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

PROVIDERS' NEWS

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Health Advantage and *BlueAdvantage Administrators of Arkansas* are affiliates of the *Arkansas Blue Cross and Blue Shield family of companies.*
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2019 Open Enrollment: please use AHIN

The 2019 Open Enrollment period begins October 4 and will continue through December 15. The enrollment of many new members and renewal of current members are producing extremely high call volumes, which are expected to remain elevated through January 31, 2020.

Arkansas Blue Cross and Blue Shield strongly encourages provider offices and facilities to use the Advanced Health Information Network (AHIN) website for verifying eligibility, benefits and claims status. AHIN displays information on benefits to assist providers when scheduling appointments, checking eligibility and identifying benefits. Arkansas Blue Cross is planning and staffing to answer these higher call volumes, but please be aware that they 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.

Arkansas Prescription Monitoring Program requirement

Any provider requesting participation with the Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation dba Preferred Provider Networks of Arkansas (collectively, the "Networks") must be registered with the Arkansas Prescription Monitoring Program (PMP) if that provider holds an active Drug Enforcement Agency (DEA) certificate and licensure issued to provide healthcare services in Arkansas.

Registration of all current network providers was due on April 1, 2017, in order to comply with the Networks' revised credentialing standards. If a provider has not yet registered, network termination letters will be received requesting participation in accordance with the Networks' standards. Registration for the PMP is free and takes about five (5) minutes to complete. The registration page can be found online at https://arkansas.pmpaware.net/login.

Under the law, a prescriber may designate someone in the facility, such as a nurse, to be that prescriber's delegate for checking the PMP database, once that delegate has also registered. When a prescriber checks the PMP, they become aware of patient issues and can begin discussions leading to safer drug use, better pain management and treatment for addictions, when appropriate.

The Networks require contracted providers in Arkansas to register and encourages use of the Arkansas Prescription Monitoring Program.

Assignment of benefits to a healthcare provider

Act 736 of the 2019 Arkansas General Assembly provides that a person who is entitled to receive reimbursement for a healthcare service under the terms of a health benefit plan may assign to a licensed Arkansas healthcare provider such right to receive reimbursement regardless of whether the healthcare provider is a participating provider or an out-of-network provider. If the healthcare provider is not a participating provider in the provider network used by the member's health plan (e.g., Arkansas Blue Cross and Blue Shield Preferred Payment Plan, Health Advantage HMO, Preferred Provider Networks' True Blue PPO, Arkansas' FirstSource), a benefit assignment form must be completed and attached to each claim that is submitted to Arkansas Blue Cross and its family of companies in order for the non-par provider to receive reimbursement. An electronic benefit assignment indicator will not be accepted from non-participating providers.

The benefit assignment form must clearly state that the member – or in case of a minor, the legal guardian – is assigning the benefit. A new assignment form must be attached for each claim that is submitted. Of course, in order for a provider to receive payment, the service submitted for payment must be a covered service by the health plan.

If you are a non-par licensed Arkansas provider, you may not have a provider record in our systems and therefore cannot submit claims. Please contact ProviderNetwork@arkansasbluecross.com in order to receive the forms to enroll as a non-par provider.

Coverage policy manual updates

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

Policy ID	Policy Name
2004046	Genetic test: FMR 1 mutations including fragile X syndrome
2012003	Genetic test: Molecular markers in fine needle aspirates of the thyroid
2016004	Lab test: Identification of microorganisms using nucleic acid probes
1999001	Nerve conduction studies (NCS), electromyography (EMG) and surface EMG (SEMG)
2001009	Glucose monitoring, continuous
2001032	Closure devices for atrial or ventricular septal defects (ASD, VSD) or patent foramen ovale (PFO), percutaneous
2011053	Autism spectrum disorder, applied behavioral analysis
2014017	Transcatheter mitral valve repair
2017019	Molecular testing in the management of pulmonary nodules

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Policy ID	Policy Name
2019002	Phrenic nerve stimulation for central sleep apnea
2019004	Wilderness therapy
1997112	Intradialytic parenteral nutrition
1998144	Pulmonary arterial hypertension, pharmacological treatment with prostacyclin analogues, endothelin receptors antagonists, or phosphodiesterase inhibitors
1998158	Trastuzumab AND Trastuzumab and Hyaluronidase-oysk
2006016	Rituximab (Rituxan)
2006020	Abatacept (Orencia) for rheumatoid arthritis
2008031	Rilonacept (Arcalyst)
2013014	Ado-Trastuzumab Emtansine (Trastuzumab-DM1) for treatment of HER-2 positive malignancies
2014016	Phosphodiesterase-5 (PDE-5) inhibitors for benign prostatic hypertrophy (Tadalafil)
2016003	Omalizumab (Xolair)
2016005	Anti-PD-1 (programmed death receptor-1) therapy (Nivolumab) (Durvalumab) (Cemiplimab)
2016012	Daratumumab (Darzalex)
2016013	CD 5 complement inhibitors
2016017	Radium Ra 223 dichloride for symptomatic osseous metastatic prostate cancer (Xofigo®; Ra 223)
2017009	Denosumab (XGEVA™ and Prolia™)
2017016	Ramucirumab (Cyramza™)
2017020	Pemetrexed (Alimta)
2017024	Panitumumab (Vectibix™)
2017031	Dupilumab
2017037	Direct acting antiviral medications for treatment of chronic hepatitis c
2018025	Mucopolysaccharidoses Agents
2019005	Pembrolizumab (KEYTRUDA®)
2019006	Caplacizumab-yhdp (Cablivi)
2011016	Preventive services for non-grandfathered (PPACA) plans: BRCA testing; genetic counseling and evaluation
2011020	Preventive services for non-grandfathered (PPACA) plans: Bacteriuria screening in pregnant women
2011034	Preventive services for non-grandfathered (PPACA) plans: Intensive behavioral counseling to promote a healthy diet and physical activity in adults with high risk for cardiovascular disease
2011044	Preventive services for non-grandfathered (PPACA) plans: Depression screening in adolescents
2011066	Preventive services for non-grandfathered (PPACA) plans: Overview
2012035	Preventive services for non-grandfathered (PPACA) plans: Contraceptive use and counseling
2012042	Preventive services for non-grandfathered (PPACA) plans: Media use by children & adolescents, screening & counseling
2012044	Preventive services for non-grandfathered (PPACA) plans: Bicycle helmet use for children & adolescents, counseling
2019003	Pilot policy: noninvasive coronary fractional flow reserve using computed tomography angiography
1997080	Neuromuscular stimulation, functional
1997026	Blepharoplasty/blepharoptosis

Policy ID	Policy Name
1997208	Spinal cord neurostimulation for treatment of intractable pain
1998010	Transplant, small bowel
1999022	Percutaneous angioplasty, stenting & atherectomy of the lower extremity, abdominal aortic & visceral arteries
2013015	Treatment of varicose veins/venous insufficiency

Formulary changes

The tables below show the formulary changes for Health Advantage, Arkansas Blue Cross and Blue Shield, BlueAdvantage Administrators of Arkansas, USAble Group Health and USAble Administrators, and individuals and groups that use the Standard, Standard with Step, Value, Essential and Complete formularies. These changes will be effective October 1, 2019, and do not apply to any of our Medicare plans.

Standard/Standard with Step/Value/Essential/Complete Formulary Changes for 10/1/2019

ADDITIONS:

Product	Therapeutic Category/ Subcategory	Indication	Options/Alternatives
Brand Agents:			
Skyrizi (risankizumab-rzaa) subcutaneous solution for injection	Immunologic Agents/ Autoimmune Agents	Skyrizi is indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.	To provide an additional option for the treatment of moderate-to-severe plaque psoriasis.
Generic Agents:			
clobazam oral suspension, oral tablet	Central Nervous System/ Anticonvulsants	Clobazam is indicated for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in patients 2 years of age or older.	To provide an additional generic option for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome.
vigabatrin oral powder for solution	Central Nervous System/ Anticonvulsants	Vigabatrin is indicated for the treatment of: • Refractory complex partial seizures as adjunctive therapy in patients ≥10 years of age who have responded inadequately to several alternative treatments • Infantile Spasms - monotherapy in infants 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss.	To provide a generic option for the treatment of refractory partial complex seizures and infantile spasms.
vigabatrin oral tablet	Central Nervous System/ Anticonvulsants	Vigabatrin is indicated for the treatment of: • Refractory complex partial seizures as adjunctive therapy in patients ≥10 years of age who have responded inadequately to several alternative treatments.	To provide a generic option for the treatment of refractory partial complex seizures.

Moving from Preferred to Non-Preferred Tier:

Brand Agents:			
AndroGel 1.62% (testosterone gel) transdermal gel	Endocrine and Metabolic/ Androgens	AndroGel 1.62% is indicated for replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone: • Primary hypogonadism (congenital or acquired) • Hypogonadotropic hypogonadism (congenital or acquired).	Availability of other options for the treatment of hypogonadism. Preferred options on the include testosterone cypionate, testosterone enanthate, testosterone gel, testosterone solution, and Androderm (testosterone transdermal).
Differin (adapalene) topical cream, gel, lotion	Topical/ Dermatology/ Acne/ Topical	Differin is indicated for the topical treatment of acne vulgaris.	Availability of other options for the treatment of acne vulgaris. Preferred options include adapalene, adapalene-benzoyl peroxide, benzoyl peroxide, clindamycin gel/lotion/solution, clindamycin-benzoyl peroxide, erythromycin gel 2%, erythromycin solution, erythromycin-benzoyl peroxide, sulfacetamide lotion 10%, tazarotene, tretinoin, tretinoin – Avita, tretinoin gel microsphere, Benzac AC (benzoyl peroxide), Benzamycin (erythromycin-benzoyl peroxide), Cleocin T (clindamycin gel/lotion/solution), Duac (clindamycin-benzoyl peroxide), Epiduo (adapalene-benzoyl peroxide), Epiduo Forte (adapalene-benzoyl peroxide), Klaron (sulfacetamide lotion 10%), Retin-A (tretinoin), Retin-A Micro (tretinoin gel microsphere), and Tazorac (tazarotene).
Ganirelix acetate (ganirelix acetate) subcutaneous solution for injection	Endocrine and Metabolic/ Fertility Regulators/ GNRH/LHRH Antagonists	Ganirelix acetate is indicated for the inhibition of premature luteinizing hormone (LH) surges in women undergoing controlled ovarian hyperstimulation.	Availability of other options for regulating hormones during infertility treatment. Preferred include ganirelix acetate and Cetrotide (cetrorelix).
Oracea (doxycycline monohydrate) oral delayed-release capsule	Topical/ Dermatology/ Rosacea	Oracea is indicated for the treatment of only inflammatory lesions (papules and pustules) of rosacea in adult patients.	Availability of a generic oral option for the treatment of rosacea. The preferred option is doxycycline monohydrate delayed-rel capsule.
Ranexa (ranolazine ext-rel) oral extended-release tablet	Cardiovascular/ Miscellaneous	Ranexa is indicated for the treatment of chronic angina.	Availability of a generic for the treatment of chronic angina. The preferred option is ranolazine ext-rel.

