December 2022

PROVIDERS' NEWS

Published for providers and their office staffs by Arkansas Blue Cross and Blue Shield

2022 Open Enrollment – Please use Availity

Page 4

Arkansas Blue Medicare 2023 Plans

Page 26

Upcoming holidays

New Year's Day
Friday, December 30

Martin Luther King Jr Day
Monday, January 16, 2023

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

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To receive Providers' News via email, please submit a request to providersnews@arkbluecross.com

PROVIDERS' NEWS

What's inside?

Arkansas Blue Cross and Blue Shield

Arkansas School Employees / Public School Employees

Federal Employee Program (FEP)

Arkansas BlueCross BlueShield
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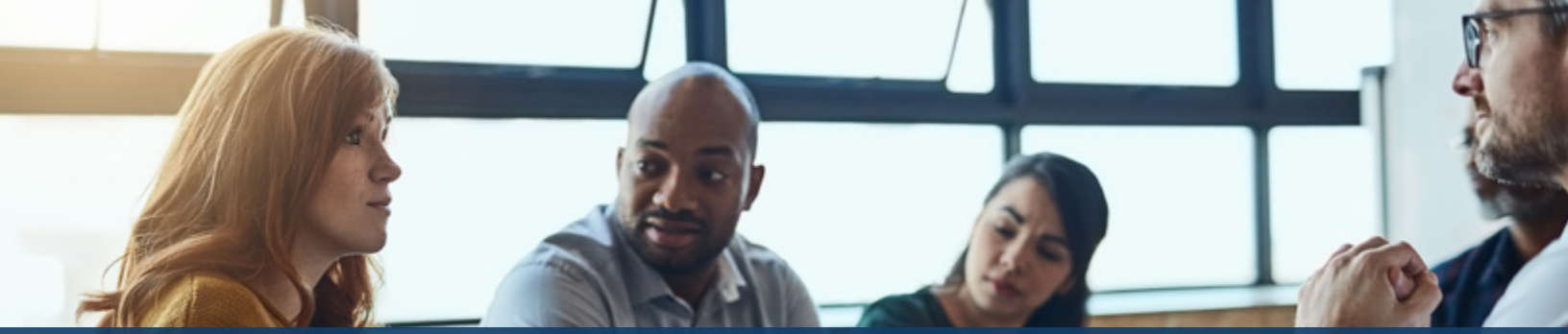
Arkansas Blue Medicare

Medicare Advantage

Blue & You Fitness Challenge



Arkansas Blue Cross and Blue Shield

2023 Open Enrollment – Please use Availity

The 2023 Open Enrollment period begins October 1 and will continue through January 15, 2023. The enrollment of many new members and renewal of current members produces extremely high call volumes, which are expected to remain elevated through January 31, 2023.

Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the website for the following:

- Availity – Use for information regarding eligibility, benefits, and claims status. Availity displays information on benefits to assist providers when scheduling appointments, checking eligibility, and identifying benefits.
- AIM portal – If you need to request a prior authorization for imaging and high-tech radiology, please continue to use the AIM portal.

Please be aware that call volume can spike and exceed our ability to answer every call. Availity uses the same information available to our customer service representatives and can save you valuable time. **Effective immediately, we encourage providers to use the appropriate provider portal to request prior authorization. This will help reduce call volume and result in quicker service to members.**

Annual compliance training

The federal annual compliance training through the Centers for Medicare and Medicaid has changed. The Medicare Part C and D compliance training is no longer required, but a training link is available for providers to view on the Availity payer space. Providers are not required to attest. Contact Regulatory Compliance at regulatorycompliance@arkbluecross.com with any questions.

Availity enhancements for solicited and unsolicited medical attachments

With the sunset of AHIN, the bar-coded medical record request letter search page was also sunset. Arkansas Blue Cross is continuing to work with Availity to add enhancements that will allow the transition of bar-coded letter requests from the current fax process to a new process of electronically requesting medical records through a convenient dashboard on Availity Essentials portal. This process is referred to as a solicited attachment. It will take some time for all record requests to be transitioned from the bar-coded, faxed letter to the new electronic solicited attachment format by using a LOINC request process. During this transition, providers will continue to receive the faxed, bar-coded request and should continue to maintain the appropriate

medical record fax number on file with Arkansas Blue Cross. Training opportunities will be offered by Availity when solicited attachments are available. Please continue to watch for more information from Availity and Arkansas Blue Cross.

On September 17, Availity added functionality that allows Arkansas Blue Cross and Blue Shield providers to send unsolicited attachments with 837 institutional and professional claims. If you believe a medical record is needed to adjudicate your claim, you can now send information with your claim in advance of receiving a bar-coded request. To learn more about this enhancement you can access the Availity Learning Center (ALC) and register for a course or webinar by taking the following steps:

1) Log in to the **Availity Portal** (for login assistance please contact, 1-800-282-4548 or your Availity administrator).
2) Click **Help & Training** | **Get Trained** in the top navigation bar. The Availity Learning Center (ALC) displays in a separate tab/window.
3) Locate and select the learning option using one of these methods:
   - For live webinars, click **Sessions** at the top of the page and select the month of the webinar. Once you've located a session you want to enroll in, click **View Course**.
   - For on-demand courses, search by keyword or filter by category to locate the course.
4) Once the course is located, click **Enroll** at the top right of the screen.
5) You'll receive your registration confirmation by email from the Availity Learning Center shortly after registering. For live webinars, you will also receive an email reminder with the details to join prior to the session.

CHI St Vincent (Common Spirit Health) medical plans administered by BlueAdvantage Administrators of Arkansas

CHI St Vincent Medical Plans will be administrated by BlueAdvantage effective 01/01/2023. St. Vincent will have two plans for their employees to choose from. An Integrated High Deductible/HSA and an Integrated Network PPO.

Both plans will have a nested network comprised of AR NetPartners providers and CommonSpirit Health-owned providers located outside the state of Arkansas. These providers must be utilized to receive the highest "Enhanced" level of benefits for these two plans.

Eligible services rendered by other providers who participate in the CHI St. Vincent Employee PPO network will generally be reimbursed at a tier-2 in-network benefit level. The CHI St. Vincent Employee PPO network is comprised of most True Blue PPO providers within the Arkansas service area and BlueCard PPO providers outside the state of Arkansas. Eligible services rendered by all other providers are generally reimbursed at the out-of-network benefit level.

Important: CommonSpirit Health and CHI St. Vincent determine which True Blue PPO providers shall be included in the CHI St. Vincent Employee PPO network.

Members can access the online directory to identify which providers are included in the networks accessed by CHI St. Vincent at blueadvantagearkansas.com effective January 1, 2023.

Claims incurred during the credentialing process

Arkansas Act 1232 requires payers to complete their credentialing process for physicians within 60 days of receiving a completed application. The law allows for certain circumstances where the clock is stopped during the credentialing process. Arkansas Blue Cross and Blue Shield and its family of companies consistently meet or beat this turnaround time requirement for physicians and nonphysician providers.

In addition, once a physician's application has been approved through the payer's credentialing process, Act 1232 requires a physician's network participation effective date to be backdated to the day the payer received a completed application. Arkansas Blue Cross applies this rule to physicians and nonphysician providers.

We ask that providers hold their claims and not bill us until the provider receives the notice from Arkansas Blue Cross that his or her credentialing has been fully completed and approved. Billing prematurely only causes unnecessary problems for the providers and our members.

Act 1232 offers protection to physicians against unacceptable credentialing wait times. In addition, Arkansas Blue Cross has been able to provide compliance to these requirements. As a result, Arkansas Blue Cross, and Health Advantage enacted a policy that we will not adjust claims from providers who file their claims during their credentialing process. In addition, our members cannot be billed and held responsible for more than their applicable in-network deductible, copay and/or coinsurance amounts. Again, we ask providers to hold your claims until you receive our letter indicating full network participation.

This article is considered an official notification of a policy change for Arkansas Blue Cross and Health Advantage.

Coverage policy manual updates

Since June 2021, Arkansas Blue Cross has added or updated several policies in its Coverage Policy manual. The table below highlights these additions and updates. If you want to view the entire policies, you can access the coverage policies located on our website at arkansasbluecross.com.

