PROVIDERS' NEWS

September 2017

A publication for participating providers and their office staffs

No out-of-area coverage on some Exchange products in 2018

Beginning in January 2018, Arkansas Blue Cross and Blue Shield will be marketing some exchange products, including Arkansas Works, that will not have out-of-area benefits. This means that any elective service outside of the service area (state of Arkansas) will not be covered by the member's policy. Please note that there are participating True Blue PPO network providers in counties and parishes bordering Arkansas that will be covered. You can recognize these members by the lack of a "suitcase" on their member ID card. The ID prefixes for these members are EXX, AEE, and AXC.

Before referrals are made on these members, please check the True Blue PPO Provider Directory and refer these members to participating providers in the True Blue PPO network for Individual Metallic policies; there are participating True Blue PPO providers in states bordering Arkansas. These products services must be provided by a True Blue participant; please do not refer them to providers not in the True Blue PPO network. If the service is not available, you may request a prior approval and a referral to an out-of-state BlueCard provider or other provider as appropriate. This does not apply if the service is an emergency.

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Utilization management changes for health plans in the individual market 2017-2018

Arkansas Blue Cross and Blue Shield values its close and trusted relationships with its providers, and we continually seek to strengthen these relationships in a way that ensures our members receive high-quality, cost-effective care with simple and efficient administrative processes. To that end, in 2018 we are incorporating proven utilization and care management measures for our **members enrolled in individual market health plans including Arkansas Works**. These health plans are identified by the following prefixes: XCQ, XCB, XCR, EXX, AEE, or AXC along with a policy identification number beginning with a 6 or a 7. These measures are designed to support quality care, identify and improve care for high-risk members, enhance patient safety, and support better use of healthcare resources.

Prior approval is required for certain services. When a provider does not obtain prior approval, the provider will be financially responsible for the charges of the non-approved services. By seeking prior approval for certain designated services, we hope to improve health outcomes for our members while supporting the long-term sustainability of Arkansas' healthcare system.

Prior approval is a general term that determines if a service meets certain criteria to be paid for by the health plan. These criteria include member eligibility, benefits and clinical appropriateness. It is not a sole reflection of the medical necessity of services.

We understand that providers may have concerns regarding the new utilization management measures. We want to clarify that prior approval will NOT be required for:

- Emergency services
- Ambulances
- Urgent care
- Primary care/specialist office visits
- Screenings and preventive care
- Generic drugs

We DO NOT want to stand in the way of needed care for our members or be an obstacle for our providers. We DO want to ensure our members receive the highest quality of care in the most appropriate settings and from the most appropriate providers.

The utilization management measures for Arkansas Blue Cross members with health plans issued in the individual market will focus on prior approval for the following areas:

- Inpatient admissions (behavioral and medical)
- Select outpatient services
- High-tech imaging procedures
- Select behavioral health services
- Transplant services
- Out-of-area/out-of-state services
- Pharmacy Services

We do request that providers submit the most detailed and accurate diagnosis coding on both the prior approval request and on the subsequent claim for services. Accurate and complete diagnosis coding will assist in the processing of the prior approval and the claim.

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Utilization management changes for health plans in the individual market 2017-2017 (Continued from page 2)

Additional information on the 2017- 2018 Utilization Management Program will be detailed in the coming weeks through *Providers' News,* the Arkansas Health Information Network (AHIN), provider workshops, and your network development representatives will also provide you with more detailed information.

Updating your provider information

Maintaining accurate provider information is critically important to ensure that consumers have timely access to care. Updated information helps us maintain accurate provider directories and also ensures that providers are more easily accessible to members. Additionally, plans are required by Centers for Medicare & Medicaid Services (CMS) to include accurate information in provider directories for certain key provider data elements and accuracy of directories are routinely reviewed/audited by CMS.

Since it is the responsibility of each provider to inform plans when there are changes, providers are reminded to notify Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries of any changes to their demographic information or other key pieces of information, such as a change in their ability to accept new patients, street address, phone number or any other change that affects patient access to care. For Arkansas Blue Cross to remain compliant with federal and state requirements, changes must be communicated within 30 days so that members have access to the most current information in the Provider Directory.

Key Data Elements
The data elements required by CMS and crucial for member access to care are as follows:

- Physician Name
- Location (i.e. Address, Suite, City/State, Zip Code) If in several locations, specify which is the primary location
- Phone Number
- Accepting New Patient Status
- Hospital Affiliations
- Medical Group Affiliations

Providers are encouraged to include accurate information for the following provider data elements:

- Physician gender
- Languages spoken
- Signage name
- Office hours
- Specialties
- Physical disabilities accommodations
- Indian health service status
- Licensing information
- Provider credentials
- Email and website address

How to Update Your Information
You should routinely check your current practice information by going to www.arkansasbluecross.com and select "**Find A Doctor Or Hospital**" on the left near the bottom of the page. If your information is not correct and updates are needed, please provide the correct information as soon as possible by completing the Provider Change of Data form located at www.arkansasbluecross.com/providers/forms.aspx. You also may receive a data verification letter from Provider Network Operations to provide you with an additional opportunity to confirm you information as well.

For more information, contact Provider Network Operations at (501) 210-7050 or email to providernetwork@arkbluecross.com.

Arkansas Prescription Monitoring Program registration

As a network participation standard requirement, Arkansas Blue Cross and Blue Shield required all providers authorized to prescribe and dispense controlled substances in any of our networks to register with the Arkansas Department of Health Prescription Monitoring Program (AR PMP) by April 1, 2017. **Providers who have not registered may have their network participation status suspended with Arkansas Blue Cross and its affiliates and subsidiaries**.

Registration in the AR PMP assists in the prevention, detection and early intervention of prescription drug abuse. The web-based system stores data related to prescribing, dispensing and use of controlled substance prescription drugs. Registration information for practitioners, pharmacists, and their delegates licensed in Arkansas can be found at www.arkansaspmp.com. Click the **Practitioner/Pharmacist** link located on the left menu and click the **Practitioner/ Pharmacist Registration** link to display the login window to establish an RXSentry account.

Benefits of the AR PMP

- Supports appropriate access of controlled substances intended for legitimate medical reasons.
- Helps identify and prevent drug abuse and addiction in Arkansas and allows links to other state's prescription monitoring databases.
- Facilitates the identification, intervention with and treatment of patients addicted to prescription drugs.
- Supports public health initiatives by providing prescription claim data to develop important utilization and trend reporting.
- Includes the education of medical personnel about prescription monitoring and the use, abuse, diversion and addiction to prescription drugs.

Regular Review of Patient History

For new and existing patients, prescribers must check the patient's prescription history on the AR PMP website prior to prescribing controlled substance drugs by logging in to RXSentry and selecting the Recipient Query.