VESIcare (solifenacin succinate) oral tablet	Genitourinary/ Urinary Antispasmodics	VESIcare is indicated for the treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency.	Availability of other options for the treatment of overactive bladder. Preferred options include darifenacin ext-rel, oxybutynin ext-rel, solifenacin, tolterodine, tolterodine ext-rel, trospium, trospium ext-rel, Detrol (tolterodine), Ditropan XL (oxybutynin ext-rel), Myrbetriq (mirabegron ext-rel), and Toviaz (fesoterodine ext-rel).

Will Not Be Covered after 10/1/2019:

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
Brand Agents:			
AcipHex (rabeprazole) oral delayed-release tablet	Gastrointestinal/ Proton Pump Inhibitors	AcipHex is indicated in adults for: • Healing of erosive or ulcerative gastroesophageal reflux disease (GERD) • Maintenance of healing of erosive or ulcerative GERD • Treatment of symptomatic GERD • Healing of duodenal ulcers • Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence • Treatment of pathological hypersecretory conditions, including Zollinger-Ellison Syndrome In adolescent patients 12 years of age and older for: • Short-term treatment of symptomatic GERD.	Availability of other proton pump inhibitors for the acute or maintenance treatment of gastroesophageal disease (GERD), duodenal ulcers, and hypersecretory conditions. Preferred generic options include esomeprazole delayed-rel, lansoprazole delayed-rel, omeprazole delayed-rel, pantoprazole delayed-rel.
AcipHex Sprinkle (rabeprazole) oral delayed-release sprinkle capsule	Gastrointestinal/ Proton Pump Inhibitors	AcipHex Sprinkle is indicated for the treatment of gastroesophageal reflux disease (GERD) in pediatric patients 1 to 11 years of age.	Availability of other proton pump inhibitors for the treatment of gastroesophageal reflux disease (GERD) in children ages 1 to 11 years.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
			Preferred generic options include esomeprazole delayed-rel, lansoprazole delayed-rel, omeprazole delayed-rel, pantoprazole delayed-rel.
Baraclude tablet (entecavir) oral tablet	Anti-Infectives/ Antivirals/ Hepatitis Agents/ Hepatitis B	Baraclude is indicated for the treatment of chronic hepatitis B virus (HBV) infection in adults and children at least 2 years of age with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.	Availability of other options for the treatment of chronic hepatitis B virus (HBV) infection. Preferred options include entecavir tablet, lamivudine, Baraclude solution (entecavir solution), and Vemlidy (tenofovir alafenamide).
Beyaz (ethinyl estradiol-drospirenone-levomefolate) oral tablet	Endocrine and Metabolic/ Contraceptives/ Monophasic/ 20 mcg Estrogen	Beyaz is indicated for use by women to: • Prevent pregnancy • Treat symptoms of premenstrual dysphoric disorder (PMDD) for women who choose to use an oral contraceptive for contraception • Treat moderate acne for women at least 14 years old only if the patient desires an oral contraceptive for birth control • Raise folate levels in women who choose to use an oral contraceptive for contraception.	Availability of other oral contraceptive options for preventing pregnancy, treating premenstrual dysphoric disorder, treating moderate acne, and raising folate levels. Preferred options include desogestrel/EE 0.15/30, drospirenone/EE 3/20, drospirenone/EE 3/30, drospirenone/EE/levomefolate 3/20 and levomefolate, drospirenone/EE/levomefolate 3/30 and levomefolate, ethynodiol diacetate/EE 1/35 - Zovia 1/35, levonorgestrel/EE 0.1/20 – Lessina, levonorgestrel/EE 0.15/30 – Levora, norethindrone acetate/EE 1/20, norethindrone acetate/EE 1/20 and iron, norethindrone acetate/EE 1/20 and iron chewable, norethindrone acetate/EE 1.5/30, norethindrone acetate/EE 1.5/30 and iron, norethindrone/EE 0.5/35, norethindrone/EE 1/35, norgestimate/EE 0.25/35, norgestrel/EE 0.3/30 - Low-Ogestrel, Loestrin 1/20 (norethindrone acetate/EE 1/20), Loestrin 1.5/30 (norethindrone acetate/EE 1.5/30), Loestrin Fe 1/20 (norethindrone acetate/EE 1/20 and iron), Loestrin Fe 1.5/30 (norethindrone acetate/EE 1.5/30 and iron), Ortho-Cyclen (norgestimate/EE 0.25/35), Ortho-Novum 1/35 (norethindrone/EE 1/35), Safyral (drospirenone/EE/levomefolate 3/30 and levomefolate), and Yasmin (drospirenone/EE 3/30).
Cialis (tadalafil) oral tablet	Genitourinary/ Erectile Dysfunction/	Cialis is indicated for the treatment of: • Erectile dysfunction (ED)	Availability of generic phosphodiesterase inhibitor options. Preferred options include sildenafil and tadalafil.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
	Phosphodiesterase Inhibitors	• The signs and symptoms of benign prostatic hyperplasia (BPH) • ED and the signs and symptoms of BPH (ED/BPH).	
Colcrys (colchicine) oral tablet	Analgesics/ Gout	Colcrys is indicated for: • Prophylaxis and treatment of gout flares in adults • Familial Mediterranean fever (FMF) in adults and children 4 years or older.	Availability of a generic option for the prophylaxis and treatment of gout and Familial Mediterranean fever (FMF). The preferred option is the colchicine tablet.
Coumadin (warfarin) oral tablet	Hematologic/ Anticoagulants/ Oral	Coumadin is indicated for: • Prophylaxis and treatment of venous thrombosis and its extension, pulmonary embolism • Prophylaxis and treatment of thromboembolic complications associated with atrial fibrillation and/or cardiac valve replacement • Reduction in the risk of death, recurrent myocardial infarction, and thromboembolic events such as stroke or systemic embolization after myocardial infarction.	Availability of a generic oral anticoagulant for the prevention and/or treatment of clots. The preferred option is warfarin.
Evekeo (amphetamine sulfate) oral tablet	Central Nervous System/ Attention Deficit Hyperactivity Disorder	Evekeo is indicated for: • Narcolepsy • Attention deficit disorder with hyperactivity as an integral part of a total treatment program which typically includes other remedial measures (psychological, educational, social) for a stabilizing effect in children with behavioral syndrome characterized by the following group of developmentally inappropriate symptoms: moderate to severe distractibility, short	Availability of other amphetamine options. Preferred options include amphetamine-dextroamphetamine mixed salts, dexmethylphenidate, dextroamphetamine, methylphenidate, Focalin (dexmethylphenidate), Methylin (methylphenidate), and Ritalin (methylphenidate).