Policy ID	Policy Name
1997113	Immune Globulin, Intravenous and Subcutaneous
1997128	Leuprolide (e.g., Lupron)
1997166	PET or PET/CT for Miscellaneous (Noncardiac, Nononcologic) Applications
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1997229	Cardiac Event Recorder, External Loop or Continuous Recorder
1998109	Chimeric Antigen Receptor Therapy for Hematologic Malignancies (CAR-T) (e.g., Kymriah™, Yescarta™, Tecartus™, Breyanzi®, Abecma®, Carvykti™)

Policy ID	Policy Name
1998161	Infliximab (e.g., Remicade and Unbranded Infliximab)
2000041	Cryoablation of Neoplastic Conditions
2001009	Non-Implantable Insulin Infusion Devices, Hybrid Insulin Infusion Devices, and Continuous Glucose Monitoring Devices
2001015	Human Papilloma Virus Testing of Cervical Pap Smears
2001035	PET or PET/CT for Prostate Cancer
2001039	PET or PET/CT for Neuroendocrine Tumors
2002005	Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Congestive Heart Failure
2003015	Intensity Modulated Radiation Therapy (IMRT)
2003055	Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric Disorders
2004017	Genetic Test: Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
2004053	Circulating Tumor Cells in the Management of Patients with Cancer, Detection of
2008007	Cardiac Event Recorder, Mobile Telemetry
2008012	Radiation Therapy, Proton Beam or Helium Ion Irradiation
2009029	Immune Cell Function Assay
2009047	Hormone Pellet Implantation for Hormone Therapy
2010005	Electrical Stimulation, Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)
2010046	Intravitreal, Punctum Corticosteroid Implants and Ranibizumab (e.g., Susvimo)
2011006	Ipilimumab (e.g., Yervoy™)
2011060	Biomarker, Auto-antibody, and Molecular Signature Testing for Monitoring Disease Activity in Rheumatoid Arthritis
2011066	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: OVERVIEW
2011070	Electrical Stimulation, Auricular Stimulation and Cranial Electrotherapy Stimulation
2012003	Genetic Test: Molecular Markers in Fine Needle Aspirates of the Thyroid
2012005	Genetic Test: Molecular Testing of Tumors for Genomic Profiling as a Therapeutic Guide
2012009	Skin and Soft Tissue Substitutes, Bio-Engineered Products
2012025	Biomarkers for Liver Disease
2012049	Genetic Test: Prenatal Analysis of Fetal DNA in Maternal Blood to Detect Fetal Aneuploidy
2012068	Genetic Test: Preconception or Prenatal Testing as a Carrier Screen
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment
2013035	Genetic Test: Whole Exome and Whole Genome Sequencing
2013046	Genetic Test: Testing for the Diagnosis and Management of Mental Health Conditions
2014020	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: LUNG CANCER SCREENING
2014021	Multitarget Polymerase Chain Reaction Testing for Diagnosis of Bacterial Vaginosis (e.g., SureSwab, NuSwab)
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients With Non-Small-Cell Lung Cancer
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015024	Ablative Procedures for Benign Prostatic Hyperplasia (BPH) and Minimally Invasive Benign Prostatic Hyperplasia Treatments
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes

Policy ID	Policy Name
2016005	Anti-PD-1 (programmed death receptor-1) Therapy (e.g., Nivolumab) (e.g., Durvalumab) (e.g., Cemiplimab)
2016013	C5 Complement Inhibitors [(Eculizumab (e.g., Soliris®) and Ravulizumab-cwvz (e.g., Ultomiris™)]
2016018	Natalizumab (e.g., Tysabri)
2017006	Bevacizumab (e.g., Avastin™) for Oncologic Indications
2017031	Dupilumab (e.g., Dupixent)
2017037	Direct Acting Antiviral Medications for Treatment of Chronic Hepatitis C
2018002	Chemodenervation, Botulinum Toxins
2019012	Brexanolone (e.g., Zulresso™)
2020004	Teprotumumab-trbw (e.g., TEPEZZA™)
2020005	Self-Administered Medication
2020009	Givosiran (e.g., GIVLAARI®)
2020015	Fam-trastuzumab deruxtecan-nxki (e.g., Enhertu®)
2020029	Covid-19 Monoclonal Antibody Therapy
2021024	White Blood Cell Growth Factors (Colony Stimulating Factors)
2021034	Rituximab (e.g., Rituxan) and Biosimilars – Non-Oncologic Indications
2021036	Iobenguane I 131 (e.g., Azedra®)
2022001	Efgartigimod (e.g., Vyvgart)
2022013	Medical Technology Assessment, Non-Covered Services
2022014	Lutetium Lu 177 vipivotide tetraxetan (e.g., Pluvicto)
2022020	Tumor-informed Circulating Tumor DNA Testing (e.g., Signatera) for Cancer Management
2022023	Tebentafusp-tebn (e.g., Kimmtrak)
2022024	Sutimlimab-jome (e.g., Enjaymo)
2022028	PPACA: Prevention Of Human Immunodeficiency Virus (HIV) Infection, Preexposure Prophylaxis
2022032	Air Ambulance
2022033	Ground Ambulance
2022034	Allogenic processed thymus tissue-agdc (e.g., Rethymic)
2022035	Dry Hydrotherapy for Chronic Pain Conditions
2022036	Digital Health Technologies: Diagnostic Applications
2022037	Dexmedetomidine (e.g., Igalmi)
2022038	Nivolumab and relatlimab-rmbw (e.g., Opdualag)

Data required on UB04 facility claims submitted for secondary payment

Arkansas Blue Cross and Blue Shield and its affiliated companies will no longer be able to manually process facility claims submitted on paper with incorrect or incomplete information in the payer fields (boxes 50, 56, and 57) and the patient fields (boxes 58, 59, and 60).

Any time providers are filing for secondary payment on the UB04, complete information about the payer from whom the provider is seeking payment should always be filed in line 50A with the Explanation of Benefits attached. All others payer information should be filed in line 50B and 50C. Payment will always be made to the payer that is in line 50A. If the claim does not have complete and accurate information, the claim will be returned to the provider.

Arkansas Blue Cross can accept electronic submissions for secondary payment and would prefer that claims be sent in this medium. Providers are encouraged to submit claims electronically for all Arkansas Blue Cross lines of business.

With the implementation of the national coordination of benefits process for Medicare, it is unnecessary to submit claims to Arkansas Blue Cross for secondary payment for Medi-care primary claims. Arkansas Blue Cross asks that providers not send paper claims for payment secondary to Medicare until at least 30 days after the primary payment was made by Medicare.

If after 30 days a secondary payment has not been received from Arkansas Blue Cross, providers can confirm that Arkansas Blue Cross has received the crossover in the AHIN system. If providers see the claim in AHIN, there is no need to file paper for secondary payment.

High-tech radiology billing requirements

On September 1, 2006, Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation (Arkansas' FirstSource® PPO and True Blue PPO) changed the billing requirements for high-tech radiology, defined as CT scans, magnetic resonance, PET scans or nuclear cardiology. This change does not affect hospitals billing for these services. Imaging centers should use their NPI as the rendering provider when billing services for high-tech radiology on the standard electronic claims transactions. In most cases, these imaging center NPI's are the clinic's NPI. Imaging centers will likewise use their NPI in the appropriate block of the CMS 1500 claim form as the rendering provider for high-tech radiology (Block 24J). Imaging centers will also use their NPI as the clinic billing number on electronic claims and CMS 1500 claim form (Block 33B). Imaging centers may bill "Total Component" on one line for the high-tech radiology services provided that the imaging center-based physician performing the supervision and interpretation meets the requirements described within the imaging center provider agreement. All applicable modifiers should be used (e.g., Modifier 26 for Professional Component, TC for Technical Component). Professional component reimbursement for high-tech radiology will only be made to physicians; therefore, payment will be made for the Professional Component only when submitted under a physician's provider number. Physicians billing with Modifier TC will receive a denial. Professional services billed with the imaging centers NPI and /or Modifier 26 will be denied. Imaging center claims should be submitted with place of service "11". This listing of specific claims filing requirements for imaging centers is not exclusive or comprehensive of all Arkansas Blue Cross claims filing or coding policies and procedures. These specific requirements are in addition to and not a substitute for other Arkansas Blue Cross claims filing and coding policies.

HMO Plus Network Update

This is a notice that the HMO Plus network will no longer be operational effective January 1, 2023. The HMO Plus network was used by the Focus Care benefit plan product which will also not be in effect January 1, 2023. It is possible that the HMO Plus network might be used for future products but as of January 1, 2023, it will not have any business tied to it. HMO Plus is a subnetwork of the Health Advantage HMO network and while HMO Plus will no longer be operational, it has no effect on the Health Advantage network.

Mailed remittance advices ending

Documents may be accessed/printed via the Availity Essentials platform

As you may be aware, for the past several months, Arkansas Blue Cross and Blue Shield has been in the process of moving your healthcare provider portal functionality from AHIN (Advanced Health Information Network) to the Availity Essentials platform – with the goal of having all functionality moved to Availity by September 29, 2022.

Because this a very complex undertaking, we have chosen to migrate AHIN functionality to the Availity platform in various phases.

One upcoming phase affects remittance advices. Until now, we have been able to send you paper remittance advices in the mail.

The option of mailing remittance advices to you will not be present on Availity (availity.com/arkansasbluecross). Remittance advices are accessible and available in electronic form on Availity (to be viewed, downloaded and/or printed by you at your convenience, but there will be no option to elect to have a physical copy mailed to you.

In effort to give you time to transition to this digital access and printing capabilities at your convenience, if you have been receiving mailed remittance advices, you will continue to receive them through December 31, 2022 – but will need to become familiar with personal printing well before this end date.

Providers needing assistance accessing remittance advices through Availity may contact Availity Client Services at 800-282-4548 or at availity.com/arkansasbluecross.

Thank you for your understanding as we transition to computerized access for all. We appreciate you and all you do to serve our members each day.