The complete training guide is available at https://arpmp-ph.hidinc.com/AR_PMP_Training_Guide_for_AR_Practitioners_and_Pharmacists.pdf.

2017 Open Enrollment: please use AHIN

2017 Open Enrollment periods will begin on October 1, 2017, and runs through December 15, 2017. Due to the anticipated enrollment of many new members and current member renewals, we are expecting extremely high call volume through January 31, 2018. Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use AHIN (Advanced Health Information Network) for verifying eligibility, benefits, and claims status. AHIN displays information on benefits to assist providers when scheduling appointments, checking eligibility and benefits. Arkansas Blue Cross is planning and staffing to answer a higher call volume, but call volumes can spike and exceed our ability to answer every call. AHIN uses the same information available to our customer service representatives and can save you valuable time.

Provider data transparency

Publication Of Claims, Utilization, Quality and Other Practice Data

In this rapidly changing health care environment, health insurers and network sponsors are faced with the challenge of meeting market demand for more information about health care providers. Consumers now expect to be able to find reliable, standardized, comparative performance data for health care providers, including cost and quality rankings where available. As sponsors of health maintenance organization and preferred provider organization networks, we are not alone in dealing with market pressure for increased transparency of cost and quality information relating to the medical services our members receive.

Published on February 1, 2012, the "terms and conditions" for participation in Health Advantage's HMO network and for USAble Corporation's Arkansas' FirstSource® and True Blue PPO networks indicate that any provider participating in the Health Advantage HMO network or in either of the two PPO networks of USAble Corporation will be subject to publication of any and all claims, utilization, cost, quality or other practice data.

Participating providers should note that it may be necessary or beneficial to the networks or their members to publish provider claims, utilization, quality and other practice data to a wide variety of sources or audiences in order to facilitate new initiatives aimed at improving quality of services and devising new reimbursement or payment methodologies to contain rising health care costs. Accordingly, USAble Corporation, Health Advantage, and their parent entity, Arkansas Blue Cross and Blue Shield, may elect, in their discretion, to publish or release claims, utilization, cost, quality and other practice data that they collect or maintain regarding participating providers to members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies or the general public as deemed necessary or helpful with respect to various initiatives from time to time.

Arkansas Blue Cross will not provide advance copies of limited releases of provider claims, utilization, quality or other practice data to specific members, group health plans, employers, hospitals or other categories of providers, consultants, or vendors, or subsets of such audiences. A copy of the information that has been released by Arkansas Blue Cross or its family of companies specific to a provider's practice may be obtained if a written request is received from interested providers. Providers with questions about their data may contact their respective regional Network Development Representative.

Special Note on Data of Non-Participating Providers

Data transparency also applies to non-participating providers that any claims, utilization, quality, cost or other practice data that may be submitted to, collected or maintained by Arkansas Blue Cross and its family of companies is also subject to publication or release, in their discretion, to members, group health plans, employers, hospitals or other categories of providers, consultants, vendors, government agencies or the general public as deemed necessary or helpful with respect to various initiatives from time to time.

The information in this article was originally published in the June 2012 issue of *Providers' News*.

Formal benefit inquiry process in effect

Effective August 1, 2017, Arkansas Act 815 of 2017 allows providers to ask for pre-service review of, and approval of coverage for, services not yet provided to a specific Arkansas Blue Cross and Blue Shield or Health Advantage member. This process, which the legislation calls a "benefit inquiry," only applies to provider-initiated inquiries and only applies to services that are not already subject to prior approval requirements under the terms of the member's health plan. The act requires fully insured health plans to facilitate such benefit inquiries.

Benefit inquiries are only available for Arkansas Blue Cross and Health Advantage members including the Arkansas State/Public School Employee members. They are not available for members of self-funded employer group health plans, even if the plans are administered by Arkansas Blue Cross, doing business as BlueAdvantage Administrators of Arkansas, or by Health Advantage. Also, supplemental plans like Medi-Pak® are not included. Providers who are submitting a prior approval request for an Arkansas State Employee/Public School Employee member should direct this prior approval to the utilization review entity for ASE/PSE. Benefit inquiries are also not available for members covered by the Federal Employee Program.

To initiate and receive a response to a benefit inquiry for services you intend to provide to a specific Arkansas Blue Cross or Health Advantage member, you must follow these steps:

- You must complete and submit a Provider Initiated-Pre-Service/Formal Benefit Coverage Information Form that can be found on AHIN or on the Arkansas Blue Cross and Health Advantage websites under "Forms."
- This form, along with any supporting documents that may assist in the review, may be emailed. To protect the privacy of our members, email submissions must be encrypted.
    1. Completed forms received after 12 p.m. will be considered received on the next business day.
- Diagnosis coding must be detailed and complete on the request form and the subsequent claim for services. If the benefit inquiry is approved and the member's coverage was effective on the date the service is actually provided, payment of the claim is guaranteed only if the information on the benefit inquiry request form matches exactly the post service claim submission.
- If a benefit inquiry is approved, it is not a guarantee that the claim for the service, if provided, will be paid when the claim for that service is submitted. Among other things, the act allows for the claim to be denied if the member's coverage has lapsed after the approval but before the service is provided due to nonpayment of premium if the carrier provides a way for the requesting provider to check the member's coverage status at the time the service is performed. Providers using AHIN may check the status of the member's coverage prior to performing the service in several ways:
    1. AHIN will display the individual's policy status as "active," "termed" or in a "grace period."
    2. For members with Arkansas Blue

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Formal benefit inquiry process in effect (Continued from page 6)

Cross or Health Advantage coverage through Arkansas Works and group employer policies, AHIN displays the most current information that has been received from the state of Arkansas or from the member's group employer.

3. AHIN also displays information on the status of a member's coverage limits. However, if multiple providers filing claims for similar services on the same member and depending on the sequence/timely filing of claims, the status of these limits would be updated.

- Please be advised that MyBlueLine, the interactive voice system, is also available 24/7 with information on member status.
- Provider-initiated requests for approval of coverage for services not yet provided to specific individuals will not be handled or answered by our customer service staff or by any other method other than the form submission process outlined above.
- Please be advised that **informal benefit inquiries continue to be available by calling customer service**; these are not prior approvals.

4. For members with Arkansas Blue Cross or Health Advantage coverage through Arkansas Works and group employer policies including the ASE/PSE, AHIN displays the most current information that has been received from the state of Arkansas or from the member's group employer.