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
		attention span, hyperactivity, emotional lability, and impulsivity • Exogenous obesity as a short term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction for patients refractory to alternative therapy (e.g., repeated diets, group programs, and other drugs).	
Finacea Gel (azelaic acid) topical gel	Topical/ Dermatology/ Rosacea	Finacea Gel is indicated for topical treatment of inflammatory papules and pustules of mild to moderate rosacea.	Availability of other topical options for the treatment of rosacea. Preferred options include azelaic acid gel, metronidazole crm 0.75%, metronidazole gel 0.75%, metronidazole gel 1%, metronidazole lotion 0.75%, Finacea foam (azelaic acid foam), Metrocream (metronidazole crm 0.75%), Metrogel (metronidazole gel 1%), Metrolotion (metronidazole lotion 0.75%), and Soolantra (ivermectin).
Lamictal (lamotrigine) oral chewable tablet, oral tablet	Central Nervous System/ Anticonvulsants	Lamictal is indicated for: • Epilepsy—adjunctive therapy in patients aged 2 years and older: ○ Partial-onset seizures ○ Primary generalized tonic-clonic seizures ○ Generalized seizures of Lennox-Gastaut syndrome • Epilepsy—monotherapy in patients aged 16 years and older: ○ Conversion to monotherapy in patients with partial-onset seizures who are receiving treatment with carbamazepine, phenytoin, phenobarbital, primidone, or valproate as the single AED • Bipolar disorder: ○ Maintenance treatment of bipolar I disorder to delay the	Availability of other anticonvulsant options. Preferred options include carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, gabapentin, lamotrigine, lamotrigine ext-rel, levetiracetam, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, primidone, tiagabine, topiramate, valproic acid, zonisamide, FYCOMPA, OXTELLAR XR, VIMPAT.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
		time to occurrence of mood episodes in patients treated for acute mood episodes with standard therapy.	
Lamictal ODT (lamotrigine) orally disintegrating tablet	Central Nervous System/ Anticonvulsants	Lamictal ODT is indicated for: • Epilepsy—adjunctive therapy in patients aged 2 years and older: ○ Partial-onset seizures ○ Primary generalized tonic-clonic seizures ○ Generalized seizures of Lennox-Gastaut syndrome • Epilepsy—monotherapy in patients aged 16 years and older: ○ Conversion to monotherapy in patients with partial-onset seizures who are receiving treatment with carbamazepine, phenytoin, phenobarbital, primidone, or valproate as the single AED • Bipolar disorder: ○ Maintenance treatment of bipolar I disorder to delay the time to occurrence of mood episodes in patients treated for acute mood episodes with standard therapy.	Availability of other anticonvulsant options. Preferred options include carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, gabapentin, lamotrigine, lamotrigine ext-rel, levetiracetam, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, primidone, tiagabine, topiramate, valproic acid, zonisamide, FYCOMPA, OXTELLAR XR, VIMPAT.
Lamictal XR (lamotrigine) oral extended-release tablet	Central Nervous System/ Anticonvulsants	Lamictal XR is indicated for: • Adjunctive therapy for primary generalized tonic-clonic seizures and partial-onset seizures with or without secondary generalization in patients aged 13 years and older • Conversion to monotherapy in patients aged 13 years and older with partial-onset seizures who are	Availability of other anticonvulsant options. Preferred options include carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, gabapentin, lamotrigine, lamotrigine ext-rel, levetiracetam, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, primidone, tiagabine, topiramate, valproic acid, zonisamide, FYCOMPA, OXTELLAR XR, VIMPAT.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
		receiving treatment with a single AED.	
Lexapro (escitalopram) oral tablet	Central Nervous System/ Antidepressants/ Selective Serotonin Reuptake Inhibitors (SSRIs)	Lexapro is indicated for: • Acute and maintenance treatment of major depressive disorder (MDD) in adults and adolescents aged 12-17 years • Acute treatment of generalized anxiety disorder (GAD) in adults.	Availability of other options for the treatment of major depressive disorder (MDD) and generalized anxiety disorder (GAD). Preferred generic options include citalopram, escitalopram, fluoxetine, fluoxetine 60 mg, paroxetine HCl, paroxetine HCl ext-rel, sertraline.
Lialda (mesalamine) oral delayed-release tablet	Gastrointestinal/ Inflammatory Bowel Disease/ Oral Agents	Lialda is indicated for the induction of remission in adults with active, mild to moderate ulcerative colitis and for the maintenance of remission of ulcerative colitis.	Availability of other options for the induction of remission in patients with active, mild to moderate ulcerative colitis and for the maintenance of remission of ulcerative colitis. The preferred options include balsalazide, mesalamine delayed-rel tabs, sulfasalazine, sulfasalazine delayed-rel, Apriso (mesalamine ext-rel caps), Azulfidine (sulfasalazine), Azulfidine EN-tabs (sulfasalazine delayed-rel), and Pentasa (mesalamine ext-rel caps).
Minastrin 24 FE (ethinyl estradiol-norethindrone acetate-iron) oral chewable tablet	Endocrine and Metabolic/ Contraceptives/ Monophasic	Minastrin 24 FE is indicated for use by women to prevent pregnancy.	Availability of other monophasic oral contraceptive options. Preferred options include desogestrel/EE 0.15/30, drospirenone/EE 3/20, drospirenone/EE 3/30, drospirenone/EE/levomefolate 3/20 and levomefolate, drospirenone/EE/levomefolate 3/30 and levomefolate, ethynodiol diacetate/EE 1/35 - Zovia 1/35, levonorgestrel/EE 0.1/20 – Lessina, levonorgestrel/EE 0.15/30 – Levora, norethindrone acetate/EE 1/20, norethindrone acetate/EE 1/20 and iron, norethindrone acetate/EE 1/20 and iron chewable, norethindrone acetate/EE 1.5/30, norethindrone acetate/EE 1.5/30 and iron, norethindrone/EE 0.5/35, norethindrone/EE 1/35, norgestimate/EE 0.25/35, norgestrel/EE 0.3/30 - Low-Ogestrel, Loestrin 1/20 (norethindrone acetate/EE 1/20), Loestrin 1.5/30 (norethindrone acetate/EE 1.5/30), Loestrin Fe 1/20 (norethindrone acetate/EE 1/20 and iron), Loestrin Fe 1.5/30 (norethindrone acetate/EE 1.5/30 and iron), Ortho-Cyclen (norgestimate/EE 0.25/35), Ortho-Novum 1/35 (norethindrone/EE 1/35), Safyral

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
			(drospirenone/EE/levomefolate 3/30 and levomefolate), and Yasmin (drospirenone/EE 3/30).
Minivelle (estradiol) transdermal patch	Endocrine and Metabolic/ Estrogens/ Transdermal	Minivelle is indicated for the treatment of moderate to severe vasomotor symptoms due to menopause and prevention of postmenopausal osteoporosis.	Availability of other options for the treatment of vasomotor symptoms associated with menopause. Preferred options include estradiol, Climara (estradiol), Divigel (estradiol), and Evamist (estradiol).
Onfi (clobazam) oral suspension, oral tablet	Central Nervous System/ Anticonvulsants	Onfi is indicated for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older.	Availability of other anticonvulsant options for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome. Preferred options include clobazam, lamotrigine, topiramate, and topiramate ext-rel.
Ortho Tri-Cyclen Lo (ethinyl estradiol-norgestimate) oral tablet	Endocrine and Metabolic/ Contraceptives/ Triphasic	Ortho Tri-Cyclen Lo is indicated for use by women to prevent pregnancy.	Availability of other triphasic oral contraceptive options. Preferred options include desogestrel/EE, levonorgestrel/EE – Trivora, norethindrone/EE, norgestimate/EE, Ortho-Novum 7/7/7 (norethindrone/EE), Ortho Tri-Cyclen (norgestimate/EE), and Tri-Norinyl (norethindrone/EE).
Percocet (oxycodone-acetaminophen) oral tablet	Analgesics/ Opioid Analgesics	Percocet is indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate.	Availability of other options for pain management. Preferred options include codeine/acetaminophen, hydrocodone-acetaminophen, hydromorphone, morphine, oxycodone caps and tabs 5 mg, oxycodone concentrate 20 mg/mL, oxycodone tabs 15 mg and 30 mg, oxycodone solution 5 mg/5mL, oxycodone-acetaminophen 5/325, oxycodone-acetaminophen soln, Dilaudid (hydromorphone), Norco (hydrocodone-acetaminophen), Nucynta (tapentadol), Roxicet (oxycodone-acetaminophen soln), and Roxicodone (oxycodone tabs 15 mg, 30 mg, soln 5mg/5mL).
PreviDent 5000 Plus (sodium fluoride) dental cream	Topical/ Mouth /Throat/ Dental Agents/ Miscellaneous	PreviDent 5000 Plus is used as a dental caries preventive in adult and pediatric patients.	Availability of other options for dental caries prevention. Consult doctor for preferred options on the Prescribing Guide – Standard Control.
PreviDent Gel (sodium fluoride) dental gel	Topical/ Mouth /Throat/ Dental Agents/ Miscellaneous	PreviDent Gel is used as a dental caries preventive in adult and pediatric patients.	Availability of other options for dental caries prevention. Consult doctor.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
PreviDent 5000 Booster Plus (sodium fluoride) dental paste	Topical/ Mouth /Throat/ Dental Agents/ Miscellaneous	PreviDent 5000 Booster Plus is used as a dental caries preventive in adult and pediatric patients.	Availability of other options for dental caries prevention. Consult doctor.
PreviDent 5000 Sensitive (sodium fluoride-potassium nitrate) dental paste	Topical/ Mouth /Throat/ Dental Agents/ Miscellaneous	PreviDent 5000 Sensitive is a dental caries preventive and sensitive teeth toothpaste.	Availability of other options for dental caries prevention. Consult doctor.
PreviDent Rinse (sodium fluoride) oral solution	Topical/ Mouth /Throat/ Dental Agents/ Miscellaneous	PreviDent Rinse is used as a dental caries preventive in adult and pediatric patients.	Availability of other options for dental caries prevention. Consult doctor.
Pristiq (desvenlafaxine) oral extended-release tablet	Central Nervous System/ Antidepressants/ Selective Norepinephrine Reuptake Inhibitors (SNRIs)	Pristiq is indicated for the treatment of adults with major depressive disorder (MDD).	Availability of generic options for the treatment of major depressive disorder. Preferred options include desvenlafaxine ext-rel, duloxetine delayed-rel, venlafaxine, and venlafaxine ext-rel capsule.
Prozac (fluoxetine) oral capsule	Central Nervous System/ Antidepressants/ Selective Serotonin Reuptake Inhibitors (SSRIs)	Prozac is indicated for: • Acute and maintenance treatment of major depressive disorder (MDD) • Acute and maintenance treatment of obsessive compulsive disorder (OCD) • Acute and maintenance treatment of bulimia nervosa • Acute treatment of panic disorder, with or without agoraphobia.	Availability of other options for the treatment of major depressive disorder (MDD), obsessive compulsive disorder (OCD), bulimia nervosa, and panic disorder. Preferred generic options include citalopram, escitalopram, fluoxetine, fluoxetine 60 mg, paroxetine HCl, paroxetine HCl ext-rel, sertraline.
Rapaflo (silodosin) oral capsule	Genitourinary/ Benign Prostatic Hyperplasia	Rapaflo is indicated for the treatment of the signs and symptoms of benign prostatic hyperplasia (BPH).	Availability of other options for the treatment of benign prostatic hyperplasia (BPH). Preferred options include alfuzosin ext-rel, doxazosin, silodosin, tamsulosin, terazosin, Cardura (doxazosin), and Flomax (tamsulosin).
Sabril (vigabatrin) oral powder for solution, oral tablet	Central Nervous System/ Anticonvulsants	Sabril is indicated for the treatment of: • Refractory complex partial seizures as adjunctive therapy in patients	Availability of a generic option for treatment of refractory complex partial seizures and infantile spasms.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
		≥10 years of age who have responded inadequately to several alternative treatments • Infantile spasms - monotherapy in infants 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss.	The preferred option is vigabatrin.
Singulair (montelukast) oral chewable tablet, oral granules, oral tablet	Respiratory/ Leukotriene Modulators	Singulair is indicated for: • Prophylaxis and chronic treatment of asthma in patients 12 months of age and older • Acute prevention of exercise-induced bronchoconstriction (EIB) in patients 6 years of age and older • Relief of symptoms of allergic rhinitis (AR): seasonal allergic rhinitis (SAR) in patients 2 years of age and older, and perennial allergic rhinitis (PAR) in patients 6 months of age and older.	Availability of generic options for the asthma, exercise-induced bronchoconstriction, and allergic rhinitis. Preferred options include montelukast, zafirlukast, and zileuton ext-rel.
Suboxone (buprenorphine-naloxone) sublingual film	Central Nervous System/ Psychotherapeutic – Miscellaneous/ Partial Opioid Agonist / Opioid Antagonist Combinations	Suboxone is indicated for treatment of opioid dependence.	Availability of other options for the treatment of opioid dependence. Preferred options include buprenorphine-naloxone sublingual tablet, buprenorphine-naloxone sublingual film, and Zubsolv (buprenorphine-naloxone sublingual tablet).
Toprol-XL (metoprolol succinate) oral extended-release tablet	Cardiovascular/ Beta-Blockers	Toprol XL is indicated for the treatment of: • Hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and non-fatal cardiovascular events, primarily strokes and myocardial infarctions • Angina Pectoris	Availability of other beta-blocker options for various heart conditions. Preferred generic options include atenolol, bisoprolol, carvedilol, carvedilol phosphate ext-rel, labetalol, metoprolol succinate ext-rel, metoprolol tartrate, nadolol, pindolol, propranolol, propranolol ext-rel.

