equivalent ICD-10 claims.

Step 3: Submission and review

- Follow submission instructions in test guide.
- Review results.
- Select and submit additional claims if needed.

Can providers afford to wait?

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

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

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

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

Provider Re-Reviews:

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

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

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

Original article located in the June 2011 issue of *Providers' News*.

Medi-Pak Advantage: Follow-up to notice of face-to-face visit for home health services

In follow-up to the notice* of the face-to-face (FTF) visit requirement, the FTF visit will not be required to be reported on Medi-Pak Advantage claims for home health services. According to "Home Health Face-to-Face Encounter Question & Answers" effective immediately, the FTF visit is not required for Medicare Advantage plans. Any claim denied due to no documentation of the FTF visit will be provided further consideration upon request.

Home health services are covered when a patient is homebound and under the care of the certifying physician. An order (verbal or written) must be obtained prior to delivery of services. There must be a plan of care for qualifying services with specific visit frequency and duration, signed and reviewed at least every 60 days by the certifying physician. Evidence of these documentation requirements must be maintained in the patient's record and available for review upon request.

*Medicare Benefit Manual (IOM 100-02) - Chapter 7, section 30; Home Health Face-to-Face Encounter Question & Answers - CMS Medicare Fee for Service Payment/Home Health PPS (http://www.cms.gov/homehealthpps - Keywords: face-to-face, Medicare Advantage)

Medi-Pak Advantage: Notice of projected denial for vacuum erection systems prosthetic devices

As a Medicare replacement plan, Medi-Pak Advantage follows Medicare (CMS) guidelines for processing services provided to Medi-Pak Advantage members. CMS has released notification, Medicare Learning Network Matters Special Edition SE1511, that vacuum erection systems prosthetic devices will no longer be covered for dates of service on or after July 1, 2015.

Medi-Pak Advantage wishes to notify our providers that, as a Medicare replacement plan, Medi-Pak Advantage will follow the new CMS directives for these devices. For dates of service on or after July 1, 2015, each of the following devices will be denied as statutorily excluded/patient liability:

- L7900 - Male vacuum erection system
- L7902 - Tension ring, for vacuum erection device, any type, replacement only.

Medi-Pak Advantage: Provider incentive programs

Medi-Pak Advantage is focusing its efforts in 2015 on "CMS (Centers for Medicare and Medicaid Services) Stars' Quality Improvement" with a variety of provider incentive programs aimed at improving "stars" scores through comprehensive evaluation and documentation during office visits. The overall goal of these programs is to encourage preventive screenings and maintenance of chronic conditions for improved health and quality of life for our members.

Arkansas Blue Cross and Blue Shield is committed to being a high quality health plan for our seniors and we realize our network providers are paramount in achieving this goal. Look for more information in the near future regarding these new provider incentive programs

Medi-Pak: Remittance advice changes

Effective June 1, 2015, changes were made to the Medi-Pak Remittance Advice (RA). The column header currently named "Explanation" will be changed to "Remarks Codes". The remark code(s) will display under the new column header on the far right side of the RA.

The explanation for each remark code will display on the last page of the RA above the place of service and type of service codes. This change will allow for current and future expansion in the remarks code explanations.

Providers with questions regarding the RA changes should contact the Medi-Pak Customer Service division at 1-800-238-8379.

ASE/PSE: Bariatric Program

On February 1, 2015, enrollment into the Bariatric program for Arkansas State and Public School Employees was closed. Employee Benefits Division (EBD) will evaluate claims and spending as the year progresses to determine if the program will be reopened for new enrollment. Please contact EBD at 877-815-1017 for questions.

Testing for drugs of abuse or drugs at risk of abuse

The American Medical Association (AMA) has made major coding changes to the CPT codes for testing for drugs of abuse. The old CPT coding system focused on "qualitative" versus "quantitative" testing. The new CPT coding system focuses on "presumptive" versus "definitive testing." A presumptive drug test is a test whose results indicate possible, but not definitive, use or non-use of a drug or drug class. A definitive drug test is a test that provides specific identification of individual drugs and drug metabolites.

The CPT codes for drug screening services (80100, 80101, 80102, 80103, and 80104) were deleted and replaced with new presumptive drug class screening CPT codes that define the drug class and the methodologies involved in the testing (80300, 80301, 80302, 80303, and 80304). Additionally, new definitive drug testing CPT codes (80320-80377) were added.