Telemedicine credentialing update

The Arkansas State Medical Board Centralized Credentials Verification Services (CCVS) increased their fee for initial credentialing profiles of telemedicine physicians to $275 in 2012 as a result of increased cost in verifying information with multiple state licensing boards and hospitals in different states. CCVS implemented the higher fee for telemedicine physicians as an alternative to an increase on all other fees. Initial CCVS profiles for physicians licensed and practicing in Arkansas currently cost $80 and recredentialed practitioners cost $60. This applies to any provider the Arkansas State Medical Board defines as a telemedicine provider.

Provider Network Operations (PNO) division of Arkansas Blue Cross and Blue Shield does not charge a fee for the normal initial CCVS profile for physician applicants to the True Blue PPO and Health Advantage HMO networks. Due to the significant cost increase imposed on telemedicine physicians, PNO requires telemedicine physicians to pay a fee of $195.00 before processing their application to cover the additional cost to complete the credentialing application. New applicants classified as telemedicine physicians by CCVS must include a check for $195.00 with their application for the True Blue PPO and Health Advantage HMO networks. Existing network physicians are required to pay $215.00 at time of re-credentialing for continued network participation. Personal or company checks are the only acceptable payment method.

Payment check and network application should be sent to:
Provider Network Administrator
Attn: Telemedicine Fee
P. O. Box 2181
Little Rock, AR 72203-2181

New ID cards effective January 2018

Arkansas Blue Cross and Blue Shield individual members will receive new ID cards, with new member ID numbers for January 2018 coverage as part of an improvement to our internal systems. By moving all lines of business to the new claims system, we will improve productivity and processes, provide consistent security measures and lower administrative and maintenance costs. Claims will process by date of service, using the ID for that respective coverage period.

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

Correct complete coding and payer policy reminder

The need for correct and specific diagnosis and procedure coding has never been more important. It's not just a matter of ensuring claims contain a payable diagnosis, it now includes proving to our state and federal regulators that Arkansas needs additional funding to improve the state's health status.

Because Arkansas Blue Cross and Blue Shield and its family of companies are involved in state federal government programs, we must submit our claims data to regulators in order for them to gather health statistics. Coding your claims to the very most specific diagnosis codes is very important in this endeavor. Gone are the days of always using "unspecified" or" not otherwise specified coding." In addition, the clinical documentation of these diagnoses within your medical records is also critical, as these regulators may choose your particular patient in an audit, thereby requiring our request and review of these medical records.

As a reminder, all of our provider network agreements indicate that facilities and providers agree "to accept and comply with the claims filing and coding policies or procedures established by the applicable payer for health plan claims." Most of our policies have been placed in the online provider manual as well as this quarterly newsletter, Providers' News.

Our agreements also state that facilities and providers agree "that all reimbursement is subject to all terms, conditions, limitations and exclusions of the member's health plan, and to the application of a payer's coverage policy and coding, billing and claims processing and appeals policies and procedures (Payer Policies and Procedures) as established by payers and as modified from time to time." Our payer policies and procedures and claims filing and coding polices use various coding criteria and protocols including, but not limited to, the CPT Manual published by the American Medical Association, the National Correct Coding Initiative, Specialty Society guidelines and industry coding standards from the Centers for Medicare & Medicaid Services (CMS).

The agreements require that facilities and providers follow these noted industry coding standards.

Radiology management program updates

Arkansas Blue Cross Blue Shield, Blue Advantage and Health Advantage ("Arkansas Blue Cross") is adding to its Radiology Management Program with services provided by National Imaging Associates, Inc. (NIA). This program promotes quality and patient safety for selected outpatient, non-emergency imaging services. Using NIA's medical policy and nationally accepted clinical criteria, Arkansas Blue Cross and NIA work closely with imaging providers and ordering physicians to ensure members receive the most appropriate imaging tests, avoid the inconvenience and expense of unnecessary and/or duplicative services, and to reduce members' exposure to unnecessary radiation. Providers who order selected outpatient, non-emergency imaging scans for their patients must obtain prior authorization through NIA.

Clinical Validation of Records (CVR)
NIA will also be implementing a Clinical Validation of Records process for the codes listed below that are part of the Radiology Management Program. This process will help to ensure Arkansas Blue Cross members receive the most appropriate, effective care.

The CVR process will include the request and review of clinical information by NIA:

- As part of the authorization process, providers will now be required to fax or upload on www.radMD.com to NIA certain pieces of a patient's medical records and/or additional clinical information as part of the clinical review for determination.
- At the end of an authorization request, if the request is pended for additional clinical information, a fax to the ordering provider will immediately go to the office specifying what clinical documentation from the patient's medical record for the study ordered is needed. The provider will fax or upload on www.radMD.com to NIA the requested information. This is required before final determination can be made.
- NIA will be validating the clinical criteria within the patients' medical records, ensuring that the clinical criteria support the requested procedures and are clearly documented in medical records.
- All reviews will continue to be processed under the URAC and regulatory guidelines set forth in NIA's contract with Arkansas Blue Cross as they are today.
- Urgent reviews will continue to be called into NIA and clinical validation will not be required under those circumstances.

For more information regarding the CVR process for these procedure codes to the Radiology Management Program, providers should call Provider Services or can find detailed information about this program, including clinical guidelines and the most current list of authorized CPT codes that are included on www.radMD.com or on the Arkansas Blue Cross Blue Shield website at www.arkansasbluecross.com.

CT Imaging CPT codes requiring clinical validation of records

70450	CT Head/Brain	70450, 70460, 70470
71250	CT Chest/Thorax	71250, 71260, 71270, G0297
74176	CT Abdomen and Pelvis Combination	74176, 74177, 74178
70486	CT Maxillofacial/Sinus	70486, 70487, 70488, 76380

Coverage policy manual updates

Since May 2017, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The table highlights the additions and updates. To view entire policies, access the coverage policies located on our website at arkansasbluecross.com.

Policy ID#	Policy Name
1997014	Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions
1997018	Cardioverter Defibrillator; Implantable, Subcutaneous, and Wearable Cardioverter Defibrillator
1997208	Spinal Cord Neurostimulation for Treatment of Intractable Pain
1998031	Oscillatory Devices for Chest Physical Therapy
1998046	External Enhanced Cardiac Counterpulsation (EECP)
1999012	Vertebroplasty, Percutaneous
2000014	Uterine Artery Embolization for the Treatment of Leiomyomas or Abnormal Uterine Bleeding
2004046	Genetic Test: FMR 1 Mutations Including Fragile X Syndrome
2009015	Golimumab
2011013	Preventive Services For Non-Grandfathered (PPACA) Plans: Aspirin to Prevent Cardiovascular Disease and Colorectal Cancer in Adults
2011023	Preventive Services For Non-Grandfathered (PPACA) Plans: Hypothyroidism Screening in Newborns
2011025	Preventive Services For Non-Grandfathered (PPACA) Plans: Obesity Screening in Adults
2011030	Preventive Services For Non-Grandfathered (PPACA) Plans: Obesity in Children; Screening and Counseling
2011041	Preventive Services For Non-Grandfathered (PPACA) Plans: Folic Acid for Prevention of Neural Tube Defects
2011066	Preventive Services For Non-Grandfathered (PPACA) Plans: Overview
2012035	Preventive Services For Non-Grandfathered (PPACA) Plans: Contraceptive Use and Counseling
2012037	Preventive Services For Non-Grandfathered (PPACA) Plans: High Blood Pressure, Screening in Infants, Children and Adolescents
2012040	Preventive Services For Non-Grandfathered (PPACA) Plans: Congenital/Inherited Metabolic Disorders & Hemoglobinopathy, Screening in Newborns
2012042	Preventive Services For Non-Grandfathered (PPACA) Plans: Media Use by Children & Adolescents, Screening & Counseling
2014006	Sofosbuvir (Sovaldi)
2014018	Biomarker Panel Testing for Systemic Lupus Erythematosus
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab)