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
		• Heart Failure - for the treatment of stable, symptomatic (NYHA Class II or III) heart failure of ischemic, hypertensive, or cardiomyopathic origin.	
Vivelle-Dot (estradiol) transdermal patch	Endocrine and Metabolic/ Estrogens/ Transdermal	Vivelle-Dot is indicated for: • Treatment of moderate to severe vasomotor symptoms due to menopause • Treatment of moderate to severe symptoms of vulvar and vaginal atrophy due to menopause.	Availability of other options for the treatment of vasomotor symptoms associated with menopause. Preferred options include estradiol, Climara (estradiol), Divigel (estradiol), and Evamist (estradiol).
Xanax (alprazolam) oral tablet	Central Nervous System/ Antianxiety/ Benzodiazepines	Xanax is indicated for: • Management of anxiety disorder or the short-term relief of symptoms of anxiety • Treatment of panic disorder, with or without agoraphobia.	Availability of other options for the management of anxiety or panic disorder. Preferred options include alprazolam, clonazepam, diazepam, lorazepam, oxazepam, Ativan (lorazepam), Klonopin (clonazepam), and Valium (diazepam).
Xanax XR (alprazolam) oral extended-release tablet	Central Nervous System/ Antianxiety/ Benzodiazepines	Xanax XR is indicated for the treatment of panic disorder, with or without agoraphobia.	Availability of other options for the management of panic disorder. Preferred options include alprazolam, clonazepam, diazepam, lorazepam, oxazepam, Ativan (lorazepam), Klonopin (clonazepam), and Valium (diazepam).
YAZ (ethinyl estradiol-drospirenone) oral tablet	Endocrine and Metabolic/ Contraceptives/ Monophasic	YAZ is indicated for use by women to: • Prevent pregnancy • Treat symptoms of premenstrual dysphoric disorder (PMDD) for women who choose to use an oral contraceptive for contraception • Treat moderate acne for women at least 14 years old only if the patient desires an oral contraceptive for birth control.	Availability of other oral contraceptive options for preventing pregnancy, treating premenstrual dysphoric disorder, and treating moderate acne. Preferred options include desogestrel/EE 0.15/30, drospirenone/EE 3/20, drospirenone/EE 3/30, drospirenone/EE/levomefolate 3/20 and levomefolate, drospirenone/EE/levomefolate 3/30 and levomefolate, ethynodiol diacetate/EE 1/35 - Zovia 1/35, levonorgestrel/EE 0.1/20 – Lessina, levonorgestrel/EE 0.15/30 – Levora, norethindrone acetate/EE 1/20, norethindrone acetate/EE 1/20 and iron, norethindrone acetate/EE 1/20 and iron chewable, norethindrone acetate/EE 1.5/30, norethindrone acetate/EE

Product	Therapeutic Category/ Subcategory	Indication	Options/Comments
			1.5/30 and iron, norethindrone/EE 0.5/35, norethindrone/EE 1/35, norgestimate/EE 0.25/35, norgestrel/EE 0.3/30 - Low-Ogestrel, Loestrin 1/20 (norethindrone acetate/EE 1/20), Loestrin 1.5/30 (norethindrone acetate/EE 1.5/30), Loestrin Fe 1/20 (norethindrone acetate/EE 1/20 and iron), Loestrin Fe 1.5/30 (norethindrone acetate/EE 1.5/30 and iron), Ortho-Cyclen (norgestimate/EE 0.25/35), Ortho-Novum 1/35 (norethindrone/EE 1/35), Safyral (drospirenone/EE/levomefolate 3/30 and levomefolate), and Yasmin (drospirenone/EE 3/30).
Generic Agents:			
mupirocin cream topical cream	Topical/ Dermatology/ Antibiotics	Mupirocin cream is indicated for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm in area) due to susceptible isolates of *Staphylococcus aureus* and *Streptococcus pyogenes*.	Availability of generic topical antibiotics. Preferred options include gentamicin and mupirocin ointment.

How to tell if a Blue Cross and Blue Shield plan is self-funded or insured

During the 2019 Regular Session, the Arkansas General Assembly enacted Act 706, which requires health payers to issue identification cards to members that provide an indication of whether the member's health benefit plan is insured or self-funded.

Identification cards issued by Arkansas Blue Cross and Blue Shield, Health Advantage and other Blue Cross or Blue Shield health plans satisfy the Act 706 requirements. If the health plan is self-funded by an employer group, the reverse side of the member's ID card will contain the statement: "[Name of Blue Cross and Blue Shield Plan] provides administrative services and does not assume any financial risk for claims." If this statement does **not** appear on the identification card, the health benefit plan is insured by the Blue Cross and Blue Shield Plan named on the front of the card.

Medical specialty prior approval medications 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. ASE/PSE and Medicare are not included in this prior approval (PA) program. 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.

Drug	Indication	Benefit
Aldurazyme	MPS I	Medical
(laronidase)	Hurler syndrome	

Drug	Indication	Benefit
Berinert	Hereditary angioedema	Medical
(c1 esterase, inhib, human)		
Brineura	CLN2 disease	Medical
(ceroliponase alfa)		
Cablivi	Thrombocytic thrombocytopenia	Medical & Pharmacy
(caplacizumab-yhdp)		
Cinqair	Severe asthma	Medical
(reslizumab)		
Cinryze	Hereditary angioedema	Medical
(c1 Esterase, inhib, human)		
Crysvita	hypophosphatemia	Pharmacy
(burosumab - twza)		
Duopa	Parkinson's	Medical
(levodopa-carpidopa intestinal		
Elaprase	MPS II	Medical
(idursulfase)	Hunter syndrome	
Elzonris	BPDCN	Medical
(tagraxifusp-erzs)		
Evenity	Severe Osteoporosis	Medical
(romosozumab-aqqg)		

Drug	Indication	Benefit
Fasenra	Hereditary angioedema	Medical
(benralizumab)		
Firazyr	Hereditary angioedema	Pharmacy
(icatabant acetate)		
Gamifant	HLH	Medical
(emapalumab-lzsg)		
Haegarda	Hereditary angioedema	Pharmacy
(c1 esterase, inhib, human)		
Kalbitor	Hereditary angioedema	Pharmacy
(ecallantide)		
Krystexxa	Gout	Medical
(pegloticase)		
Kymriah	Cancers	Medical
(tisagenlecleucel)		*Reviewed by transplant coordinator
Lemtrada	Multiple Sclerosis	Medical
(alemtuzumab)		
Lutathera	Neuroendocrine tumors	Medical
(lutetium Lu 177 Dotatate)		
Mepsevii	MPS VII	Medical

Drug	Indication	Benefit
(vestronidase-Alfa)	Sly syndrome	
Myalept	Lipodystrophy	Pharmacy
(metreleptin)		
Nagalzyme	MPS VI	Medical
(galsulfase)	Maroteaux-Lamy syndrome	
Nucala	Mod to severe asthma	Pharmacy
(mepolizumab)		
Ruconest	Hereditary angioedema	Medical
(c1 esterase, inhib, recombinant		
Soliris	PNH	Medical
(eculizumab)	aHUS	
	Myasthenia Gravis	
	NMOSD	
Spinraza	Spinal muscle atrophy	Medical
(nusinersen)		
Strensiq	Hypophosphatasia	Pharmacy
(asfotase alfa)		
Takhzyro	Hereditary angioedema	Pharmacy
(lanadelumab-flyo)		
Ultomiris	PNH	Medical

Drug	Indication	Benefit
(ravulizumab-cwyz)		
Vimizim	MPS IV	Medical
(elosulfase alfa)	Morquio A	
Yescarta	Cancers	Medical
(axicabtagene ciloleucel)		*Reviewed by transplant coordinator
Xolair	Mod to severe asthma	Pharmacy
(omalizumab)	Urticaria	
Zolgensma	Spinal muscle atrophy	Medical
(onasmnogene abeparvovec-XIOI)		
Zulresso	Postpartum depression	Medical
(brexanolone)		

For more information on how to submit a request for prior approval of one of these medications, call the appropriate customer service phone number on the back of the member ID card.

Customer service will direct callers to the prior approval form specific to the member's group. BlueAdvantage members can find the form at the following link: https://www.blueadvantagearkansas.com/providers/forms.aspx.

For all other members, the appropriate prior approval form can be found at the following link: https://www.arkansasbluecross.com/providers/resource-center/provider-forms.

These forms and any additional documentation should be faxed to 501-378-7051 for BlueAdvantage members. For all other members, the appropriate fax number is 501-378-6647.

Network opt-out revision

Providers have been able to opt out of participating in the individual metallic programs (Arkansas Works, PPO Exchange) that use the True Blue PPO provider network while remaining in the commercial business that uses the True Blue PPO, and that is not changing. In addition, beginning September 1, 2019, providers licensed in Arkansas can opt out of the True Blue PPO commercial business, yet stay in the individual metallic programs.