Medical specialty medications prior approval update

On April 1, 2018, Arkansas Blue Cross and Blue Shield and its family of companies enacted prior approval for payment of specialty medications used in treating rare, complex conditions that may go through the medical benefit. Since then, medications have been added to the initial list as products come to market.

The table below is the current list of medications that require prior approval through the member's medical benefit. It is also indicated when a medication is required to be processed through the pharmacy benefit. Any new medication used to treat a rare disease should be considered to require prior approval. **ASE/PSE and Medicare are not included in this article but have their own prior approval programs.**

Drug	Benefit
Abecma (idecabtagene vicleucel)	Medical

Drug	Benefit
Actemra (tocilizumab)	Medical & Pharmacy
Adakveo (crizanlizumab-tcma)	Medical
Aldurazyme (laronidase)	Medical
Amvuttra (vutrisiran)	Medical
Apretude (cabotegravir)	Medical
Arcalyst (rilonacept)	Medical
Asparlas (calaspargase pegol)	Medical
Avsola (infliximab-axxq)	Medical
Benlysta (belimumab)	Medical & Pharmacy
Berinert (c1 esterase, inhib, human)	Medical
Botox (onabotulinumtoxin a)	Medical & Pharmacy
Breyanzi (lisocabtagene maraleucel)	Medical
Brineura (cerliponase alfa)	Medical
Cabenuva (cabotegravir & rilpivirine)	Medical
Cablivi (caplacizumab-yhdp)	Medical & Pharmacy
Carvykti (ciltacabtagene autoleucel)	Medical
Cinqair (reslizumab)	Medical
Cinryze (c1 Esterase, inhib, human)	Medical
Crysvita (burosumab – twza)	Medical & Pharmacy

Drug	Benefit
Duopa (levodopa-carpidopa intestinal gel)	Medical
Durysta (bimatoprost)	Medical
Dysport (abobotulinumtoxin a)	Medical
Elaprase (idursulfase)	Medical
Elzonris (tagraxifusp-erzs)	Medical
Enjaymo (sutimlimab-jome)	Medical
Enspryng (satralizumab-mwge)	Medical & Pharmacy
Entyvio (vedolizumab)	Medical
Evenity (romosozumab-aqqg)	Medical
Evkeeza (evinacumab-dgnb)	Medical
Fabrazyme (agalsidase beta)	Medical
Fasenra (benralizumab)	Pharmacy
Firazyr (icatabant acetate)	Pharmacy
Fyarro (sirolimus protein-bound particles)	Medical
Gamifant (emapalumab-lzsg)	Medical
Givlaari (givosiran)	Medical
Haegarda (c1 esterase, inhib, human)	Pharmacy
Ilaris (canakinumab)	Medical & Pharmacy
Inflectra (infliximab-dyyb)	Medical
Invega Sustenna or Invega Trinza (paliperidone palmitate)	Medical & Pharmacy

Drug	Benefit
Ixifi (infliximab-qbtx)	Medical
Kalbitor (ecallantide)	Medical & Pharmacy
Kimmtrak (tebentafusp-tebn)	Medical
Krystexxa (pegloticase)	Medical
Kymriah (tisagenlecleucel)	Medical
Lemtrada (alemtuzumab)	Medical
Leqvio (inclisiran)	Medical
Lumizyme (alglucosidase alfa)	Medical
Lutathera (lutetium Lu 177 Dotatate)	Medical
Mepsevii (vestronidase-Alfa)	Medical
Myalept (metreleptin)	Pharmacy
Myobloc (rimabotulinumtoxin b)	Medical
Nagalzyme (galsulfase)	Medical
Nexviazyme (avalglucosidase alfa-ngpt)	Medical
Nucala (mepolizumab)	Pharmacy
Oncaspar (pegaspargase)	Medical
Onpattro (patisiran)	Medical
Opdualag (nivolumab and relatlimab-rmbw)	Medical
Orencia (abatacept)	Medical & Pharmacy
Oxlumo (lumasiran)	Medical

Drug	Benefit
Pluvicto (Lutetium Lu 177 vipivotide tetraxetan)	Medical
Reblozyl (luspatercept)	Medical
Remicade and Unbranded Infliximab (infliximab)	Medical
Renflexis (infliximab-abda)	Medical
Rethymic (allogeneic processed thymus tissue–agdc)	Medical
Revatio (sildenafil)	Medical
Riabni (rituximab-arrx)	Medical
Rituxan (rituximab)	Medical
Ruconest (c1 esterase, inhib, recombinant)	Medical
Rylaze (asparaginase erwinia chrysanthemi)	Medical
Ruxience (rituximab-pvvr)	Medical
Ryplazim (plasminogen)	Medical
Saphnelo (anifrolumab-fnia)	Medical
Simponi Aria (golimumab)	Medical
Skyrizi (risankizumab)	Medical & Pharmacy
Soliris (eculizumab)	Medical
Spinraza (nusinersen)	Medical
Spravato (esketamine)	Pharmacy
Stelara (ustekinumab)	Medical & Pharmacy
Strensiq (asfotase alfa)	Pharmacy

Drug	Benefit
Susvimo (ranibizumab)	Medical
Takhzyro (lanadelumab)	Pharmacy
Tecartus (brexucabtagene autoleucel)	Medical
Tepezza (teprotumumab)	Medical
Testopel (testosterone pellet)	Medical
Tezspire (tezepelumab)	Medical
Tivdak (tisotumab vedotin-tftv)	Medical
Truxima (rituximab-abbs)	Medical
Tysabri (natalizumab)	Medical
Ultomiris (ravulizumab-cwyz)	Medical
Uplizna (inebilizumab)	Medical
Vimizim (elosulfase alfa)	Medical
Vyepti (eptinezmab-jjmr)	Medical
Vyvgart (efgartigimod alfa-fcab)	Medical
Xeomin (incobotulinumtoxin a)	Medical
Xolair (omalizumab)	Pharmacy
Yescarta (axicabtagene ciloleucel)	Medical
Zolgensma (onasmnogene abeparvovec-XIOI)	Medical
Zulresso (brexanolone)	Medical
Zynteglo (betibeglogene autotemcel)	Medical

Oscillatory devices for chest physical therapy policy

Notice of Material Amendment

As a reminder, our coverage policy, Oscillatory Devices for Chest Physical Therapy has been updated effective January 1, 2023. Criteria for high-frequency chest wall Oscillation and Intrapulmonary Percussive Ventilation Devices has been updated to include criteria for initiation of a 3-month trial and criteria for continuation beyond the 3-month trial. For specific details, please see coverage policy 1998031.

Testing for Drugs of Abuse or Drugs at Risk of Abuse, including Controlled Substances

Notice of Material Amendment

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 precedent screening (presumptive) test for each specific drug or drug class prior to confirmatory (definitive) drug testing. 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 or for the management of an individual on medication assisted treatment for opioid use disorder).

Note: Urine drug testing is expected to be performed by in-network providers. Referral to out-of-network providers – including labs – constitutes a breach of the network participation agreement except where referral is unavoidable due to an emergency or if a covered service is not available in-network. For a list of current in network laboratory service providers, visit the Arkansas Blue Cross website at arkbuecross.com.

The following guidelines for screening and confirmatory testing have been in effect since January 2019, however, there was a delay in full implementation. Please note, effective 2/1/2022, these guidelines will be fully implemented for all LOBs effective 2/1/2022.

Screening (Presumptive) Testing

- Three CPT codes are available for Drug Screening (Presumptive Testing). These codes include 80305, 80306, 80307. Please note that per Coverage Policy #2009013, Services billed using CPT 80307 do not meet member benefit certificate primary coverage criteria and are not covered.
- Only one presumptive code (80305 or 80306) may be billed per day.
- There is a limit of one unit per date of service for procedure codes 80305 and 80306 per date of service.
- There is a limit of 24 screening services per year (combined total of 80305 and 80306).

Confirmatory (Definitive) Testing

- Confirmatory (Definitive) Testing should be billed using the HCPCS codes G0480-G0482 and G0659 as appropriate. CPT codes 80321-80328; 80332-80377; 83992 are not accepted for processing claims. These services should be reported with G0480-G0482, G0659.
- Please note that per Coverage Policy #2009013 Services billed using HCPCS G0483 do not meet member benefit certificate primary coverage criteria and are not covered.

- Only one of the five definitive codes (G0480, G0481, G0482, G0659) may be billed per day.
- There is a limit of one unit per date of service for procedure codes G0480-G0482 and/or G0659.
- There is a limit of 24 confirmatory services per year (combined total of G0480-G0482 and/or G0659)
- Confirmatory (Definitive) drug testing performed on saliva, hair, sweat or nails is not covered.

For definitive testing, the selection of the correct definitive G code to bill is based on two factors:

1) The use or absence of specific (1) calibration controls, (2) quality controls, and (3) internal standards. (CMS, 2017)

2) The number of drug classes documented as tested.
- The available drug classes are specified by CMS.
- The AMA CPT Manual may be consulted for examples of individual drugs within each drug class.