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Coverage policy manual updates (Continued from page 10)

Policy ID#	Policy Name
2016007	Noninvasive Imaging Technologies to Detect Liver Fibrosis or Cirrhosis (Elastography)
2017016	Ramucirumab (Cyramza™)
2017017	Pilot Policy: Total Hip Arthroplasty (THA)
2017018	Sphenopalatine Ganglion Block for Headache
2017019	Molecular Testing in the Management of Pulmonary Nodules
2017020	Pemetrexed (Alimta)
2017021	Ocrelizumab (Ocrevus)
2017022	Cerliponase Alfa (Brineura™)
2017023	Bezlotoxumab (Zinplava™)
2017024	Panitumumab (Vectibix™)
2017025	Etelcalcetide
2017026	Edaravone
2017027	Sebelipase Alfa

Coverage change for ultrasound accelerated fracture healing devices

Effective November 1, 2017, Arkansas Blue Cross and Blue Shield and its family of companies will no longer cover ultrasound accelerated fracture healing devices billed with CPT code 20979 and HCPCS code E0760. Medical Coverage Policy #1998023 has been changed to indicate this service does not meet primary coverage criteria and is considered not medically necessary for those members with contracts that do not include primary coverage criteria.

The complete coverage policy #1998023 can be accessed on the Arkansas Blue Cross website at www.arkansasbluecross.com/members/other_links/coverage_policy.aspx

Surgery for morbid obesity coverage policy

Arkansas Blue Cross and Blue Shield's medical coverage policy #1998118 has been revised to address hiatal hernia repair in conjunction with bariatric surgery in members for plans with no benefits for surgical treatment of obesity or weight loss. Effective August 1, 2017, if a hiatal hernia repair is done concomitantly with a bariatric procedure for members with no bariatric surgery benefits, there is no coverage for either procedure.

A complete copy of the medical coverage policy is accessible by selecting "**Coverage Policy**" at www.arkansasbluecross.com/members.

Provider compensation news

Changes and/or updates to Arkansas Cross and Blue Shield fee schedules.

No fee schedule update for lab
The June 2017 *Providers' News* notified providers of changes to the laboratory fee schedule effective October, 1, 2017. Upon reconsideration, these changes will not be made to the lab codes of the Arkansas Blue Cross and Blue Shield Physician Fee Schedule.

Fee schedule update for DME
Arkansas Blue Cross will begin our pricing update to durable medical equipment on the physician fee schedule, effective October 1, 2017. This update is intended to more accurately align our pricing with Medicare.

New Influenza Virus Vaccine Code - 90756
On August 4, 2017, CMS announced the development of a new Influenza Virus Vaccine code (90756) effective for dates of service January 1, 2018 and after. It is recommended that for services rendered prior to January 1, 2018; providers submit HCPCS code Q2039 on their claim forms.

- 90756 – Influenza virus vaccine, quadrivalent (ccllV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) – 1/1/2018
- Q2039 – Influenza virus vaccine, not otherwise specified - current

Arkansas Blue Cross and Blue Shield will adopt the recommendations made by CMS. Please do not hesitate to contact your Network Development Representative or e-mail providerreimbursement@arkbluecross.com if you have any questions.

Bundling of surgery and implant for OPH and ASC facilities
Effective January 1, 2018, Arkansas Blue Cross and Blue Shield and its family of companies will begin bundling the allowable for surgery procedures and their associated implants into one allowance.

CMS has used a method of applying a weight to approved surgical procedures to calculate Medicare payment. For surgery procedures, the cost of implants and supplies has been included in the total weight of the CPT/HCPCS code. ABCBS will use this same procedure, eliminating the need for providers to submit implant invoices for payment consideration.

A proposed list of these CPT/HCPCS codes will be e-mailed to OPH and ASC providers prior to the January 1, 2018 implementation date.

Rural health reporting requirement change
On April 1, 2016, CMS changed the reporting requirements for rural health centers and federally qualified health clinics. CMS now requires a HCPCS/CPT code to be included for each service line along with a revenue code for each Medicare claim. Medi-Pak® Advantage made the decision to exclude this requirement for the remainder of the 2016 claims. On January 1, 2017, claims began to deny if the required HCPCS/CPT was not included on the claim. As a courtesy to our providers, Arkansas Blue Cross Medi-Pak waived the requirement until July 31, 2017. All claims previously denied for submission of HCPCS code will be reprocessed to allow payment. Effective August 1, 2017, all rural health center and federally qualified health clinic claims not billed with the appropriate HCPCS/CPT code will be denied.

Blood sugar monitoring lab services reimbursement

Arkansas Blue Cross and Blue Shield will only reimburse physician offices for blood sugar monitoring lab services (HgbA1c) for Arkansas Medi-Pak® Advantage members with submission of the appropriate CPT® and CPT® Category II codes.

Accurate coding of blood sugar claims can also reduce administrative work by the provider office because Arkansas Blue Cross will not have to ask for manually provided lab values.

2017 blood sugar monitoring billing guidelines
When billing the HgbA1c lab test CPT code 83036 and 83037, providers must also bill the associated CPT II codes that represent test results in the form of a range of values.

Please refer to the chart below when billing.

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

Urgent: 2016 plan year HHS ACA risk adjustment data validation (RADV)/initial validation audit

The Centers for Medicare and Medicaid Services (CMS), requires all organizations participating in the Marketplace/Exchange offering 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.

Datafied, a company working with our auditor Altegra, is conducting the retrieval and review of randomly selected patient charts on our behalf in order to comply with program requirements. Datafied has already begun this effort and has been contacting providers to request these randomly selected patient charts for 2016 dates of service. If your office or facility has been contacted by Datafied, we are requesting your cooperation and prompt attention in extending them your assistance in order to comply with these chart requests in a timely manner. If you have any questions regarding any portion of this process, you may contact your Arkansas Blue Cross 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.