Providers should fully understand that the commercial business using the True Blue PPO network includes all Arkansas Blue Cross fully insured PPO business, most of the self-insured PPO employer groups and the Federal Employee Program. True Blue PPO business is the largest commercial block of business affiliated with Arkansas Blue Cross and its family of companies.

In order to opt out of commercial True Blue PPO business, Arkansas licensed providers must send written correspondence on the provider's clinic or facility letterhead with the instruction to opt out of the commercial True Blue PPO business yet remain in the individual metallic program. These documents should be attached to email and sent to ProviderNetwork@arkbluecross.com.

Network terms & conditions changes

Revision to the notice of Network Terms and Conditions for all networks sponsored by Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation dba Preferred Provider Networks of Arkansas

Effective July 1, 2019, the Network Terms and Conditions of participation applicable to all individual network participants and applicants for the Arkansas Blue Cross and Blue Shield Preferred Payment Plan network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage PFFS network, Arkansas Blue Cross and Blue Shield Medi-Pak® Advantage LPPO network, Health Advantage Medi-Pak® Advantage HMO network, Preferred Provider Networks' Arkansas' FirstSource® PPO network, Preferred Provider Networks' True Blue PPO network, and Health Advantage HMO network (collectively, the "Networks") have been revised as indicated below:

II. Re-Application after Termination from the Networks:

This section has been revised to include:

(f) Exclusions Based on Malpractice Claims or Moving Practice Locations:

"If a provider is excluded from the networks on the basis of the provider's malpractice history or the number or nature of the provider's practice location moves, such excluded provider shall be ineligible to participate or re-apply for participation in the networks for a period of three years from the date of the networks' final denial or

termination notice (a "final" notice meaning the last letter of denial or termination issued in response to any written request or appeal, or series of requests/appeals, of the practitioner or of any representative of the practitioner acting on the practitioner's behalf)."

IX. Malpractice Claims:

The wording of this term and condition is revised to read:

"The Networks' credentialing standards have always taken malpractice claims into account in evaluating providers for initial and ongoing credentialing for participation in the Networks. Providers have been and will continue to be subject to exclusion based on their malpractice history. In looking at malpractice history, the Networks reserve the right to exclude a provider based on the number of cases filed against a provider, the types of cases filed, the amount of any settlement made on behalf of the provider, as well as any combination of the preceding factors or any other factors that appear relevant to evaluating the provider's degree of culpability or responsibility for alleged harm to a patient. The Networks shall be entitled to exclude a provider based on their assessment of the provider's malpractice background, regardless of whether some or all claims have been dismissed, withdrawn, settled or resolved at trial, i.e., the Networks reserve the right to make an independent judgment regarding whether the provider's conduct, as questioned in the malpractice allegations, was negligent or otherwise culpable so as to disqualify the provider from network participation."

X. Moving Practice Locations:

A. General Standard:

The wording of this term and condition is revised to read:

"Because providers with competency, quality or other problems arising in one location sometimes move to another, the Networks reserve the right to take into account how often a provider has moved practice location, and may, in some circumstances, exclude a provider from network participation based on the number or nature of such moves. For purpose of these policies/terms, the phrase "moving" or "moved" in reference to "practice locations" means and includes the following two-part definition (1 and 2):

(1) Changing the physical location at which the provider spends the majority of the provider's weekly work activities from one country to another country, from one state to another state, from one city to another city, or from one county to another county; or

(2) Time spent in the military or medical school or a residency or fellowship program shall not count as a "practice location" except in the following circumstances: (i) any resident who begins a residency program and fails to satisfactorily complete that residency in the original location shall be deemed to have moved practice locations upon entering into any subsequent residency program in a different country, state or city; and (ii) any discharge, termination or other cessation of a military medical position that is involuntary or dishonorable shall be deemed a move of practice location (and may also independently disqualify such provider from participation in the Networks, depending on the nature of the discharge, termination or other cessation of a military medical position)."

B. ***Locum Tenens*** **Exception**

The wording of this term and condition is revised to read:

"The Networks may, in appropriate cases, recognize an exception for certain providers whose frequent moves are attributable solely to participation in a bona fide *locum tenens* program(s), and are shown not to be related to any licensing, malpractice, hospital privileging, peer review or other practice issues, disciplinary actions or efforts to escape an adverse or unfavorable practice history. In order to qualify for a *locum tenens* exception, a provider must meet the following criteria:

(a) Demonstrate a clean credentialing and practice history not marred by *any* (i) disciplinary or licensing actions or sanctions of any kind, including but not limited to any reprimands, fines, penalties, CME requirements, Medical Board or other disciplinary agency appearances, physician health committee participation (or similar program for non-physicians); or (ii) problems of any kind with hospital privileges; or (iii) peer review actions, citations or findings, including but not limited to any peer review investigations opened but not concluded for any reason (including voluntary surrender of privileges or other practice prerogatives while under investigation; and

(b) Demonstrate a clean practice history not marred by *any* problems with the provider's participation in any government program, including but not limited to Medicare and Medicaid, whether or not such problems have been resolved (e.g., a temporary suspension; and

(c) Demonstrate that *no* malpractice lawsuits have been filed against provider (regardless of whether such lawsuits were later voluntarily withdrawn, dismissed or judgment was entered in favor of the provider) during the past five years, and that no lawsuit is now pending; and

(d) Provide evidence satisfactory to the Networks that each practice location move that counts toward the minimal disqualification in subsection (B), above, was made as part of a bona fide *locum tenens* program(s) in which the provider's exclusive practice activity for the time periods in question was devoted to providing health care services on a temporary basis only, with no intention by either the provider or the employing or compensating person or entity that the provider would establish a permanent residence or practice within the community; and

(e) Provide evidence satisfactory to the Networks that for each *locum tenens* practice location of provider within the past five years, provider is eligible to return to such practice location, i.e., that the clinic, facility, practice, employer or payer for each such *locum tenens* location will verify that provider is eligible for re-hire or return without conditions; and

(f) Provide references (that are deemed satisfactory in the discretion of the Networks) from provider's supervisor at each of the five most recent *locum tenens* practice locations."

XIV. Hospital Privileges

B. Ineligibility Period and Conditions for Re-Application

The wording of this term and condition is revised to read:

"If a hospital privileges action (whether a denial, termination, limitation, suspension or voluntary or involuntary surrender of privileges) is deemed by the networks as sufficiently egregious or significant to justify network exclusion, that action shall, by itself, render the affected practitioner ineligible for network participation (or consideration for network participation) for a minimum period of four years. After four years have expired from the date of a hospital privileges action, the affected practitioner shall no longer be deemed ineligible for consideration for network participation, based solely on the privileges action, provided the criteria set forth below are met when the affected practitioner's network status or application is reviewed by the networks and their credentialing or appeals committees.

With respect to any practitioner whose network participation is denied or terminated on the basis of a hospital privileges action that occurred less than four years prior to the date of the denial or termination and involved questions of competency or fitness, or the quality of services rendered, such practitioners shall be ineligible to participate or re-apply for participation in the networks for a period of four years from the date of the hospital privileges action. Notwithstanding the preceding sentence, if (i) a past hospital privileges action is renounced or withdrawn in writing by the hospital that took the action under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or, (ii) if the hospital that took the privileges action reinstates the practitioner to full privileges without restrictions or conditions of any kind under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or (iii) if a court of competent jurisdiction overturns the hospital privileges action in a final judgment not subject to further challenge/appeal by the hospital, then in such circumstances, the four-year ineligibility period shall expire upon presentation by the practitioner of sufficient documentation of the occurrence of such events. Practitioners claiming early expiration of a four-year ineligibility period on any of the above-referenced grounds must, in order to regain eligibility on such bases, fully respond to all inquiries of the networks regarding such circumstances, including but not limited to, supplying the networks with complete documentation of any court proceedings, hospital peer review process and related records and communications.

Upon expiration of any four-year ineligibility period referenced above, a practitioner to which it applied shall become eligible to be considered by the networks' Credentialing Committee if and only if the following additional conditions are met:

1. No other hospital privileges actions of any kind have been taken against the practitioner during the six-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date of a final credentialing/appeals decision); and

2. No other hospital privileges actions of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and

3. The practitioner has not been subject during the six-year period immediately prior to the date that application is submitted to the networks (or at any time thereafter up to the date of a final credentialing/appeals decision) to any actions or required appearances before the Arkansas State Medical Board or any equivalent licensing or disciplinary board, committee or entity in Arkansas or in any other jurisdiction; and

4. No such Medical Board (or equivalent licensing or disciplinary board or entity) actions or required appearances of any kind not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and

5. No malpractice lawsuits not previously known to the networks, and not considered in the original network denial or termination decision, have since been discovered; and

6. The practitioner must not be disqualified by any other network standard, term or condition, including but not limited to the networks' published credentialing standards, terms and conditions of network participation, or network participation agreements.

Please note that satisfaction of the preceding seven conditions will not automatically qualify the practitioner for network admission, but will render a practitioner formerly ineligible due to a past hospital privileges issue, eligible to be considered by the Credentialing Committee. The Credentialing Committee still must find, based on all the circumstances presented at the time of re-application, that the practitioner is qualified under applicable credentialing standards, and in doing so will consider whether past quality or safety questions or issues, including any hospital privileges issues, have been adequately addressed and resolved. The Credentialing Committee may take into account all factors deemed relevant in this respect by the Committee, which may include but shall not be limited to (i) whether the practitioner has undergone any additional education, training or remediation of any kind; and (ii) whether the practitioner has cooperated with the peer review process or requirements of the hospital that took the adverse privileges action; and (iii) whether the practitioner has unrestricted privileges at any hospital.

With respect to hospital privileges actions not involving questions of competency or fitness of a practitioner, or the quality of any services rendered (e.g., non-habitual tardiness in completing medical records or charts, or willingness to sign up for call rotation), the affected practitioner shall be ineligible to participate in or re-apply for participation in the networks for one year from the date that the hospital privileges action is taken, unless, in the interim, the hospital renounces or withdraws the privileges action, or unless, in the interim, the hospital reinstates the affected practitioner to full hospital privileges without restrictions or conditions of any kind, or unless a court of competent jurisdiction overturns the hospital privileges action.