In 2015, Medicare announced that they will not recognize the new 2015 CPT codes for testing of drugs of abuse and has instead created HCPCS codes (G6030-G6058) to replace the 2014 CPT codes that are being deleted for 2015.

Arkansas Blue Cross and Blue Shield will recognize all of the new HCPCS and CPT codes for drug testing. Coverage will be dependent upon criteria outlined in the Arkansas Blue Cross Coverage Policy.

Arkansas Blue Cross and Blue Shield has a coverage policy for Testing for Drugs of Abuse or Drugs at Risk of Abuse, including Controlled Substances (Policy #2009013). This coverage policy requires a positive precedent qualitative drug screen for each specific drug prior to quantitative drug testing. A screening test billed with one of the new CPT codes (80300 or 80301) or HCPCS codes (G0431 or G0434) will be required before qualitative or definitive testing codes will be allowed.

Policy/Coverage 2009013: Testing for Drugs of Abuse or Drugs at Risk of Abuse including Controlled Substances:

Meets Primary Coverage Criteria or is Covered for Contracts without Primary Coverage Criteria

Quantitative or definitive testing (80320-80377 or G6030-G6058) for specific drugs of abuse or drugs at risk of abuse, including controlled substances, meets member benefit certificate primary coverage criteria only when a precedent qualitative drug screen (80300-80301 or G0431, G0434) has been positive for the specific drug. For cases in which a specific drug test is performed in the absence of a positive drug screen, medical records should be submitted to justify the exception (e.g., in the event of an unexpected negative test where medication diversion may be expected).

Does not Meet Primary Coverage Criteria or is Investigational for Contracts without Primary Coverage Criteria

Quantitative or definitive testing (80320-80377 or G6030-G6058) for specific tests for drugs of abuse or drugs at risk of abuse, including controlled substances, in the absence of a positive drug screen do not meet member benefit primary coverage criteria for effectiveness as such additional testing is not cost-effective.

For members with contracts without primary coverage criteria, quantitative or definitive testing (80320-80377 or G6030-G6058), specific tests for drugs of abuse or drugs of risk of abuse including controlled substances, in the absence of a positive drug screen, are considered not medically necessary and are not covered. Services that are

(Continued on page 7)

Testing for drugs of abuse or drugs at risk of abuse (Continued from page 6)

considered not medically necessary are specific contract exclusions in most member benefit certificates of coverage.

The use of quantitative testing as a drug screen (80302-80304) does not meet member benefit certificate primary coverage criteria that there be scientific evidence of effectiveness and such testing is not cost-effective.

For members with contracts without primary coverage criteria, the use of quantitative testing as a drug screen (80302-80304) is considered not medically necessary and is not covered. Services that are considered not medically necessary are specific contract exclusions in most member benefit certificates of coverage.

Opting out of individual metallic benefit plans

Currently, the True Blue PPO network is utilized by several health benefit plans and participation in the True Blue PPO network has necessitated that providers be in–network for all of these plans. Effective July 1, 2015, providers who participate in the True Blue PPO provider network will be able to remove their participation (i.e. opt out) from being in-network for metallic plans in the individual health insurance Marketplace/ Exchange yet remain in the True Blue PPO network for all other benefit plans.

To opt out of the metallic plans in the individual marketplace, providers must send a written request that indicates the provider wants to "opt out of the network for members who have the individual metallic benefit plans." This written request must be placed on the provider's official letterhead and must be signed by the provider making the request. Providers are not required to terminate their True Blue PPO participating agreement if they wish to opt out from the individual metallic plans. Please remember that if you are contracted through a physician hospital organization (PHO) or other group arrangement, that you must follow their respective contracting procedures requirements which may include obtaining their approval.

Requests to opt out of the individual metallic plan provider network should be mailed to:

USAble Corporation
Attn: PNO - 3 North
P.O. Box 1489
Little Rock, AR 72203-1489

Please understand that opting out applies to all individual metallic plans and all of a provider's locations.

Once a provider has chosen to be removed from the metallic plans in the individual marketplace, the provider cannot be reinstated for these benefits plans for at least 12 months. To be reinstated, the provider will need to complete full application forms and must go through the initial credentialing process. Any provider who opts out will be designated as out of network for individual metallic plans and all services will be processed at the out of network benefit levels with any covered services paid to the member. Provider directories will include a notation that the provider is not participating as an in-network provider for individual metallic plans.

This notice is considered an amendment to the USAble Corporation True Blue PPO participating provider agreement. True Blue agreements issued in the future will contain a separate exhibit addressing participation in the individual metallic plans' network.