Reminder: Annual compliance training due by December 31

As a contractor with Centers for Medicare & Medicaid Services (CMS) and a Qualified Health Plan (QHP) through the U.S. Department of Health and Human Services (HHS) through the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act (ACA)), Arkansas Blue Cross and Blue Shield is required to develop and maintain an effective compliance program and ensure annual compliance training is satisfied by our first-tier, downstream and related entities (FDRs) and delegated entities (DEs).

According to the Federal Register Notice CMS-4124-FC and 45 C.F.R. Subpart D §156.340, Providers are considered first tier and/or delegated entities because there is a direct contract for Medicare/ACA Services between Arkansas Blue Cross and each provider. All providers we contract with and providers' staff that have contact (indirect or direct) with Medicare beneficiaries and ACA patients **are required to** complete the annual CMS compliance training by 12/31/2017 for this plan year. More information on the annual training requirement can be located here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf.

MLN General Compliance Training Link/ Download Information

As a contractor with CMS and as a QHP through the ACA, Arkansas Blue Cross requires all contracted providers complete annual compliance training to remain in compliance with the regulations. Although it is specified as Medicare Part C and D, this is general compliance for all our lines of business.

For organizations that do not conduct their own general compliance training, this requirement can be met by completing the training on the Medicare Learning Network® (MLN). Should your organization choose to incorporate the General Compliance Training into your internal training, the materials can be downloaded at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf. These training materials cannot be modified and must be retained along with a training log, which includes the name and date the individual completed the training.

To obtain a certificate (which includes contact hours), each user must complete the CMS MLN training on the link below and a certificate of completion is generated upon a passing score of 70 percent or higher. The updated and **FREE** Medicare Parts C and D General Compliance Training Web-Based Training (WBT) course is available through the Learning Management System by logging into or creating an account through the MLN https://learner.mlnlms.com/Default.aspx. Each provider will need to create their own account if not already an MLN user. To create a new user account on the MLN, select "new user" and follow the prompts. When you get to the Organization Section; select "Search" and then select "CMS-MLN Learners Domain Organization," select "Save". Once your account is created, you will be on the home page of the MLN. To the

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Annual compliance training reminder (Continued from page 14)

right of the page, above "Browse Categories" in the search box; type "Compliance Training and search. Medicare Parts C and D General Compliance Training (January 2017) (Contact hours: 20 min.)" will populate. Select the course, then select "Enroll". For specific instructions and use of the MLN: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LMPOS-FAQs-Booklet-ICN909182.pdf.

When Should The Training Be Completed?
The general compliance training must occur within 90 days of initial hire and annually thereafter, but no later than December 31 of any given contract year.

What do we do with our training records?
No documentation should be returned to Arkansas Blue Cross at this time. However, Arkansas Blue Cross has developed an online attestation, administered through AHIN and will require that the AHIN user administrator (AUA) attest on behalf of the facility, that each FDR/DE has completed the appropriate general compliance through their organization or through the MLN. Starting in September, the AUAs will receive the online attestation, via AHIN, and should attest that **ALL** applicable staff at the facility has completed the required annual compliance training through one of the approved methods.

All training documents, including a copy of the training materials and training logs, should you choose to download the materials, must be retained by your organization for 10 years, in accordance with CMS/HHS record retention guidelines. All documentation is subject to random audit by Arkansas Blue Cross or may be requested as part of a Compliance Program Audit by CMS/HHS or CMS/HHS designees.

After reviewing the above information and questions still remain, please direct them to: regulatorycompliance@arkbluecross.com.

Reminder on billing qualified Medicare beneficiaries

Medicare providers are prohibited by federal law from billing qualified Medicare beneficiaries for Medicare coinsurance, copayments, or coinsurance. Providers should accept Medicare and Medicaid payments received for billed services as payment in full. Dual-eligible members classified as qualified Medicare beneficiaries (QMBs) are covered under this rule. QMBs have Medi-Pak® Advantage as primary coverage and Medicaid as secondary coverage. Payments are considered accepted in full even if the provider does not accept Medicaid. Providers are subject to sanctions if you bill a QMB patient for amounts not paid by Arkansas Blue Cross and Blue Shield and Medicaid.

Additional information about dual-eligible coverage is available under the Medicare Learning Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

Comprehensive diabetes care

Arkansas Blue Cross and Blue Shield continuously strives to assist in improving the quality of care for your patients and our members. The National Committee for Quality Assurance establishes Healthcare Effectiveness Data and Information Set (HEDIS®) measures to assess a broad range of health issues and allow consumers to compare health plans on quality measures. HEDIS® has become an integrated system that improves the accountability of the managed health care industry with the ultimate goal of improving the quality of care for members. Both health plans and providers are evaluated and "graded" based on HEDIS® outcome data as well as the CMS Star rating program. It is important for participating providers and their staffs be aware of the standards measured by HEDIS® and CMS Stars and how they can improve the quality of care for their patients.

Improve patient health while reducing medical record reviews

The "Comprehensive Diabetes Care" measure is a composite measure meant to provide a comprehensive picture of the clinical management of patients with diabetes. Diabetes requires consistent medical care and monitoring to reduce risk of severe complications and improve outcomes. Interventions to improve diabetes outcomes go beyond glycemic control as diabetes affects the entire body.

The guide below provides:

- Brief descriptions about the Commercial (HEDIS ®) and Medicare (Star) rating measures.
- Ways you can close gaps in care for patients with diabetes.
- Common chart deficiencies to help you keep on top of proper documentation.

Also, the descriptions include CPT II® codes that can facilitate data collection for HEDIS®. This reduces the need for you to provide medical records to Arkansas Blue Cross for review.

Star Rating Measure	Measure Description
Comprehensive Diabetes Care (CDC) Exclusion criteria apply to all CDC measures	**Definition:** Patients 18-75 years of age with diagnosis of diabetes (Type 1 and Type 2) who have had each of the following: • Retinal eye exam • Medical attention for nephropathy • Hemoglobin A1c (HbA1c) testing • Hemoglobin A1c (HbA1c) control 1. HbA1c <9% (Medicare reporting) 2. HbA1c <8% (Commercial reporting) 3. HbA1c <7% (Optimal for most people) • BP control (<140/90 mm Hg) (Commercial reporting) **Exclusion criteria (applies to all Comprehensive Diabetes Care measures):** If any of the following occurred any time during the member's history on or before December 31 of the measurement year • Gestational diabetes or steroid induced diabetes during the measurement year or the year prior. • Patients in hospice any time in the measurement year.