Special Note on Failure to Notify Networks of Privileges Actions:

Notwithstanding any of the preceding provisions regarding the ineligibility period or conditions for re-application, if a practitioner who is subject to the terms of a network participation agreement is subjected to any hospital privileges action but fails to furnish written notice of the same to the networks within the time frame specified in the network participation agreement(s), such practitioner shall be ineligible to participate in the

network or to re-apply for participation in the networks for three years from the date that the networks learn of any such hospital privileges action, dated from the date of the networks' rejection or termination letter citing the hospital privileges action. For avoidance of doubt, the three-year ineligibility period referenced in this paragraph shall apply regardless of whether, in the intervening time between occurrence of the privileges action and its discovery by the networks, privileges have been fully restored without restrictions or conditions (unless privileges are restored based on the hospital renouncing or withdrawing the privileges action under circumstances clearly indicating that the hospital no longer maintains that the practitioner has any competency, fitness or quality deficiency or issue of any kind, or unless a court of competent jurisdiction overturns the hospital privileges action in a final judgment not subject to further challenge/appeal by the hospital)."

New telemedicine credentialing standards

Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation dba Preferred Provider Networks of Arkansas (collectively, the "Networks") have recently implemented the Networks Telemedicine Credentialing Standards and Attestation Form for existing and new providers requesting network participation. As telemedicine services continue to grow throughout the state, the Networks need to be mindful of member safety while ensuring the best quality of service. The new telemedicine requirements and attestation depend upon providers to maintain compliance with the Arkansas State Law (Ark Code Ann § 17-80-118) and Centers for Medicare and Medicaid (CMS) requirements. The standards include the following:

CATEGORY	CREDENTIALING STANDARD
1. TeleSite Review: All Disciplines Required on all Initial credentialing applicants' primary practice location ANY re-credentialing applicants may be selected on a random basis(*)	Performance Scores: 90% -100% - minor deficiencies or no deficiencies. 80% - 89% - recommendations for improvement. Below 80% - FAILURE; ineligible for network participation until passing score is achieved. Corrective Action Plan required for failing score of <80% and/or unmet critical Elements. Note: The foregoing is the process for routine office site review. The Networks reserve the right to take immediate action up to and including declining the request for network participation or possible termination of current network providers for other forms of office deficiencies or problems, including but not limited to member complaints, citations, reports or actions of any governmental agency, or any risk to the health or safety of patients.

	Full credentialing is required at the originating site at which the patient is located and the distant site. If telemedicine practitioner is offering telehealth services for a patient located within hospital or critical access facility, the facility is required to be a Medicare participating facility or have deemed status. The professional or entity at the distant site must be an enrolled Arkansas Medicaid provider. As part of the telesite review process, each practitioner is required to complete the **"Attestation for Recognition of Telemedicine Providers"**.
2. Clinical/Focused Quality Activities	When data is available, the Networks may, upon initial credentialing or re-credentialing, consider the relative quality, or lack thereof, of any services provided by any practitioner. Issues concerning quality of services may be submitted by the Networks for review at any time (not just upon initial credentialing or re-credentialing) by the Credentialing Committee. The Networks may also separately or simultaneously evaluate any quality issues or concerns with respect to any practitioner, and the relative quality, or lack thereof, of any services may be grounds for network participation decisions, including but not limited to denial of participation, termination of participation or limits, restrictions or conditions on network participation.
3. DEA and Arkansas Prescription Monitoring Program	In accordance with Arkansas Regulation 38, Act 887, A.C.A §17-80-117, all practitioners are responsible for complying with all applicable state and federal laws and regulations related to the prescribing and administration of medications. This includes a network requirement (consistent with applicable law) that applicants or current network participants who prescribe or intend to prescribe controlled medications must hold an active Drug Enforcement Agency certificate and Bureau of Narcotics ("BON") certificate (in applicable states) in good standing. In addition, applicants and current network participating practitioners who hold an active DEA certificate must be registered with the Arkansas Prescription Monitoring Program as a condition of network participation. A practitioner whose DEA certificate or Bureau of Narcotics certificate (in applicable states) is subject to any Action (as hereinafter defined) shall lose eligibility to participate in the network for the longer of (a) 365 days or (b) the date that the network determines, in its sole discretion, that the conditions leading to any Action have been appropriately alleviated or redressed by the practitioner and any applicable disciplinary board oversight or monitoring program. For purposes of this standard, "Action" means any voluntary or involuntary surrender, restriction, limitation, suspension or revocation of a DEA or BON certificate, including but not limited to any arrangement whereby the practitioner agrees to a surrender, restriction, limitation, suspension or revocation of the DEA or BON certificate, or any arrangement whereby practitioner's use of the DEA certificate is limited or restricted (voluntarily or involuntarily) in terms of the scope or classifications of medications that may be prescribed, the location(s) or conditions under which the DEA or BON certificate may be utilized to legally prescribe medications, or the length of time that the DEA or BON certificate may be utilized

	without further review or approval from any government agency or disciplinary board or program. Any practitioner whose DEA or BON certificate is subject to any Action must give written notice of the same to the network not later than three business days following the Action, and failure to promptly provide such notice shall, in itself, constitute separate grounds upon which network participation may be denied or terminated. The preceding notwithstanding, the network recognizes one exception under which a practitioner who has been subject to an Action may, in the judgment of the network, remain eligible for network participation and not be excluded from the network as provided in subpart (b), above: if the practitioner is actively enrolled in and fully compliant with all terms of a practitioner health/rehabilitation program that is officially sanctioned and overseen by the practitioner's applicable disciplinary board or agency and such practitioner is (i) otherwise in good standing with the practitioner's applicable disciplinary board or agency; and (ii) otherwise in good standing with all regulatory authorities and state and federal agencies and programs, including but not limited to Medicaid and Medicare; and (iii) otherwise in good standing with the network and in compliance with all other terms and conditions of the practitioner's network participation agreement and network terms and conditions; and (iv) practicing with competence and quality and in a manner that does not pose a risk of harm to the network's members, as determined in the network's sole discretion.
4. Collaborating and Supervisory Physician Agreements Required for APRNs, PAs and certain other practitioners	Certified Nurse Practitioners (CNPs), Clinical Nurse Specialists (CNSs) and Physician Assistants (PAs), collectively referred to as Extender, must hold a certificate of prescriptive authority maintain a Collaborating Practice Agreement, with Quality Assurance Plan, or Physician Assistant Protocol and Delegation of Services Agreement, which meets all the requirements of their respective licensing board, with a collaborating/supervising physician that is currently a participating provider in good standing in the Networks. The collaborating or supervising physician must be skilled and trained in the same scope of practice as the care that will be provided by the CNP, CNM, CNS or PA, i.e., Networks require that the practice specialty or scope of actual practice of the collaborating or supervising physician must match the practice specialty or scope of actual practice in which the CNP, *CNM*, CNS or PA is engaged or intends to engage. The collaborating/supervising physician must be licensed by the state(s) at which they provide services to be a telemedicine practitioner. If at any time the network participation status of the collaborating/supervising physician is terminated, the network participating status of the Extender will also be terminated (unless an acceptable replacement collaborating practice agreement or supervisory agreement, as outlined above, with another participating physician is obtained and in place prior to the termination of the current collaborating/supervising physician).

	Upon request, each Extender shall be obligated to provide a complete copy of the current agreement with the collaborating/supervising physician to the Networks, including any information or documentation regarding the circumstances or status of any collaborative or supervisory agreement or relationship with a collaborating or supervising physician, including but not limited to access to all related records to verify the status, nature or extent of the collaborative or supervisory agreement or relationship. The Networks are not obligated to accept all collaborating practice or supervisory agreements, as written, but reserves the right to evaluate whether the terms of such agreements are adequate to ensure proper oversight and management by the collaborating or supervising physician of the activities of the Extender. In the event that the Networks identify any deficiencies in the terms of a collaborating practice agreement or supervisory agreement, the Networks may decline to admit or to continue participation of any Extender in the Networks, or may condition admission or continued participation upon revisions to the terms of any such agreement. In addition, the Networks shall be entitled to review the actual practice activities, oversight and monitoring methods or practices, physical proximity between any Extender and their collaborating or supervising physician, and other conditions of the relationship to verify that the written terms of the collaborating or supervisory agreement are, in fact, being fulfilled by both parties to the agreement, and that adequate procedures, protocols and protections are in place to ensure proper oversight of the activities of the Extenders. Should the Networks or its representatives identify any breach or violation of the terms of the collaborating or supervising agreement, or should failure to honor the terms of such agreements come to the attention of the Networks, the network participation of the applicable Extender shall be subject to immediate termination for failure to meet network credentialing standards.
5. License	All participating practitioners must hold and maintain continuously a current, active and unrestricted license(s) to practice in the state(s) where the practitioner conducts any medical practice or delivers any health care services and in the state(s) at which the patient is located, as determined by the applicable disciplinary board or licensing or oversight agency. In addition, license restrictions in other states or countries (i.e., states other than the state where a practitioner currently conducts any medical practice or delivers any health care services) will be considered in applying these license standards, i.e., even if a practitioner no longer practices or intends to practice in a given jurisdiction, if the practitioner's license in any jurisdiction is restricted (including but not limited to any limitation, restriction, suspension, surrender (whether voluntary or involuntary), withdrawal or revocation of any license due to any disciplinary action or investigation, or while under investigation, or to avoid investigation or a final administrative finding) then in such circumstances the affected practitioner shall be deemed ineligible for network participation pursuant to this "License" standard. While the networks have adopted a policy of deferring to the applicable disciplinary board or licensing or oversight agency on the question of whether a particular action by such board or agency constitutes a "restriction" on