G0659 must be reported if the definitive drug testing method was performed:

- Without method or drug-specific calibration,
- Without matrix-matched quality control material, or
- Without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen.

Specimen validity testing is not eligible to be separately billed under any procedure codes (e.g., 81000, 81001, 81002, 81003, 81005, 81099, 82570, 83986, or any other code). This is because for all codes in range 80305 – 80307 & G0480 – G0483, G0659, the code description indicates that this testing is included if it was performed.

Please see the complete coverage policy for details on coverage criteria for testing of drugs of abuse. The complete Coverage Policy #2009013 can be accessed on the Arkansas Blue Cross website under the "Coverage Policy" page under the "Doctors and Hospitals" tab (http://www.arkansasbluecross.com/members/other_links/coverage_policy.aspx).

Standard formulary changes effective January 1, 2023

Arkansas Blue Cross and Blue Shield large groups, Health Advantage large groups, and Blue Advantage plans that have selected our prescription drug benefits use the standard formulary.

Product/Drug Label Name	Change	Alternatives
ADDERALL XR CAP	No longer covered	amphetamine-dextroamphetamine mixed salts ext-rel, dexmethylphenidate ext-rel, methylphenidate ext-rel, AZSTARYS, JORNAY PM, MYDAYIS, VYVANSE
ARNUITY ELPT INH	No longer covered	FLOVENT HFA, PULMICORT FLEXHALER
CONCERTA TAB	No longer covered	amphetamine-dextroamphetamine mixed salts ext-rel, dexmethylphenidate ext-rel, methylphenidate ext-rel, AZSTARYS, JORNAY PM, MYDAYIS, VYVANSE

Product/Drug Label Name	Change	Alternatives
FIRAZYR INJ	No longer covered	icatibant, RUCONEST
FLOVENT DISK INH	No longer covered	FLOVENT HFA, PULMICORT FLEXHALER
MULTAQ TAB	No longer covered	Current utilizers will be grandfathered for 2 years
NUCALA INJ	No longer covered	Current utilizers will be grandfathered for 2 years
NUCYNTA ER TAB	No longer covered	fentanyl transdermal, hydrocodone ext-rel, hydromorphone ext-rel, methadone, morphine ext-rel, XTAMPZA ER
QVAR REDIHAL INH	No longer covered	morphine ext-rel, XTAMPZA ER
TOVIAZ TAB	No longer covered	darifenacin ext-rel, oxybutynin ext-rel, solifenacin, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, GEMTESA
VOTRIENT TAB	No longer covered	Current utilizers will be grandfathered for 2 years

Metallic formulary changes effective January 1, 2023

On Exchange, Off Exchange, Arkansas Works, Arkansas Blue Cross and Blue Shield small group, Health Advantage small group and USAble Mutual small group members use the metallic formulary.

(This drug list is used by On Exchange, Off Exchange, ARHome, and small group metallic plans.)

Product/Drug Label Name	Change	Alternatives
ABRAXANE INJ	No longer covered	generic paclitaxel inj (protein-bound particles)
AIMOVIG INJ	No longer covered	AJOVY INJ, EMGALITY INJ
ALIMTA INJ	No longer covered	generic pemetrexed inj
ANADROL	No longer covered	oxandrolone tab
ARNUITY ELPT INH	Drug movig to a higher tier	PULMICORT INH, QVAR REDIHALER AER
AVONEX PEN KIT	Current utilizers will be grandfathered for 2 years	USE AUBAGIO TAB, BETASERON INJ, COPAXONE INJ, dimethyl fum cap, GILENYA CAP, glatiramer inj , Glatopa Inj , TYSABRI INJ

Product/Drug Label Name	Change	Alternatives
BALCOLTRA TAB	Current utilizers will be grandfathered for 2 years	USE Altavera tab, Chateal tab, Cryselle tab, drospirenone/ethinyl estradiol tab, Elinest tab, Kurvelo tab, levonorgestrel/ethinyl tab estradiol, Levora tab, Low-Ogestrel tab, Marlissa tab, norgestimate/ethinyl tab estradiol, Ocella tab, Portia tab, Syeda tab, Tilia Fe tab
BARACLUDE SOL	Drug moving to a higher tier	"lamivudine sol/tab, EPIVIR HBV SOL, tenofovir tab, VIREAD POW/TAB Prior Authorization is required, call 866-814-5506"
BETAMETH DIP OIN	No longer covered	aug betamethasone cre , desoximetasone cre/oin , desoximetasone gel, diflorasone cre , fluocinonide cre/gel/oin/sol, , triamcinolone oin
BOSULIF TAB	Current utilizers will be grandfathered for 2 years	USE imatinib mes tab, SPRYCEL TAB
CYCLOSET TAB	Current utilizers will be grandfathered for 2 years	USE metformin tab/tab ER, JARDIANCE TAB, OZEMPIC INJ, TRULICITY INJ, VICTOZA INJ
DEXLANSOPRAZOLE	No longer covered	esomeprazole magnesium, lansoprazole, Nexium pack, omeprazole, omeprazole-sodium bicarb pack, pantoprazole sodium, rabeprazole sodium
EPIDIOLEX SOL	Current utilizers will be grandfathered for 2 years	USE clobazam sus/tab, felbamate sus/tab, lamotrigine chw/tab ODT/tab/tab ER, rufinamide sus/tab, topiramate cap/tab
ERGOLOID MES TAB	No longer covered	donepezil tab/tab ODT, galantamine cap ER/sol/tab, memantine cap ER/sol/tab, rivastigmine cap
FARXIGA TAB	No longer covered	JARDIANCE TAB
FLAVOXATE TAB	No longer covered	darifenacin tab, fesoterodine tab, oxybutynin syp/tab/tab ER, solifenacin tab, tolterodine cap ER/tab, trospium cap ER/tab
LEVORPHANOL TAB	No longer covered	hydrocodone tab ER, hydromorphone tab ER, methadone con/sol/tab, morphine sul cap ER/tab ER, NUCYNTA ER TAB, oxycodone tab ER oxymorphone tab ER, tramadol tab ER, XTAMPZA ER CAP
LINDANE SHA	No longer covered	Drug is no longer covered-USE ivermectin lot, malathion lot, lice treatment (permethrin) lot/liq, spinosad sus
METHYLTESTOS CAP	No longer covered	testosterone cyp inj, testosterone enan inj, testosterone gel

Product/Drug Label Name	Change	Alternatives
MEXILETINE CAP	Current utilizers will be grandfathered for 2 years	Drug is no longer covered-Consult Prescriber
NEXAVAR TAB	No longer covered	generic sorafenib tab
NUCALA INJ	Current utilizers will be grandfathered for 2 years	USE FASENRA INJ/PEN INJ, XOLAIR INJ/SOL
OZEMPIC INJ 2/1.5ML	QL change	Qty limit of 1.5 mL every 28 days applied
PLEGRIDY INJ	Current utilizers will be grandfathered for 2 years	USE AUBAGIO TAB, BETASERON INJ, COPAXONE INJ, dimethyl fum cap, GILENYA CAP, glatiramer inj L, Glatopa Inj , TYSABRI INJ
PROMACTA TAB	Current utilizers will be grandfathered for 2 years	USE DOPTELET TAB
QUINIDINE SU TAB	Current utilizers will be grandfathered for 2 years	Drug is no longer covered-Consult Prescriber
REBIF INJ	Current utilizers will be grandfathered for 2 years	USE AUBAGIO TAB, BETASERON INJ, COPAXONE INJ, dimethyl fum cap, GILENYA CAP, glatiramer inj , Glatopa Inj , TYSABRI INJ
REBIF REBIDO INJ	Current utilizers will be grandfathered for 2 years	USE AUBAGIO TAB, BETASERON INJ, COPAXONE INJ, dimethyl fum cap, GILENYA CAP, glatiramer inj , Glatopa Inj , TYSABRI INJ
REXULTI TAB	No longer covered	aripiprazole sol/tab/tab ODT, asenapine sub, LATUDA, TAB, olanzapine tab/tab ODT, paliperidone tab ER, quetiapine tab/tab ER, risperidone sol/tab/tab ODT, VRAYLAR CAP, ziprasidone cap
STIOLTO AER	No longer covered	ANORO ELLIPT AER, BEVESPI AER
TACROLIMUS OIN	Drug moving to a higher tier	"EUCRISA OIN Step Therapy is required-USE corticosteroid of medium or higher potency or PA required; call 855-582-2022"
TARGRETIN GEL	No longer covered	generic bexarotene gel

Product/Drug Label Name	Change	Alternatives
TENCON TAB	No longer covered	diclofenac tab, etodolac cap/tab/ER tab, flurbiprofen tab, ibuprofen sus/tab, ketorolac tab, meclofenamate cap, mefenamic acid cap, meloxicam tab, nabumetone tab, naproxen tab, oxaprozin tab, piroxicam cap, sulindac tab
TOLCAPONE TAB	Current utilizers will be grandfathered for 2 years	USE entacapone tab
TOVIAZ TAB	No longer covered	generic fesoterodine tab
TRIUMEQ TAB	Drug moving to a higher tier	BIKTARVY TAB, efavirenz/emtricitabine tab tenofovir, efavirenz/lamivudine tab tenofovir, GENVOYA TAB, ODEFSEY TAB
VASCEPA CAP	No longer covered	icosapent cap , omega-3-acid cap
VIIBRYD TAB	No longer covered	generic vilazodone tab
VIVITROL INJ	No longer covered	ZUBSOLV SUB, buprenorphine-naloxone mis/sub, buprenorphine sub, naltrexone tab
XIGDUO XR TAB	No longer covered	SYNJARDY TAB/XR TAB