New requirements for formulary exceptions/prior authorization requests

Real time communication with a member is necessary to gather information needed for prior approval on many medications and treatments. Valid contact numbers are absolutely mandatory in assisting a member with continuity of care. Arkansas Blue Cross and Blue Shield reserves the right to deny and return to providers any request for prior authorization that does not include the member's contact phone number. The provider's office may be called to provide the contact number for the member. To expedite a prior authorization request, please ensure that the member has supplied a current and active contact phone number on each and every formulary exceptions/prior authorization request submitted.

Implant invoices: Changes to process

On November 1, 2011, Arkansas Blue Cross and Blue Shield implemented a change to how information concerning implant invoices are collected. This change was approved in the interest of:

1. Significantly reducing medical record requests from providers.
2. Controlling utilization costs for the benefit of our members and Arkansas Blue Cross.
3. Assuring fair and reasonable reimbursement to providers.
4. Easing administrative burdens on both Arkansas Blue Cross and providers.

Implementation of the new reporting process for outpatient facilities and ambulatory surgery centers to report their cost for implants (revenue codes 0275 and 0278) will be subject to the following:

1. Provider cost will be determined by replacing existing policy of requiring a provider submit an invoice for ALL revenue code 0275 and 0278 events to only requiring an invoice above a reported charge threshold. Those events BELOW that threshold will be automatically priced and adjudicated at provider cost based upon information submitted by the provider at the time of claim filing. Those events above the established threshold will go through the existing process (requesting invoice with bar-coded letter).
2. Providers will be required to populate the HCP Segment of the 2400 Loop in AHIN for each 0275 and 0278 event (regardless of threshold amount). HCP01 must always be populated with "13" and the provider's cost will be entered into HCP02 for each line 0275 or 0278 is billed.
3. Arkansas Blue Cross will monitor data for each provider and across the networks.
4. Arkansas Blue Cross reserves the right at any time to adjust any provider's threshold, based upon our analysis of information patterns indicating such a need.
5. Periodically, Arkansas Blue Cross will randomly select a small sample of below threshold revenue codes 0275 and 0278 line items for audit.
6. Paper claims filed after the implementation date will be adjudicated according to claim attachments, if any:
   A) Honoring an attached invoice; or
   B) At $0 if no attachment.

Please note: This is not a reimbursement change.

If you have any questions regarding this upcoming process, please send an e-mail to Nancy Grove at nkgrove@arkbluecross.com.

Original article located in the September 2011 issue of *Providers' News*.

New fax number for hospital precertification services

Arkansas Blue Cross and Blue Shield is making upgrades to the utilization management services. As a result, the hospital admission fax number is changing. Beginning June 1, 2015, the new hospital admission precertification fax number will be 501-378-2050. Please make sure all clinics and facilities begin using the new fax number on June 1, 2015, when sending precertification clinical information for members of BlueAdvantage Administrators of Arkansas, FEP, and USAble Administrators.

The fax number is the only change for the utilization management services. The hospital admission precertification phone number is not changing.

Providers, who have questions regarding this change, should contact their network development representative.

Claims: Timely filing guidelines

As a reminder, the following information regarding timely claims filling applies to Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas and Health Advantage and includes claims for members of other Blue Cross Plans.

Filing Original Claim:
Providers must submit claims for any service, supply, prescription drug, test, equipment or other treatment within 180 days after such service, supply, prescription drug, test, equipment or treatment is provided.
In the case of a claim for inpatient services for multiple consecutive days, a written proof must be submitted no later than 180 days following the date of discharge for that admission.

Re-submitting Claims:
Arkansas Blue Cross and its affiliates also require providers to use this 180-day timely filing limit for re-submitting claims for adjustments, or for submitting additional information on a previously filed claim.

Adjudicated Claims/COB:
Arkansas Blue Cross and its affiliates extends the timely filing requirements to include 180 days after the primary insurer adjudicates the claim. Timely deadline for secondary claims is 180 days from the date processed by the primary carrier.

Member Responsibility:
The 180-day timely filing provision is applicable for both providers and members. When a patient covered by Arkansas Blue Cross or an affiliate does not provide their provider with proof of coverage until after the 180-day timely filing has expired, that patient is responsible for the services and the provider should not bill Arkansas Blue Cross or its affiliates.

All contract holders should have a member identification card and should present their ID card prior to each service. Arkansas Blue Cross and its affiliates encourage all providers to have their patients complete insurance coverage update forms at the time of each service. By completing an insurance coverage update form, patients are given every opportunity to provide up-to-date insurance information.