	the license of a practitioner, in the absence of a clear, official statement or direction from any such board or agency that specifies whether a particular action constitutes a "restriction" on a license, the networks have adopted and will apply the following rules for what constitutes a "restriction" on a license: In the absence of clear, official direction or specification by the applicable disciplinary board or agency as to whether a particular action constitutes a "restriction" on a license, a license shall be deemed "restricted" by any action of a disciplinary board or agency that imposes any requirements on the practitioner not generally and equally applied to all licensees, including but not limited to continuing medical education requirements, fines, penalties or assessments of any costs of proceedings against the practitioner, proctoring, chaperone or monitoring requirements of any kind in which the practice activities of the practitioner are subject to any form of oversight or review, any requirements or stipulations as to the location(s) where the practitioner may practice, any limitation on a practitioner's scope or manner of practice (including but not limited to any restrictions as to performance of any specific service, procedure or treatment), any limitations on the numbers or categories of patients the practitioner may serve, or any ongoing audit or reporting requirements as to the practitioner's practice activities, competency, qualifications or care of patients. In assessing whether a "restriction" on the license exists – in the absence of clear, official direction or specification by the applicable disciplinary board or agency – restrictions, conditions or limitations arising from any "Agreed Order," "Consent Order" or any other form of agreement or voluntary arrangement or negotiation with any disciplinary board or agency shall be considered the same as restrictions, conditions or limitations imposed without agreement or consent of the practitioner. The preceding notwithstanding, unless otherwise indicated by the applicable disciplinary board or agency, the networks do not intend to treat the following circumstances as constituting a "restriction" on a license: (a) Requirements (short of revocation or suspension of license) imposed on a practitioner solely due to missing deadlines for mandatory minimum continuing medical education requirements, provided the practitioner promptly addresses such deficiencies and is not subject to any other disciplinary action; or (b) Requirements (short of revocation or suspension of license) imposed on a practitioner solely due to omissions to meet purely administrative standards for licensure, such as payment of annual or periodic license fees or completion of related actions or forms, provided the practitioner promptly addresses such deficiencies and is not subject to any other disciplinary action; or (c) Requirements (short of revocation or suspension of license) imposed for minor infractions of applicable disciplinary or agency rules, procedures or

	standards that do not involve any lapse in professional competency, quality or the standard of care provided to any patient, nor any imposition of any proctoring, monitoring or chaperone requirements, nor restriction or limitation of any kind on scope or manner of practice; or (d) Voluntary enrollment in any impaired practitioner program of a disciplinary board or agency, i.e., self-reporting prior to being subjected to any disciplinary board or agency orders or investigation, provided the applicable board or agency permits such practitioner to continue to practice under its oversight or monitoring, and provided such practitioner complies fully at all times with all requirements of such impaired practitioner program, including but not limited to successfully completing any required rehabilitation, education and testing. (With respect to involuntary participation in any impaired practitioner program, in the absence of contrary, clear and official indication by the applicable disciplinary board or agency, such practitioners shall be deemed to have a "restricted" license for two years from the date of their enrollment in such program, and shall be ineligible to participate in any network until after two years of successful participation, including but not limited to successfully completing any required rehabilitation and testing during such two-year period. "Involuntary" participation is construed to be any participation not resulting from self-referral by a practitioner prior to any form of disciplinary board or agency action or investigation, including but not limited to any situation in which a practitioner enters into an "Agreed Order" or "Consent Order" or any other form of agreement or consensual arrangement to enroll in a program, but does so only after having been subjected to action or investigation by the disciplinary board or agency).
6. Board Certification / Residency Training (Applies to MD's and DO's)	Recognized certifying Boards for MDs and DOs are the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). Board Certification is preferred but not required. Physicians who have completed an ABMS or AOA approved residency/fellowship are not considered to have an issue which requires presentation to the Credentialing Committee. However, Physicians who request a specialty and have not completed an ABMS or AOA approved residency/fellowship[1] for that specialty are considered to have an issue and must be reviewed by the Credentialing Committee with details regarding their education, CME, work history and hospital privileges. The Credentialing Committee may, in its sole discretion, recommend approval or denial of credentials and, if approved, the specialty. Physicians who are determined by the Credentialing Committee not to meet standards for a requested specialty may be denied participation or may be restricted in participation. Physicians who are in the process of residency/fellowship training for a specialty are not eligible to be admitted to the networks as specialists until successful completion of such residency/fellowship, but, after completion of their second year in such residency/fellowship program, may apply for provisional admission to the networks as General Practitioners, pending completion of the residency/fellowship for the requested specialty, subject to the following conditions:

	(a) admission as a General Practitioner shall be at the discretion of the Credentialing Committee; and (b) the applying physician must, at the time of application, have successfully completed two years in the applicable specialty residency program, and be in good standing with such residency program; and (c) the applying physician must agree in writing to limit her/his network practice during such pre-residency/fellowship completion period to performing only such services/treatments as a non-specialist, General Practitioner would perform, i.e., the applying physician must agree not to perform or bill for any specialty services to network members during such pre-residency/fellowship completion period; and (d) the applying physician must agree to restrict the location of his/her practice during the pre-residency/fellowship completion period to the emergency department of a network-participating hospital or to an urgent care clinic approved by the Networks
7. Felony Convictions	Must have no felony convictions or guilty pleas. Two exceptions may be recognized, in the sole discretion of the Networks, in the following circumstances: (a) **Pardon**: If the practitioner has been pardoned by the appropriate governmental executive and the Networks conclude, based on available information, that the practitioner has been rehabilitated; or (b) **Exemplary Conduct Over Time**: If at least 10 years have elapsed since the felony conviction or guilty plea, during which the practitioner has demonstrated exemplary conduct with no additional infractions of the law, provided the practitioner furnishes references or other documentation satisfactory to Networks to establish that the practitioner has been fully rehabilitated. The preceding notwithstanding, the Networks reserve the right to refuse network participation to any practitioner with a felony conviction or guilty plea, regardless of any pardon, the passage of time, or any claim of rehabilitation, including but not limited to any case in which a felony conviction or guilty plea involves fraudulent submission of insurance or health plan claims, or egregious crimes causing serious physical or psychological injury to patients or other individuals.
8. Use or Abuse of Drugs, Alcohol or other Substances	Practitioners shall not use illegal drugs or substances, and shall not abuse alcohol or legal drugs. Practitioners whose use or abuse of any drug or substance, whether legal or illegal, interferes with or impairs their ability to practice medicine or deliver health care services in accordance with accepted standards of care, leads to a lapse in quality, competency or professionalism, or poses a risk to the health or safety of any patient or the public, may be excluded from network participation until such time as they can demonstrate adequate rehabilitation and assurance of appropriate conduct. At a minimum, any practitioner exhibiting substance abuse problems or impairment due to legal or illegal use of alcohol or drugs must establish that he or she has enrolled in a recognized, supervised treatment program approved by the Arkansas State Medical Board or the practitioner's equivalent licensing authority, and must show full compliance with the requirements of any such treatment program. The network-sponsoring organizations may require a minimum period of successful participation in a

	treatment program before an impaired practitioner is eligible for admission or reinstatement to network participation.
9. Practitioner Impairment	Must be physically and mentally capable to fully perform professional and medical staff duties required to provide medical services to members.
10. Professional Liability Claims History	All applicants must provide a history, with complete description, of all professional liability claims in which they have been named, including dropped, dismissed, pending, settled, or found for defendant dispositions. Applicants must respond timely to all inquiries made by the Credentialing Committee, the Networks or Provider Network Operations for additional details of malpractice suits filed.
11. Medicare/Medicaid Sanctions, Fraud, Insurance Program Restrictions or Irregularities	Must not be currently under sanction by Medicare/Medicaid or any other government agency, nor be ineligible to participate in any government program for any reason. In addition, the Networks reserve the right to review all participating practitioners at any time for suspected fraud or abusive claims practices. Participating practitioners must fully cooperate with the Networks in any review of suspected fraudulent or abusive claims activity by responding promptly to information requests, and by making appropriate staff available to address questions or provide data. If fraud or abuse is detected, the Networks may terminate network participation, report the fraudulent or abusive activity to state or federal agencies, and pursue other appropriate legal recourse.
12. Applications, Release and Attestation	All practitioners must complete a standard application and sign and date a release and attestation on forms as required by the Networks and the Arkansas State Medical Board (for Arkansas MDs and DOs).
13. Initial Credentialing Decisions	Practitioners who do not meet minimum credentialing criteria as stated above will be excluded from the Networks. Those determined to have issues regarding qualification or compliance with established standards will be reviewed and approved or denied by the Credentialing Committee, subject only to appeal rights and the Networks' right to amend or apply these Standards. The Networks reserve the right, in its sole discretion, to decline any application that does not meet all credentialing standards and terms and conditions for network participation.
14. Recredentialing Decisions	Recredentialing of practitioners will normally occur every **36** months. This cycle could vary in individual cases to allow compliance with regulatory requirements or should the Networks decide re-credentialing at an earlier date is necessary. Practitioners who do not meet minimum credentialing standards as stated above will be excluded from the Networks. Those determined to have issues regarding qualification or compliance with established standards will be reviewed and approved or denied by the Credentialing Committee, subject only to appeal rights and the Networks' right to amend or apply these Standards. The Networks reserve the right, in its sole discretion, to decline any application that does not meet all credentialing standards and terms and conditions for network participation.

15. Telemedicine Fee	New MDs and DOs telemedicine applicants that practice outside of the state of Arkansas and will be providing services to an Arkansas member must include a check for $195.00 with their application for the True Blue PPO and Health Advantage HMO networks in order to cover the cost of the Arkansas State Medical Board – Centralized Credentials Verification Service profile fee. Existing network out-of-state MD/DO telemedicine 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 methods. Payment check and network application should be sent to: Provider Network Operations Manager Attn: Telemedicine Fee P.O. Box 2181 Little Rock, AR 72203-2181 If Arkansas MD or DO is enrolling thorough the Networks' delegated vendor, MDLive, this fee is waived as MDLive is covering the profile cost.
16. Coverage Policy Requirements	**Any provider who seeks to participate in the Networks as a telemedicine provider must agree to abide by the Networks' telemedicine Coverage Policy, as outlined herein. Per that Coverage Policy, Telemedicine is covered only when ALL of the following conditions are met:** 1. The service is one which is allowed (meaning that it is clearly within the scope of practice, training, qualification, competency and licensure) for the specific provider type when done in a face-to-face setting, and which can be safely, effectively and legally performed via telemedicine to at least the same standard of care and at least the same degree of accuracy, efficiency, efficacy, thoroughness, quality and competency as would be possible in a face-to-face visit. 2. The telemedicine encounter and services must be conducted via media and equipment, and in a manner that ensures privacy and security for all aspects of the patient experience and interchange with the telemedicine practitioner, including full compliance with all applicable state or federal privacy and security standards, including but not limited to HIPAA. Without limiting the scope or breadth of the preceding requirement, this means that all telemedicine services must be provided in an environment where the telemedicine practitioner and the patient are afforded a strictly private setting not impeded or interrupted by any third parties not directly involved in the patient's care. 3. If the originating site is a clinical setting, a Presenter is available at the Originating Site to orient the patient, operate the equipment, problem solve, and gather clinical data. 4. The encounter is by real-time interactive audio communication with store and forward capabilities.