Bluechoice and Complete Care formulary changes effective January 1, 2023

Product/Drug Label Name	Change	Alternatives
ADVAIR HFA INH	No longer covered	SYMBICORT, ADVAIR DISKUS
AJOVY MNTHLY INJ	No longer covered	AIMOVIG, EMGALITY
ARNUITY ELPT INH	No longer covered	FLOVENT HFA
BREO ELLIPTA INH	No longer covered	SYMBICORT, ADVAIR DISKUS
JANUMET TAB	No longer covered	JENTADUETO
JANUVIA TAB	No longer covered	TRADJENTA
QVAR REDIHAL INH	No longer covered	FLOVENT HFA

Arkansas School Employees / Public School Employees

Bariatric surgery coverage for Arkansas state employees and public school employees

Coverage for bariatric surgery has been updated with requirements and conditions aligning with Act 109 of 2022. Effective 1/1/2023, this program provides coverage for one bariatric surgery (gastric bypass surgery, adjustable gastric banding, sleeve gastrectomy, or duodenal switch biliopancreatic diversion) per lifetime and one revision surgery if complications were caused directly by bariatric surgery. This does not include weight loss drugs.

Eligibility requirements for Bariatric surgery:

- Has a formal diagnosis of morbid obesity
- Is currently an active or retired state or public school employee
- Is 20-65 years old
- Has at least five years (or more) of continuous employment as a state or public school employee
- Has not previously undergone bariatric surgery
- Has met all the providers' program requirements and has received prior authorization for this surgery from Health Advantage on behalf of ARBenefits

Coverage will be limited to surgeries in a medical center accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program.

Federal Employee Program (FEP)

2023 FEP benefit changes

Here are some benefit changes for 2023. This is not a full list of changes. To see the full list, see section 2 of the Blue Cross and Blue Shield Service Benefit Plan brochures at fepblue.org/brochure.

Health and wellness updates

- Starting in Fall of 2022, FEP Blue Focus members can receive a $150 MyBlue Wellness Card when they complete their annual physical. Use the card for qualified medical expenses or at select Blue365® retailers.
- We will now make real-time updates, rather than annual updates, to your preventive care benefits. You can see a list of covered preventive care services at fepblue.org/preventivecare.

Maternity and reproductive care updates

- We increased the number of free mental health visits for members who are pregnant or recently gave birth to eight visits.
- Pregnant members can receive a blood pressure monitor at no cost to them. You can order the monitor via your MyBlue account or by calling **1-800-411-BLUE (2583)**.
- We will cover egg or sperm storage for members facing infertility due to a medical procedure or treatment. You can use this benefit once per lifetime.

Pharmacy updates

- We added four new drug classes related to mental health to the Standard Option Generic Incentive Program.
- Standard Option members get Preferred insulins for **$35** for a 30-day supply and **$65** for a 90-day supply, rather than paying a coinsurance amount.
- We cover approved weight-loss drugs through the Pharmacy Program to support members who are obese. You must receive prior approval for this benefit.
- We increased the Basic Option Tier 1, 2 and 3 cost share for covered drugs.

Medical benefit updates

- Basic Option members can get up to 12 rather than 10 covered acupuncture visits a year.
- We lowered the age we will begin covering weight-loss (bariatric) surgery for members to age 16.

- We removed the limit on covered non-sibling donors for transplant services.
- We increased the Basic Option cost share for diagnostic tests, inpatient visits, outpatient visits and emergency visits.

Overseas updates

We will waive the calendar year deductible for FEP Blue Focus members who receive care overseas. Learn more about overseas benefits at **fepblue.org/overseas**.

Antibiotic Stewardship - Helping with the "HOW"

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

What is the AAB measure? The percentage of episodes for members with a diagnosis of acute bronchitis/bronchiolitis that did not result in the member receiving an antibiotic prescription within three days of the diagnosis. The eligible population for the HEDIS measure for FEP members is 18-62 years of age.

Overprescribing antibiotics is a major health concern in the U.S. It has been directly linked to the prevalence of antibiotic resistance, with 2.8 million antibiotic-resistant infections and 35,000 deaths occurring annually. (Centers for Disease Control and Prevention. 2019. Antibiotic Resistance Threats in the United States.)

Acute bronchitis/bronchiolitis almost always gets better on its own; therefore, individuals without other health problems should not usually be prescribed an antibiotic. We're committed to joining you in ensuring the appropriate use of antibiotics for individuals with acute bronchitis/bronchiolitis to help them avoid harmful side effects and possible resistance to antibiotics over time.

Diagnosis codes
There are **11** acute bronchitis/bronchiolitis diagnosis codes that trigger patients into the HEDIS measure. The more common ICD-10 codes are:

- J20x - Acute Bronchitis
- J21x - Acute Bronchiolitis

Antibiotics
There are **58** total antibiotics that trigger the AAB HEDIS measure. The most common antibiotics are:

- Penicillins
- Cephalosporins
- Macrolides-like azithromycin (Z-Pak)
- Sulfonamides
- Tetracyclines

Exclusions
After examination, if a patient medically requires an antibiotic prescription due to comorbid conditions at time of the visit, documenting on the same visit claim this additional ICD-10 code will remove the patient from the AAB HEDIS measure.

Pharyngitis
There are 9 pharyngitis diagnosis that will remove the patient from the AAB HEDIS measure if antibiotics are needed. The most common diagnoses are:

- J02.x - acute pharyngitis
- J03.x - acute tonsillitis

Competing Diagnoses
There are 822 competing diagnosis that will remove the patient from the AAB HEDIS measure if antibiotics are needed. The most common diagnoses are:

- H66.xxx - Acute suppurative otitis media
- J01.xx - Acute sinusitis
- J18.xx – Pneumonia
- J32.xx - Chronic sinusitis
- J35.x-Hypertrophy tonsils
- J39.x- Disease upper respiratory tract
- LO3.xx - Cellulitis / Acute lymphangitis
- N3g.xx – UTI

FEP welcomes Virta

Arkansas Federal Employee Plan (FEP) administrated by Arkansas Blue Cross and Blue Shield is pleased to announce an enhancement of benefits for FEP primary members who have type 2 diabetes. Virta is for members who want to reverse type 2 diabetes or reduce antidiabetic medication. Virta provides management of diet, exercise and medication for a 2-year period for those members willing to engage with them via telehealth. Virta also provides a smart glucometer. Member's clinical information and data will be available to local provider when participant enrolls and designates provider. For more information click here to view letter from Dr. Mark Jansen, Chief Medical Officer.

FEP requirement for high-cost drugs

Federal Employee Plan (FEP) Directors Office in Washington, DC has given notice to all Blues Plans administrating FEP that Prior Approval (PA) is going to be required on an additional group of Medical Specialty Pharmacy Medications some having unclassified codes. FEP in AR will perform medical necessity review on these drugs as we move toward a PA process. Providers, please submit an advanced benefit determination for the drugs listed below to obtain prior approval. AR FEP will work to streamline this process and get these drugs into the Magellan Medical Specialty Pharmacy PA review system ASAP.

- J0223 givosiran 0.5 mg
- J0224 lumasiran 0.5 mg
- J1300 eculizumab 10 mg
- J9332 efgartigimod alfa-fcab 2 mg
- Tegsedi, Oxlumo, Givlaari, Vyvgart and Soliris.

Arkansas Blue Medicare

Arkansas Blue Medicare 2023 Plans

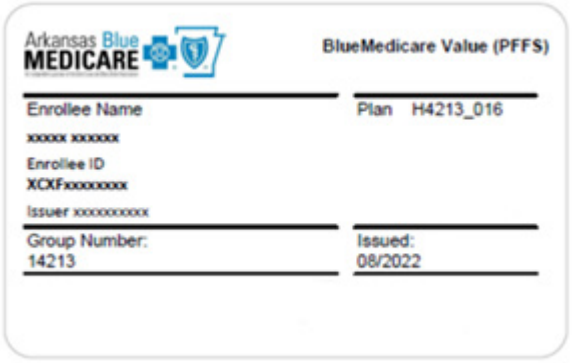
Arkansas Blue Medicare is selling an expanded suite of Medicare Advantage plans effective January 1, 2023. The Arkansas Blue Medicare and Health Advantage plans available in 2023 will focus on providing optimal, coordinated healthcare with a focus on clinical improvement through care management.