(Continued on page 17)

Comprehensive diabetes care (Continued from page 16)

<table>
<tr><th>Star Rating Measure</th><th>Measure Description</th></tr>
<tr><td>Comprehensive Diabetes Care:

HbA1c Control</td><td>
Definition: Patients 18-75 years of age with diagnosis of diabetes, and a HbA1c test performed during the measurement year:
• Control: <9% (Medicare)
• Control: <8% (Commercial)

How to close gaps:
• Perform or order HbA1c testing two to four times each year (optimal).
1. The last HbA1c of the year determines compliance.
2. Submit HbA1c claims with CPT II result codes
<table>
<tr><th>CPT II Code</th><th>Narrative</th><th>Compliance</th></tr>
<tr><td>3044F</td><td>HbA1C Level <7%</td><td>Compliant for:
<9% (Medicare)
<8% (Commercial)</td></tr>
<tr><td>3045F</td><td>HbA1C Level 7.0% - 9.0%</td><td>Compliant for <9% (Medicare)</td></tr>
<tr><td>3046F</td><td>HbA1C Level >9%</td><td>Non-compliant (All products)</td></tr>
</table>
• When the patient's A1c is out of control, adjust treatment, address medication compliance and continue to bring patient in for recheck until the A1c is controlled.
• The medical record may be requested to obtain the HbA1c lab report, result and date when an A1c claim isn't received with the CPT II result code.

Common chart deficiencies:
• An HbA1c result is noted in the medical record without a lab report or without a date the test was drawn.
• The patient has an HbA1c >9% but isn't brought back in to have the HbA1c rechecked.
</td></tr>
<tr><td>Comprehensive Diabetes Care:

Eye Exam

(CDC-E)</td><td>
Definition: Patients 18-75 years of age with diagnosis of diabetes. Screening or monitoring for diabetic retinal disease by an eye care professional (optometrist or ophthalmologist) where at least one of the following conditions is satisfied:
• A retinal or dilated eye exam by an eye care professional during the measurement year.
• A negative retinal or dilated eye exam by an eye care professional in the year prior to the measurement year (a negative exam indicates no diabetic retinopathy is present).
• Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.
</td></tr>
</table>

(Continued on page 18)

Comprehensive diabetes care (Continued from page 17)

Comprehensive Diabetes Care: **Eye Exam** **(CDC-E)** **Continued**	*Eye exams are covered as part of essential benefits under medical. Not having vision coverage shouldn't be a deterrent.* **How to close gaps:** • Educate diabetic patients regarding the importance of an annual diabetic eye exam. • Be sure patient has eyes examined yearly (or every other year if negative retinopathy). • Refer to eye care professional for eye exam if patient is overdue. • When you receive an eye exam report for your diabetic patients from an eye care professional, review the report, place it in the patient's medical record, and for all appropriate codes, submit a $0 claim: 1. CPT 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed. 2. CPT 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, documented and reviewed. 3. CPT 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photo results documented and reviewed. 4. CPT 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year). These CPT II codes may be billed alone or with other services. **Common deficiencies:** • Office receives eye exam report for a diabetic patient but doesn't submit a claim with CPT II code 2022F, 2024F, 2026F or 3072F. • Eye exam screenings aren't consistently documented in the patient's history. Document that a retinal eye exam was performed as well as the date of service, result and eye care professional's name. • Eye exam screening is outdated but without documentation that screening was discussed or encouraged during the patient's office visit. • Medical record may be requested to obtain an eye exam report if CPT II code isn't billed.
Comprehensive Diabetes Care: **Medical Attention for Nephropathy** **(CDC-N)**	**Definition:** Patients 18-75 years of age with diagnosis of diabetes. Screening for nephropathy or evidence of medical attention for nephropathy during the measurement year. Documentation needs to include at least one of the following, reported **yearly**. **How to close gaps (one or more from the bullet below and continued bullets on the next page):** • **Urine microalbumin or protein screening** Include CPT code for urine protein screening (81000, 81001, 81002, 81003, 81005, 82042, 82043, 82044, or 84156)

(Continued on page 19)

Comprehensive diabetes care (Continued from page 18)

<table>
<tr>
<td>Comprehensive Diabetes Care:

Medical Attention for Nephropathy

(CDC-N

Continued</td>
<td>How to close gaps continued:
• Treatment with an ACE/ARB
Submit an office visit claim with CPT 4010F: Angiotensin Converting Enzyme, Inhibitor or Angiotensin Receptor Blocker, therapy prescribed or currently being taken.
• Evidence of CKD stage 4, ESRD, kidney transplant or a nephrology visit
Submit an office visit claim with CPT 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)

Common deficiencies:
Urine microalbumin/protein screenings aren't done or documented in the medical record and there is no evidence of medical attention for nephropathy</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care:

Blood Pressure Control

(CDC-BP)</td>
<td>Definition: Patients who are 18-75 years of age with diagnosis of diabetes. Diabetics who had their blood pressure taken during the measurement year. Documentation in the medical record must meet the following requirements:
• Blood pressure must be the last BP reading of the measurement year from an outpatient visit.
• For the BP to be considered controlled, it must be less than 140/90 (no rounding of BP numbers, document exact reading).

How to close gaps:
Include the appropriate BP CPT II codes on your office visit claims:
<table>
<tr><th>CPT II Code</th><th>Narrative</th><th>Compliance</th></tr>
<tr><td>3074F</td><td>Most recent systolic blood pressure <130 mm Hg</td><td>Yes</td></tr>
<tr><td>3075F</td><td>Most recent systolic blood pressure 130-139 mm Hg</td><td>Yes</td></tr>
<tr><td>3077F</td><td>Most recent systolic blood pressure ≥140 mm Hg</td><td>Yes</td></tr>
<tr><td>3078F</td><td>Most recent diastolic blood pressure <80 mm Hg</td><td>Yes</td></tr>
<tr><td>3079F</td><td>Most recent diastolic blood pressure 80-89 mm Hg</td><td>Yes</td></tr>
<tr><td>3080F</td><td>Most recent diastolic blood pressure ≥90 mm Hg</td><td>No</td></tr>
</table>
Common deficiencies:
• High blood pressure readings aren't retaken.
• The patient doesn't have a follow-up visit after an out-of-control blood pressure is documented.</td>
</tr>
</table>

Managing patients with high blood pressure

This article is part of a continuing effort by Arkansas Blue Cross to educate participating providers and their staffs of the standards measured by HEDIS® and how they can improve the quality of care for their patients.

Adequate blood pressure control is defined as:

- Patients age 18 to 59 whose blood pressure was under 140/90
- Patients age 60 to 85 years of age with a diagnosis of diabetes whose blood pressure was less than 140/90
- Patients age 60 to 85 without a diagnosis of diabetes whose blood pressure was less than 150/90

Do not round manual blood pressure readings. Rounding just a few points can make a patient cross the line from controlled to uncontrolled.