For questions regarding coverage, providers should refer to AHIN (Advanced Health Information Network) for member eligibility and claims status or call The BlueLine, our voice-activated response service, available 24 hours a day, 7 days a week.

EDI claims submitter

Effective May 11, 2015, any EDI submitter will be allowed to use two clearinghouses for claims (837) transmission, but only one for retrieving remits (835). If you currently use one clearinghouse today for claims and you wish to enroll another clearinghouse, please fax a letter on letterhead to EDI authorizing the new clearinghouse listing their name and submitter number. Please have someone of authority for the clinic sign the letter.

A front-end edit has been put in place to reject EDI claims received that were sent by an unauthorized clearinghouse or billing agent not on file with us. The clearinghouse submitter ID sent in the ISA06 of the electronic claim file must be linked to your electronic submitter ID number of (EXXXX) in the NM109 1000A. Please check reports daily to verify claims were accepted.

If you currently use only one clearinghouse, please disregard this notice. If you plan on allowing a second clearinghouse in the future, please send the fax at that time.

EDI Services
(501)378-2336
855-822-2446
Fax (501) 378-2265
edi@arkbluecross.com

Coverage policy manual updates

Since March 2015, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our website at arkansasbluecross.com.

New / Updated policies:

Policy#	Policy Description
1997133	Mastectomy, Prophylactic
1997153	Iron Therapy, Parenteral
1997229	Cardiac Event Recorder, External Loop or Continuous Recorder
1998144	Pulmonary Arterial Hypertension, Pharmacological Treatment with Prostacyclin Analogues, Endothelin Receptors Antagonists, or Phosphodiesterase Inhibitors
2001030	PET or PET/CT for Esophageal or Esophagogastric Junction (EGJ) Cancer
2004022	Artificial Vertebral Disc, Lumbar Spine
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
2009031	Ingestible pH and Pressure Capsule
2011016	Preventive Services for Non-Grandfathered (PPACA) Plans: BRCA Testing; Genetic Counseling and Evaluation

Policy#	Policy Description
2011017	Preventive Services for Non-Grandfathered (PPACA) Plans: Breast Cancer Preventive Medication
2011040	Preventive Services for Non-Grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV) Counseling and Screening
2011045	Preventive Services for Non-Grandfathered (PPACA) Plans: Colorectal Cancer Screening
2011053	Autism Spectrum Disorder, Early Behavioral Intervention
2011066	Preventive Services for Non-Grandfathered (PPACA) Plans: Overview
2014003	Telemedicine Services-Pilot Policy
2014008	Infertility Services
2014021	Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis (SureSwab) (NuSwab)
2015003	Patient-actuated End Range Motion Stretching Devices
2015004	Genetic Test: PALB2 Mutations
2015005	Genetic Test: Pharmacogenetic Testing for Pain Management
2015006	Extracorporeal Membrane Oxygenation for Adult Conditions
2015007	ST2 Assay for Chronic Heart Failure
2015008	Genetic Test: Miscellaneous Genetic and Molecular Diagnostic Tests
2015009	Genetic Test: Cancer Susceptibility Panels using Next Generation Sequencing
2015010	Viekira Pak (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)

Fee schedule: additions and changes

The following additions and changes were made to Arkansas Blue Cross and Blue Shield's fee schedule:

CPT / HCPS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
21556	$853.19	$0.00	$0.00	$853.19	$0.00	$0.00
34839	BR	$0.00	$0.00	BR	$0.00	$0.00
90651	$163.09	$0.00	$0.00	$0.00	$0.00	$0.00
93660	$433.98	$153.98	$280.00	$153.98	$153.98	$0.00
0008M	$3,252.40	$0.00	$0.00	$0.00	$0.00	$0.00
E0165	$175.30	$0.00	$131.48	$0.00	$0.00	$0.00
E0619	$3,111.90	$311.19	$2,333.93	$0.00	$0.00	$0.00
E0619	$3,065.90	$306.59	$2,299.43	$0.00	$0.00	$0.00
E0781	$0.00	$9.80	$0.00	$0.00	$0.00	$0.00
J1050	$0.47	$0.00	$0.00	$0.00	$0.00	$0.00
J7302	$810.51	$0.00	$0.00	$0.00	$0.00	$0.00

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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.

We're on the Web!

arkansasbluecross.com
healthadvantage-hmo.com
blueadvantagearkansas.com
fepblue.org

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