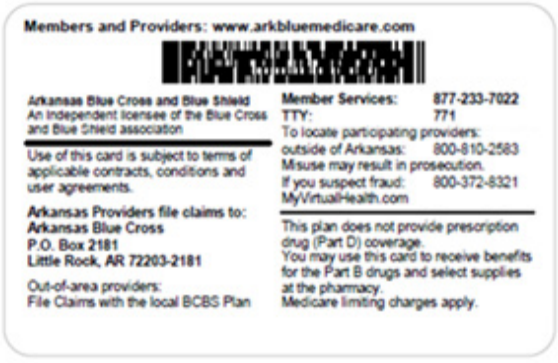
Please note the plans name and member prefix IDs below for our Medicare Advantage product lines. Our Medicare Supplement plans still maintain the Medi-Pak® Medicare Supplement name offered by Arkansas Blue Cross and Blue Shield.

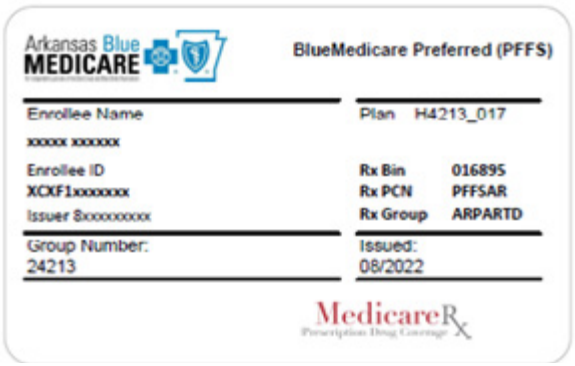
2023 Medicare Advantage Plan Overview

Arkansas Blue Medicare Plans	Health Advantage MA Plans	Arkansas Blue Cross and Blue Shield MA Plans
Arkansas BlueMedicare Premier HMO	Health Advantage Blue Premier HMO	Medi-Pak Medicare Supplement
Arkansas BlueMedicare Saver Choice PPO	Health Advantage Blue Classic HMO	
Arkansas BlueMedicare Value Choice PPO		
Arkansas BlueMedicare Premier Choice PPO		
Arkansas BlueMedicare Value PFFS		
Arkansas BlueMedicare Preferred PFFS		
Arkansas BlueMedicare Value Rx PDP		
Arkansas BlueMedicare Premier Rx PDP		
Arkansas BlueMedicare Saver Rx PDP		

2023 Member Sample ID Cards






Arkansas Blue MEDICARE

BlueMedicare Preferred (PFFS)

Enrollee Name
xxxxx xxxxxx

Plan H4213_017

Enrollee ID
XCXF1xxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN PFFSAR
Rx Group ARPARTD

Group Number:
24213

Issued:
08/2022

MedicareRx
Prescription Drug Coverage


Members and Providers: www.arkbluemedicare.com

Arkansas Blue Cross and Blue Shield
An Independent licensee of the Blue Cross and Blue Shield association

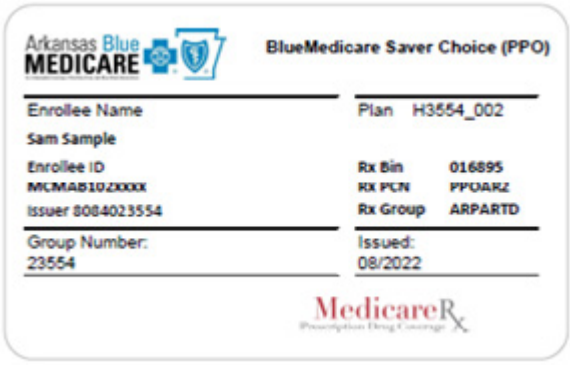
Arkansas Providers file claims to:
Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 877-233-7022
TTY: 771
Pharmacy Services:: 888-249-1556
Pharmacy Help Desk: 800-693-3815
Provider Inquiries: 800-287-4188
To locate participating outside of Arkansas: 800-810-2583
If you suspect fraud: 800-372-8321
MyVirtualHealth.com

Use of this card is subject to terms of applicable contracts, conditions and user agreements.
Medicare limiting charges apply.


Arkansas Blue MEDICARE

BlueMedicare Saver Choice (PPO)

Enrollee Name
Sam Sample

Plan H3554_002

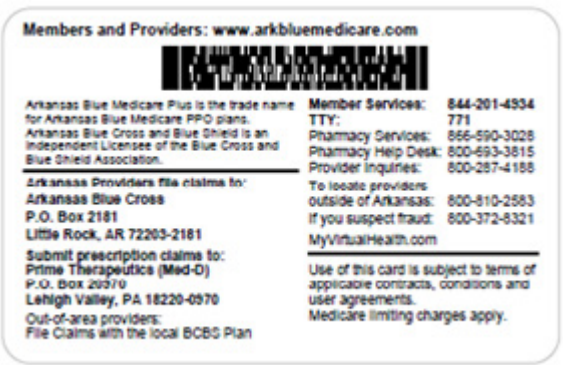
Enrollee ID
MCMAB10Zxxxx
Issuer 8084023554

Rx Bin 016895
Rx PCN PPOARZ
Rx Group ARPARTD

Group Number:
23554

Issued:
08/2022

MedicareRx
Prescription Drug Coverage


Members and Providers: www.arkbluemedicare.com

Arkansas Blue Medicare Plus is the trade name for Arkansas Blue Medicare PPO plans.
Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Arkansas Providers file claims to:
Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 844-201-4934
TTY: 771
Pharmacy Services: 866-590-3028
Pharmacy Help Desk: 800-693-3815
Provider Inquiries: 800-287-4188
To locate providers outside of Arkansas: 800-810-2583
If you suspect fraud: 800-372-8321
MyVirtualHealth.com

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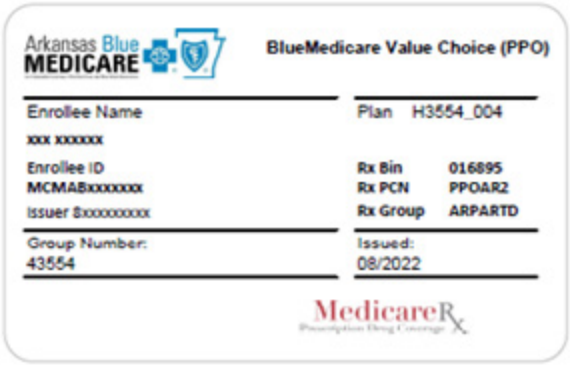
Arkansas Blue MEDICARE

BlueMedicare Value Choice (PPO)

Enrollee Name
xxx xxxxxx

Plan H3554_004

Enrollee ID
MCMABxxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN PPOAR2
Rx Group ARPARTD

Group Number:
43554

Issued:
08/2022

MedicareRx
Prescription Drug Coverage


Members and Providers: www.arkbluemedicare.com

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Arkansas Providers file claims to:
Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 844-201-4934
TTY: 771
Pharmacy Services: 866-590-3028
Pharmacy Help Desk: 800-693-3815
Provider Inquiries: 800-287-4188
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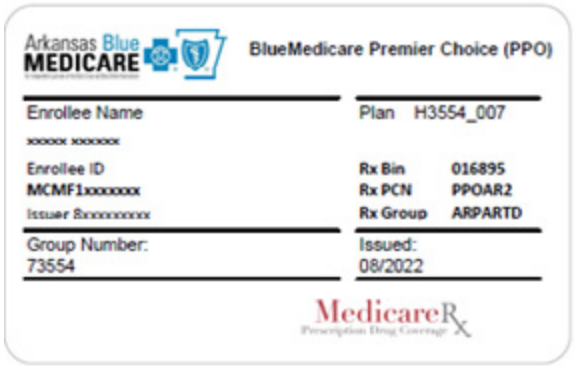
Arkansas Blue MEDICARE

BlueMedicare Premier Choice (PPO)

Enrollee Name
xxxxx xxxxxx

Plan H3554_007

Enrollee ID
MCMF1xxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN PPOAR2
Rx Group ARPARTD

Group Number:
73554

Issued:
08/2022

MedicareRx
Prescription Drug Coverage


Members and Providers: www.arkbluemedicare.com

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P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 844-201-4934
TTY: 771
Pharmacy Services: 866-590-3028
Pharmacy Help Desk: 800-693-3815
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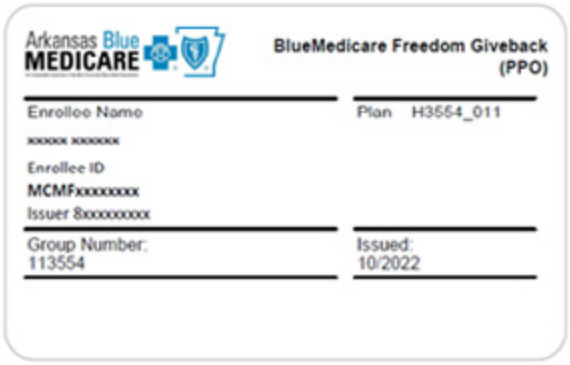

Arkansas Blue MEDICARE

BlueMedicare Freedom Giveback (PPO)