Several important things to keep in mind when caring for your hypertensive patients:

- To confirm diagnosis of hypertension, a notation of hypertension must appear in the medical record during an outpatient visit on or before June 30 of each year. Examples of notation include: hypertension, HTN, high BP, elevated BP, borderline HTN, intermittent HTN, history of HTN, hypertensive vascular disease, hyperpiesia or hyperpiesis.
- A representative blood pressure is the most recent blood pressure reading taken during the measurement year (by December 31) and it occurs after the date of service in which the diagnosis of hypertension occurred. If multiple readings occur in a single visit, the lowest systolic and lowest diastolic is the representative blood pressure and determines blood pressure control.
- A blood pressure reading must have been taken and documented in the chart during the same visit in which you assessed the patient for hypertension and again at subsequent visits.
- Self-reported blood pressure readings taken by your patients isn't considered acceptable for a diagnosis of hypertension.

For diabetic patients

If lifestyle changes alone aren't effective in keeping your diabetic patients' blood pressure controlled, it may be necessary to add anti-hypertensive medications to the patients' regimens. Best practice for patients who have hypertension associated with diabetes is to initiate pharmacologic anti-hypertensive treatment that includes an angiotensin converting enzyme inhibitor or angiotensin receptor blocker if no specific contraindications.

Be sure to educate your patients about the importance of taking their recommended medications regularly. You should also discuss possible medication side effects.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA). None of the information included herein is intended to be legal advice and as such it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

Medication reconciliation post-discharge star measure

This article is part of a continuing effort to education participating providers and their staffs on the standards measured by the CMS Star program and how they can improve the quality of care for their patients. Medication reconciliation is a review in which discharge medications are reconciled with the most recent medication list in the outpatient record.

Arkansas Blue Cross and Blue Shield reimburses providers who:

- Conduct medication reconciliation in the outpatient setting **within 30 days** of an inpatient discharge for Medi-Pak® Advantage members, and
- Submit a claim with a $10 charge for CPT® II code 1111F.

Medication reconciliation helps prevent adverse drug reactions and other medication-related issues that can occur after hospitalization.

How to receive reimbursement

Providers can receive reimbursement for medication reconciliation post-discharge (MRP) when it is conducted by either a prescribing practitioner, clinical pharmacist or registered nurse. This is in addition to receiving reimbursement for the office visit.

To receive reimbursement for your patients who are Medi-Pak® Advantage members:

- Schedule a post-discharge office visit as soon as possible after every patient discharge.
- Perform medication reconciliation during this visit.
- State in the medical record that "current and discharge medications were reconciled."
- Submit a claim with a $10 charge for 1111F within 30 days of the discharge.
  1. 1111F is a reporting CPT II code that states, "Discharge medications reconciled with the current medication list in outpatient medical record."
  2. Arkansas will reimburse an additional $10 per post-discharge office visit billed with 1111F.

Medication reconciliation post-discharge (mrp) star measure

Medication reconciliation post-discharge (MRP) is a Centers for Medicare & Medicaid Services' (CMS) Star measure. Arkansas Blue Cross is required to monitor and report compliance with CMS Star measures to help ensure quality care.

The measure assesses patients 18 and older who were discharged from an acute or non-acute inpatient stay between January 1 and December 1 of the measurement year. It looks at patients whose medications were reconciled from the date of discharge through 30 days after discharge (31 days total).

A claim submission for 1111F eliminates the need for medical record review to determine if medication reconciliation was completed within 30 days of discharge.

Importance of medication reconciliation

Hospital admissions are often associated with unintentional discontinuation of medications for chronic conditions, and significant changes can occur to a patient's medication during hospitalization.

The post-hospitalization follow-up visit provides an opportunity to address the

(Continued on page 22)

Medication reconciliation post-discharge star measure (Continued from page 21)

condition that precipitated the hospitalization and to review the patient's medications. Conducting medication reconciliation after every discharge is an important step to ensure that medication errors are addressed and patients understand new medications and which medications they should no longer take.

Two new 2017 Medicare star ratings measures for statin therapy

This article is part of a continuing effort to educate participating providers and their staffs of the standards measured by the CMS Star probram and how they can improve the quality of care for their patients.

The Centers for Medicare & Medicaid's (CMS) new star ratings measures support the importance of statin therapy. Please consider prescribing statins not only for your patients with hypercholesterolemia, but also for your patients diagnosed with:

- Atherosclerotic cardiovascular disease
- Diabetes
-

Educate your patients regarding the importance of continued statin adherence to prevent cardiovascular events and death.

In addition to the two new star statin measures, please remember there's still a separate statin measure for medication adherence. Medication adherence is a cholesterol (statin) measure for those members with dyslipidemia. It requires patients to fill their statin medication often enough, so they can adhere to their medication regimen 80 percent or more of the time.

About the new measures
Statin therapy for patients with cardiovascular disease:

The measure assesses the percentage of men ages 21-75 and women ages 40-75 who were identified as having clinical atherosclerotic cardiovascular disease and met the following criteria:

- Received statin therapy: Patients were dispensed at least one high or moderate-intensity statin medication in the measurement year.
- Statin adherence 80 percent: Patients remained on a high or moderate-intensity medication for at least 80 percent of the treatment period.

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Statin therapy for patients with diabetes:

This measure assesses the percentage of members ages 40-75 with diabetes who do not have clinical atherosclerotic cardiovascular disease and met the following criteria:

- Received statin therapy: Patients were dispensed at least one statin medication of any intensity during the measurement year
- Statin adherence 80 percent: Patients remained on a statin medication of any intensity for at least 80 percent of the treatment period.

Why statin therapy for cardiovascular disease?
Cardiovascular disease is the leading cause of death in the United States. More than 85 million American adults have one or more types of cardiovascular disease. It is estimated that by 2030, more than 43 percent of Americans will have a form of cardiovascular disease.

The amount of cholesterol-lowering effect is based on statin intensity, which is classified as high, moderate or low.

According to the American College of Cardiology and the American Heart Association, statins of moderate or high intensity are recommended for adults with established clinical atherosclerotic cardiovascular disease. Many studies support the use of statins to reduce atherosclerotic cardiovascular disease events in primary or secondary prevention.

Why statin therapy for diabetes?
Primary prevention for cardiovascular disease is an important aspect of diabetes management. The risk of an adult with diabetes developing cardiovascular disease is two to four times higher than adults without diabetes.

In addition to being at a higher risk for developing cardiovascular disease, patients with diabetes tend to have a worse survival rate after the onset of cardiovascular disease.