Enrollee Name
xxxxx xxxxxx

Plan H3554_011

Enrollee ID
MCMFxxxxxxx
Issuer 8xxxxxxxxx

Group Number:
113554

Issued:
10/2022

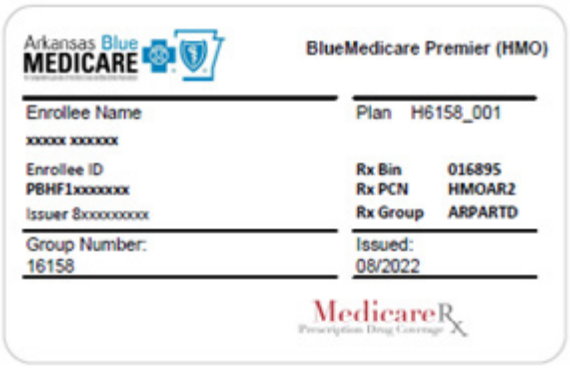

Members and Providers: www.arkbluemedicare.com

Arkansas Blue Medicare Plus is the trade name for Arkansas Blue Medicare PPO plans.
Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Arkansas Providers file claims to:
Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181
Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 844-201-4934
TTY: 771
Provider Inquiries: 800-287-4188
To locate providers outside of Arkansas: 800-810-2583
If you suspect fraud: 800-372-8321
MyVirtualHealth.com

This plan does not provide prescription drug (Part D) coverage.
You may use this card to receive benefits for the Part B drugs and select supplies at the pharmacy.
Medicare limiting charges apply.


Arkansas Blue MEDICARE

BlueMedicare Premier (HMO)

Enrollee Name
xxxxx xxxxxx

Plan H6158_001

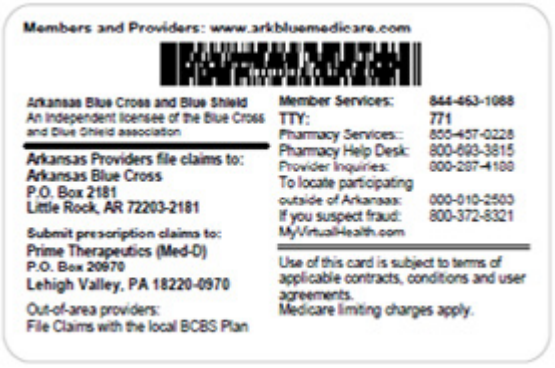
Enrollee ID
PBHF1xxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN HMOAR2
Rx Group ARPARTD

Group Number:
16158

Issued:
08/2022

MedicareRx Prescription Drug Coverage


Members and Providers: www.arkbluemedicare.com

Arkansas Blue Cross and Blue Shield
An Independent licensee of the Blue Cross and Blue Shield association

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Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 844-463-1088
TTY: 771
Pharmacy Services:: 855-457-0228
Pharmacy Help Desk: 800-693-3815
Provider Inquiries: 800-287-4188
To locate participating outside of Arkansas: 800-810-2583
If you suspect fraud: 800-372-8321
MyVirtualHealth.com

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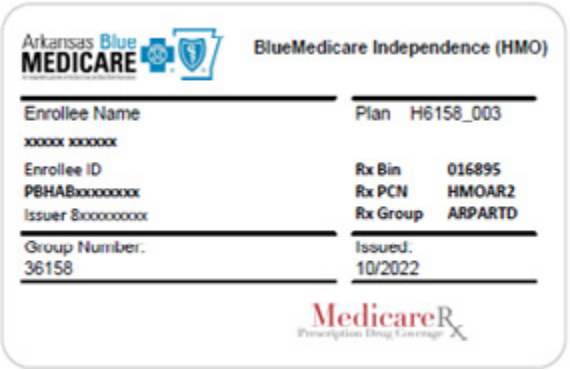
Medicare limiting charges apply.


Arkansas Blue MEDICARE

BlueMedicare Independence (HMO)

Enrollee Name
xxxxx xxxxxx

Plan H6158_003

Enrollee ID
PBHABxxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN HMOAR2
Rx Group ARPARTD

Group Number:
36158

Issued:
10/2022

MedicareRx Prescription Drug Coverage


Members and Providers: www.arkbluemedicare.com

Arkansas Blue Cross and Blue Shield
An Independent licensee of the Blue Cross and Blue Shield association

Arkansas Providers file claims to:
Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 844-463-1088
TTY: 771
Pharmacy Services:: 855-457-0228
Pharmacy Help Desk: 800-693-3815
Provider Inquiries: 800-287-4188
To locate participating outside of Arkansas: 800-810-2583
If you suspect fraud: 800-372-8321
MyVirtualHealth.com

Use of this card is subject to terms of applicable contracts, conditions and user agreements.
Medicare limiting charges apply.


Health Advantage

Health Advantage Blue Classic (HMO)

Enrollee Name
xxxxx xxxxxx

Plan H0699_004

Enrollee ID
XCSFxxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN HMOAR
Rx Group ARPARTD

Group Number:
19699

Issued:
08/2022

MedicareRx Prescription Drug Coverage


Members and Providers: www.HAmedicare.com

Arkansas Blue Cross and Blue Shield
An Independent licensee of the Blue Cross and Blue Shield association

Arkansas Providers file claims to:
Arkansas Blue Cross
P.O. Box 2181
Little Rock, AR 72203-2181

Submit prescription claims to:
Prime Therapeutics (Med-D)
P.O. Box 20970
Lehigh Valley, PA 18220-0970

Out-of-area providers:
File Claims with the local BCBS Plan

Member Services: 877-349-9335
TTY: 771
Pharmacy Services:: 888-249-1595
Pharmacy Help Desk: 800-693-3815
Provider Inquiries: 800-287-4188
Provider Pre-authorization: 800-810-2583
If you suspect fraud: 800-372-8321
MyVirtualHealth.com

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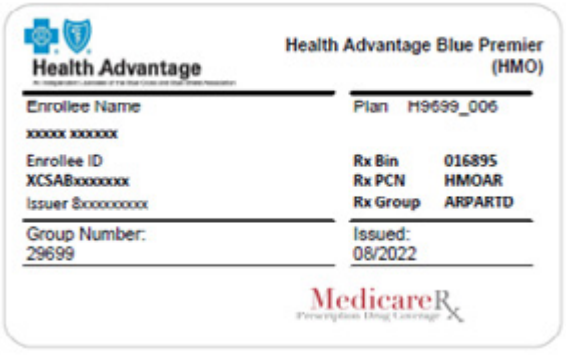
Medicare limiting charges apply.


Health Advantage

Health Advantage Blue Premier (HMO)

Enrollee Name
xxxxx xxxxxx

Plan H9699_006

Enrollee ID
XCSABxxxxxxx
Issuer 8xxxxxxxxx

Rx Bin 016895
Rx PCN HMOAR
Rx Group ARPARTD

Group Number:
29699

Issued:
08/2022

MedicareRx Prescription Drug Coverage


Members and Providers: www.HAmedicare.com

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MyVirtualHealth.com

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Medicare limiting charges apply.

Medicare Advantage

Medicare Advantage Contact Information

Provider Support Line	1-877-359-1441 Medicareprovidersupport2@arkbluecross.com
Prime Therapeutics Clinical Department (reference call center numbers for each contract)	1-800-693-6703 (fax number)
Pharmacy Help Desk	1-800-693-3815
Provider Customer Service – Medical	1-800-287-4188
Medical Customer Service Fax Number	501-301-1927
24-Hour Nurse Hotline	1-800-318-2384
ABCBS Nurse Triage Team	1-800-817-7784
Blue Medicare Advantage PPO Provider Network (The Visitor/Travel Program)	1-800-810-Blue (2583)
Medicare Benefits 1-800-MEDICARE	1-800-633-4227 – TTY 1-877-486-2048 www.medicare.gov
Senior Health Insurance Information Program (SHIIP)	1-800-224-6330 www.insurance.arkansas.gov
Social Security Benefits	1-800-772-1213 -TTY 1-800-325-0778 www.socialsecurity.gov

Medicare Advantage notice of change for medical coverage guidelines

Effective **December 15, 2022**, the Medicare Advantage networks will transition to the InterQual web-based solution to assist with streamlining the medical review process and offer an increase in provider transparency access. This change will allow the utilization management review staff the use of nationally recognized, evidence based, InterQual Criteria combined with Medicare policies to support care coordination decisions. These guidelines will be used for medical level of care facilitation, behavioral health principal review, and ambulatory care or admission planning.

This will be an internal technical solution transition and will not affect or disrupt the providers care of members. For additional questions and information, please reach out to Change Healthcare customer support at 1-866-371-9066 or online at Customer Support | Change Healthcare.

Medicare Advantage billing guidelines for telehealth

All Medicare Advantage network providers within the Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO networks are required to file submit telehealth claims listing the originating site with appropriate codes and modifier, in accordance with CMS guidelines.

CMS defines the use of HCPCS code Q3014 to be used by providers to identify the telehealth originating site fee with office place of service code 11 on a professional claim form. Facility claims should be presented on a UB form along with the billable codes of TOB 12X, 13X, 22X, 23X, 71X, 73X, 76X, and 85X for claims to be accepted for payment. Please note that if telehealth claims are not submitted with the appropriate bill type, the claim will deny and no payment will be received.

Medicare Advantage participating provider requirements

Active Medicare Advantage providers are required to verify eligibility and benefit coverage prior to rendering services to properly validate a Medicare member is enrolled in Medicare Advantage. Medicare Advantage provides members with an identification or enrollment card that must be presented to providers each time they receive care.

Providers have a reasonable opportunity to obtain Medicare Advantage Terms and Conditions for participation in these Medicare Advantage plans. The Terms and Conditions are available on the Arkansas Blue Cross website, under the "Medicare plans" section at **Medicare Advantage - Arkansas Blue Cross and Blue Shield**.

Medicare approved and active providers who render services to a Medicare Advantage member will subsequently file a claim for the services to Arkansas Blue Medicare or Medicare Advantage Health Advantage HMO to have the claims adjudicated. Once a provider has submitted claims for a Medicare Advantage member, the provider will be considered for all future claims submitted by the provider for that member as long a network participation remains in place.

Please note that providers may only collect any applicable copayments or coinsurance from the Medicare Advantage member based on his or her benefit structure and may not balance bill the member for any additional amounts. Nor may providers balance bill the member for emergency or urgent care services.

Providers may collect only the applicable copayment or coinsurance amounts from Medicare Advantage members and may not charge or bill the members direct. Balance billing is prohibited by active providers who provide services to Medicare Advantage members.

Copayments or coinsurance should be collected from a member at the time of service. If a provider inadvertently collects more from a member than the designated copayment or coinsurance amount, the provider must refund the difference to the member.

Medicare Advantage requires all claims be submitted within 365 days from the date of service. The plan will process claims following traditional Medicare billing rules, including prospective payment system requirements. Providers should submit claims using the same coding rules as traditional Medicare. Providers are required to send all claims to Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO. This shall not prohibit collection of payments for any non-covered services or member cost-share amounts.

Medicare Advantage Eligibility Inquiries and Claims Submission Guidelines

Eligibility Validation:

1. Before rendering services, providers should request to see the patient's Medicare Advantage identification card.
2. Providers may obtain available information concerning Medicare Advantage members' eligibility by calling Medicare Advantage customer service using the phone number found on the back of the members identification card. Arkansas providers may also obtain available information concerning Medicare Advantage members' eligibility by accessing **Availity** landing page.

Effect of Eligibility Responses:

Please see reference to eligibility inquiries in the "Terms and Conditions" section of these Medicare Advantage materials for an explanation of the limitations on eligibility responses, which should not be relied upon as a guarantee of eligibility of payment.

Claims Submission:

Claims for Medicare Advantage members are required to be sent to Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO and not to any Medicare carrier or fiscal intermediary, per the provider participation agreements. The only exception is for hospice services, which continue to be paid by traditional Medicare. Please send all claims for hospice services to your Medicare carrier or fiscal intermediary.

Submission of Claims:

All providers should submit claims as soon as possible after a service is provided using the standard CMS-1500, CMS-1450, UB-92, or UB-04 claim form. All Medicare billing guidelines must be followed when submitting Medicare Advantage claims. Services billed beyond 365 days from date of service are not eligible for reimbursement.

Electronic Claims:

Providers can submit Medicare Advantage claims through the **Availity** online portal. Please check your electronic filing support to make sure that you can bill and accept new source of payment changes.

Important claims information:

Be sure to include the following on the Medicare Advantage claims:

- Arkansas Blue Medicare or Medicare Advantage Health Advantage HMO Provider Number, Clinic Number (if applicable), National Provider Identification Number (NPI), Medicare Provider Number and Federal Tax identification number
- Medicare Advantage member ID number.

Laboratories:

Providers need to send laboratory claims directly to Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO and are required under CMS guidelines to use the CLIA number.

Providers Outside of Arkansas:

All providers outside of Arkansas should submit claims to the local Blue Cross plan for claims adjudication.

Coordination of Benefits:

If a Medicare Advantage member has primary coverage with another plan, please submit a claim for payment to the primary plan first. The amount payable by Medicare Advantage will be governed by the Medicare allowed amount and amount paid by the primary plan and the coordination of benefits policies.

Advanced Beneficiary Notification (ABN):

ABN's are not required for Medicare Advantage members. Providers must inform a Medicare Advantage member in advance that the service that will not be covered. A provider's notification can be verbal or in writing, but providers are encouraged to document the discussion.

Notices of Discharge and Non-Coverage:

Arkansas Blue Medicare or Medicare Advantage Health Advantage HMO delegates to providers the responsibility for issuing Notices of Discharge and Medicare Appeal Rights (NODMAR) and Notices of Non-Coverage (NOMNC) in accordance with applicable Medicare regulations.

Claims Payment:

Medicare Advantage processes claims by following the traditional Medicare billing rules including the prospective payment system requirements. Submit claims by using the same coding rules as traditional Medicare and by using CPT codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. Remember to use the CMS approved HCPCS codes and CMS-approved modifiers.

CMS requires that 95% of all clean claims be processed within 30 days from receipt. In the event that a clean claim is not processed within the 30-day timeframe, Arkansas Blue Medicare or Medicare Advantage Health Advantage HMO will comply with Medicare's prompt payment of claims requirements for all clean claims.

Medicare Advantage notice of referral to out-of-network provider

The Medicare Advantage networks have recently been noticing an increase in the utilization of referrals to non-participating providers and vendors.

Participating providers in the Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO networks agree that they will NOT refer Medicare Advantage members to out-of-network providers and vendors if the services in question can be provided by in-network providers. In the absence of an emergency where the use of in-network providers is not possible, **it is a breach of the network participation agreement to refer our members to out-of-network providers or vendors**.

Referral to out-of-network providers is more than a business or contract concern of Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO. These referral violations have adverse financial consequences for our Medicare Advantage members as members may be subjected to "balance billing" in excess of the in-network allowance. In accordance with CMS regulations, eligible Medicare Advantage members may not be balanced billed for Medicare covered and approved services. However, if the services are not Medicare approved, then a waiver of liability will need to be put in place, allowing the provider to balance bill the member. In many cases, even if the out-of-network provider does not balance bill our Medicare Advantage members, the Medicare Advantage member still is adversely affected because increased cost shares in the forms of higher deductibles, coinsurances or copayments for out-of-network services.

This memo provides written notice regarding this matter and Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO networks trust that further referral of our Medicare Advantage members to out-of-network providers and vendors will cease; if it does not, Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO, may have no choice but to remove a provider's network participation. We trust that such action will not be necessary, and that the provider will in the future abide by the terms of your network participation agreements to protect our Medicare Advantage members, your patients, from excessive billing or testing.

Inflation Reduction Act – Update

As you are aware, the Center for Medicare and Medicaid Services (CMS) has provided guidance for Medicare beneficiaries to pay a maximum of $35 copay for a one-month supply for their insulin at point-of-sale as of January 1, 2023. Due to setup limitations, we are informing you that your patients may pay more than the $35 copay for a one-month supply of insulin in January. We are working diligently with our Pharmacy Benefit Manager, Prime Therapeutics, to update their claims processing system to ensure insulin claims are processed correctly at the $35 copay for our Medicare Advantage members. We expect the claims processing system to be corrected by January 23rd, 2022. Until this time, if your patient pays more than a $35 copay, please inform them that they will be reimbursed by their Medicare Advantage plan on January 31st via check. No action is necessary from you or your patient. We apologize for this inconvenience and will have it corrected as soon as possible. We have notified members of this change coming in January. If members have further questions regarding their insulin copays, please have them call the Customer Service number on the back of their Arkansas Blue Medicare or Health Advantage (HMO) ID card.

Blue & You Fitness Challenge

The Blue & You Fitness Challenge is 20 years strong!! If you're interested in free opportunities to promote physical, mental, and emotional well-being with your workforce, community groups or even friends and family, then the Blue & You Fitness Challenge is for you! It is a great way to get you and your friends, family, and co-workers on the right track to living a healthier lifestyle. Start 2023 strong and register your group for the Blue & You Fitness Challenge.

Group registration for the 2023 Blue & You Fitness Challenge is open. You can register your group now by scanning this QR code.

Important Deadlines for 2023 Challenge

- **January 24** – deadline for group registration
- **February 1** – individual participant registration opens
- **February 28** – deadline for individual registration in groups
- **March 1** – Challenge begins

What is the Blue & You Fitness Challenge?

The Blue & You Fitness Challenge is a free three-month contest in which participants are encouraged to exercise, make healthy choices and log those activities to earn points. The Challenge is held from March 1 through May 31. Companies and organizations participate in the event as part of their wellness programs. Friends and family use the contest to focus on health goals, infuse new energy into their routines, remain connected and have fun! Points gained from logging activity lead to contest recognition and rewards, but the best bonuses are better health and fitness. The Challenge was founded in 2004 and is hosted by Arkansas Blue Cross and Blue Shield, the Arkansas Department of Health and the Arkansas Department of Human Services.

For more information, email **info@blueandyoufitnesschallenge-ark.com**.

Strong starts here!