The Centers for Disease and Prevention estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes.

Changes to the colorectal cancer screening Medicare star rating measure and coverage

Arkansas Blue Cross and Blue Shield continuously strives to improve the quality of care for your patients and our members. The National Committee for Quality Assurance establishes Healthcare Effectiveness Data and Information Set (HEDIS®) measures to assess a broad range of health issues and allow consumers to compare health plans on quality measures. HEDIS® has become an integrated system that improves the accountability of the managed health care industry with the ultimate goal of improving the quality of care for members. Both health plans and providers are evaluated and "graded" based on HEDIS® outcome data as well as the CMS Star rating program. It is important for participating providers and their staffs to be aware of the standards measured by HEDIS® and CMS Stars and how they can improve the quality of care for their patients.

Arkansas Blue Cross encourages health care providers to assist in this effort by carefully and accurately coding claims for their patients, as well as ensuring documentation is included in the medical records for the services provided. Due to the importance of screening Medicare patients for colorectal cancer, we want to make you aware of updates to the healthcare effectiveness data and information set measure for colorectal cancer screening as well as screening coverage.

According to Centers for Disease Control and Prevention (CDC) Director, Tom Frieden, M.D., M.P.H., "There are more than 20 million adults in this country who haven't had any recommended screening for colorectal cancer and who may therefore get cancer and die from a preventable tragedy."

The HEDIS® colorectal cancer screening measure examines the percentage of adults, ages 50–75, who have had appropriate screening for colorectal cancer. It excludes patients with a history of colorectal cancer or a total colectomy as well as those in hospice.

The following preventive screenings meet HEDIS® specifications. They are also fully covered by Medicare without cost sharing when provided by an in-network health care provider:

- New: FIT DNA (i.e., multi-target stool DNA, Cologuard®) test every three years for patients who show no signs of symptoms of colorectal disease and are at average risk for developing it. FIT DNA testing is not a covered benefit of Arkansas Blue Cross and Blue Shield and its family of companies.
- Screening fecal occult blood test every year. Note: Performing FIT (FOBT or iFOBT) in an office setting or on a sample collected during digital rectal exam does not meet HEDIS® and the American Cancer Society's requirements as a screening.
- Screening flexible sigmoidoscopy every five years
    1. Screening colonoscopy every 10 years: Patients at high risk for colorectal cancer are covered once every 24 months.

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Changes to colorectal cancer screening Medicare star rating measure and coverage (Continued from page 24)

2. Patients who aren't high risk are covered once every 120 months or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk.
3. HEDIS® specifications count a colonoscopy for 10 years.
4. A screening colonoscopy turns into a diagnostic colonoscopy with cost sharing if a patient has an abnormality such as a polyp.

While CT colonography meets HEDIS® screening requirements, Medicare does not reimburse for it as of April 1, 2017. Please go to this link at Medicare.gov for more information: https://www.medicare.gov/coverage/colorectal-cancer-screenings.html.

Once you screen a patient for colorectal cancer, you must either:

- Submit a claim for one of the appropriate screenings, or
- Provide documentation in the medical record of one of the following:
- Date and name of the test performed in the medical history section of the chart, or
- Report indicating the type of screening performed, date and result.

Helpful tips on improving HEDIS® scores:

- Begin colorectal screening at age 50. For high-risk patients, begin screenings sooner.
- Encourage stool tests in patients who are resistant to receiving a colonoscopy.
- Make sure to document test results in *chart.*
- Develop a callback system to ensure patients complete testing because only completed tests count.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Access Only: Current PPO groups

Group Name	PPO Network
Alternative Opportunities	True Blue Access Only
AR Sheet Metal Workers	True Blue Access Only
AR State University Athletes	True Blue Access Only
Arvest Bank	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

Tyson foods health plan AIM oncology program

Effective January 1, 2018, Tyson Foods will implement review of outpatient radiation oncology services and medical oncology treatment regimens for its employee health plan. These programs will be managed by AIM Specialty Health® (AIM). AIM works with leading insurers and employers to improve health care quality and manage costs for today's most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable.
Tyson Foods members may be identified by the **TYG prefix** on their member identification cards.

Medical Oncology Program
The AIM Medical Oncology Program promotes optimal support for our members' cancer care needs, while reducing the costs for managing one of the most complex, expensive and prevalent diseases they can encounter.
This program includes online access to support tools for selecting cancer treatment regimens, consistent with current evidence and consensus guidelines for oncologists and hematologists. The program includes AIM Cancer Treatment Pathways (Pathways) based on medical evidence and best practices developed with leading cancer experts.

Pathway regimens are widely accepted as a key component to managing oncology quality and cost. AIM Cancer Treatment Pathways offer support in identifying highly effective therapies that are often more affordable for our members. More specific than guidelines, they identify treatments based on clinical efficacy, favorable toxicity profiles and cost.

Pathway regimens in this program are informed by a clinical library and include evidence drawn from:

- Peer-reviewed published literature
- Expert consensus statements and guidelines from professional organizations, including:
  1. American Society of Clinical Oncology (ASCO)
  2. American Society of Hematology (ASH)
  3. National Comprehensive Cancer Network (NCCN)
- Federal government agencies, including:
  1. Food and Drug Administration (FDA)
  2. National Cancer Institute (NCI)

Program Administration
The program, administered by AIM Specialty Health®, will help improve cancer care quality for eligible **Tyson Foods** members, and manage the associated costs for certain complex tests and treatments by promoting patient care that's appropriate, safe and affordable.

Radiation Oncology Review Program
This program reviews certain treatment plans against clinical appropriateness criteria to help ensure that care aligns with established evidence based medicine. To request review, providers should contact AIM for pre-service review for the radiation oncology modalities and services as noted on the following page:

Pre-certification
For treatment plans that are scheduled to

(Continued on page 27)

begin on or after **January 1, 2018**, all providers must contact AIM to obtain pre-service review for the following non-emergency, outpatient radiation oncology modalities:

- 2D/3D conformational radiation therapy
- Intensity-modulated radiation therapy
- Stereotactic radiosurgery
- Stereotactic body radiotherapy
- Selective internal radiation therapy
- Brachytherapy
- Proton beam therapy

Review also included for:

- Hypo fractionation for bone metastases, non-small cell lung cancer and breast cancer when requesting EBRT and IMRT
- Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
- Image Guided Radiation Therapy (IGRT)

Radiation oncology performed as part of an inpatient admission is not part of the AIM program.

More information will be sent to the medical and radiation oncology community regarding telephone numbers and provider portals created to accommodate these programs for the Tyson Foods health plan.

Arkansas
BlueCross BlueShield
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PROVIDERS' NEWS STAFF

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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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