	5. A clinical record of the encounter which contains at least the same elements as are included in a face-to-face encounter record is maintained and must be available to the applicable claims processor or payer at any time upon request; the location of the Originating Site and Distant Site, along with the date and time of the connection must be recorded in the note. 6. For visits which include a physical exam, the equipment allows for remote examination by the provider (eg stethoscope, otoscope, etc giving a diagnostic-quality signal to the provider) OR a qualified, licensed person capable of performing the exam supplements the examination and relays the findings to the provider. 7. Data transmission must be accomplished using a HIPAA-compliant network, with sufficient bandwidth and screen resolution to permit adequate interaction with the patient and assessment of behavioral and physical features. The network must maintain a log of connections, with time, date, and duration. An example of a compliant network is Arkansas e-Link. (To connect to the Arkansas e-Link network, providers may call the Center for Distance Health at 501-686-6998 or enroll online at arkansaselink.com.). The following minimal security protocols/technology must be in place to promote minimal privacy and security of the electronic interaction between the telemedicine provider and patient: 8. The Distant Site provider must hold all licenses, certifications, registrations or approvals required by applicable law or regulation for performance of the telemedicine services, including but not limited to such licensure as is required by the appropriate state's Medical Board, and the service provided must be within the scope of practice for that provider. 9. All prescriptions of any medications must be issued in accordance with applicable state and Federal Laws and Drug Enforcement Agency ("DEA") requirements. 10. All medical records and notes shall be made available to the patient's Primary Care Physician ("PCP") upon patient request **Technology Requirements:** • High Speed service. Minimum 5Mbps. Faster is better for video consultations. Check your speed at: https://fast.com • PC-4GB memory, 2.0 GHz or faster processor. Webcam and microphone. • Google Chrome (v.61+) is preferred browser. Firefox, Safari (11+), Internet Explore (10+) may also be used. • Mobile-Android 4.1 and above. iOS 8.0 or later.

Outpatient hospital billings

Revenue codes require CPT or HCPCS codes

The implementation date announced in the June 2019 *Providers' News* for "Outpatient hospital billings: Revenue Codes require CPT or HCPCS codes" as of October 1, 2019, has been delayed. The new implementation date is scheduled for April 1, 2020. More information regarding these changes will be coming in the near future.

Patient-Centered Medical Home program

Open enrollment begins September 1, 2019

A Patient-Centered Medical Home (PCMH) is a care team that manages the overall health and coordinates the care of a patient. The PCMH program is designed to assist primary care providers (PCPs) in transitioning to become PCMHs through guidance and support, while rewarding them for high-quality, coordinated and efficient care. Open enrollment for the 2020 PCMH program begins September 1, 2019, and closes on October 31, 2019.

We are excited to announce these changes to the PCMH program in 2020:

- Nurse practitioners, physician assistants and clinical nurse specialists are eligible for participation (physicians continue to be eligible for participation).
- Medicare Advantage members will be included in the clinic's attribution.
- A performance-based incentive payment will be added.
- A new care management fee structure will be implemented.

Providers must be in one of the following specialties and in all networks to participate.

Eligible Specialties

- Family medicine
- General practice
- Geriatric medicine
- Internal medicine
- Pediatric medicine
- Primary care nurse practitioners
- Primary care physician assistants
- Primary care clinical nurse specialists

Health Advantage and *BlueAdvantage Administrators of Arkansas* are affiliates of the *Arkansas Blue Cross and Blue Shield family of companies.*
All are independent licensees of the Blue Cross Blue Shield Association.

Eligible Networks

- Arkansas Blue Cross and Blue Shield PPP
- Health Advantage HMO
- Arkansas' FirstSource PPO or True Blue PPO
- Medi-Pak Advantage HMO (in limited areas)
- Medi-Pak Advantage Private Fee-for-Service (PFFS) (in limited areas)

This is a voluntary program. There are no penalties for providers who choose not to participate.

For more information on the Arkansas Blue Cross and Blue Shield 2020 PCMH program, contact us at primarycare@arkbluecross.com.

Recall of Biocell® breast implants & tissue expanders

On July 24, 2019, Allergan announced a global recall of Biocell® textured breast implants and tissue expanders at the request of the FDA. According to an FDA news release, the recall was requested due to the risk of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL). The safety communication indicates that the overall incidence of (BIA-ALCL) is relatively low and the FDA does not recommend removal of recalled implants and tissue expanders for patients without symptoms due to potential risks.

The recalled implants include: BIOCELL® textured breast implant products, including: Natrelle Saline-Filled breast implants, Natrelle Silicone-Filled breast implants, Natrelle Inspira Silicone-Filled breast implants, and Natrelle 410 Highly Cohesive Anatomically Shaped Silicone-Filled breast implants. The recall also includes tissue expanders used by patients prior to breast augmentation or reconstruction, including Natrelle 133 Plus Tissue Expander and Natrelle 133 Tissue Expander with Suture Tabs.

As of July 25, 2019, Arkansas Blue Cross and Blue Shield will not provide coverage for claims for the recalled BIOCELL® Textured Breast Implants and Tissue Expanders implant. Claims for removal and replacement of the recalled BIOCELL® Textured Breast Implants and Tissue Expanders will be reimbursed when the original diagnosis and procedure meets the Women's Health Cancer Rights Act of 1998, the member is symptomatic and provided the member has benefits and all other criteria for the procedure are met. Implant removal and replacement for asymptomatic or cosmetic reasons are not covered services.

Federal Employee Program

Billing once-in-a-lifetime event procedures with the appropriate compatible modifier

Once-in-a-Lifetime Event procedures can be performed only once in a patient's lifetime. These procedures should always be billed with a modifier to avoid charges from being denied. Listed below are various types of Lifetime Events and the appropriate compatible modifiers.

Each unit must be billed on a separate charge line. Two or more of these modifiers should never be billed on the same line.

1. Bilateral lifetime event procedures must be billed with modifier RT, LT or 50.
2. Lifetime event procedures codes for the fingers must be billed with modifier FA, F1, F2, F3, F4, F5, F6, F7, F8 or F9.
3. Lifetime event procedures codes for the foot must be billed with modifier TA, T1, T2, T3, T4, T5, T6, T7, T8 or T9.

Billing example of a bilateral lifetime event procedure

Date of Service	Procedure	Modifier	Unit
01/01/2019	19303	LT	1
01/01/2019	19303	RT	1

Current cervical cancer screening policy for FEP members

The U.S. Preventive Services Task Force updated cervical cancer screening guidelines in 2018. The Arkansas Blue Cross and Blue Shield Federal Employee Program (FEP) covers preventive screenings, including cervical cancer, once per calendar year. The preventive screening recommendations for cervical cancer apply to women 21 to 65 years of age with the following screening guidelines:

- Ages 21–29 — receive a Pap test every three years
- Ages 30–65 — receive screening every three years with cervical cytology alone; every five years with high-risk human papillomavirus (hrHPV) testing alone; or every five years with co-testing of a Pap test and a human papillomavirus infection (HPV) test

An HPV test for a woman under the age of 30 is not recommended unless her Pap test is abnormal. Following the recommended guidelines for Pap and HPV testing can detect pre-cancers. Detecting and treating pre-cancers early can help prevent cervical cancer.

HEDIS compliance

As part of its HEDIS data requirements, the Arkansas Blue Cross FEP must report the percentage of its members who undergo or have undergone cervical cancer screenings. To support cervical cancer screening compliance requirements for your patients:

- Encourage patients to begin cervical cancer screening at age 21.
- Monitor screening by following screening guidelines.
- Check with your patients to ensure they complete testing.
- Submit a claim indicating the date a patient receives a cervical cancer screening.
- Document the results of cervical cancer screenings in patients' medical records.

The CPT codes below meet the HEDIS specifications for an appropriate screening for cervical cancer.
Cervical Cytology- CPT® Code(s): 88141**,** 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175

HPV Co-test- CPT Code(s): 87620-87622, 87624, 87625

OBRA 90 and 93 pricing

The Omnibus Budget Reconciliation Acts of 1990 and 1993 (OBRA 90 and 93) requires all Federal Employee Health Benefit (FEHB) plans to limit payments for inpatient hospital care and physician care for those payments for our members who do not have Medicare but are 65 or over.

The physician and hospital must follow Medicare rules and cannot bill the member for more than they could bill the member if they had Medicare. Outpatient hospital care and non-physician-based care are not covered by this law.

OBRA 90 refers to the provisions of federal regulations that mandate FEHB benefit payment calculations for the type of services covered under Medicare Part A. OBRA 93 refers to services covered under Medicare Part B. Members that are covered by the provisions of the OBRA 90 and 93 law are those that meet all of the following requirements:

- Age 65 or over
- Not enrolled in Medicare Part A (OBRA 90)
- Not enrolled in Medicare Part B (OBRA 93)
- Enrolled in our plan as annuitants (retirees) or former spouses or as a family members of annuitants (retirees) or former spouses
- Not employed in jobs that provide FEHBP coverage

Inpatient hospital care

- The law requires FEP to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare rules for what Medicare would pay, not on the actual charge.
- The member is responsible for any deductible, coinsurance or copayments under their plan.
- The member is not responsible for any charges greater than the equivalent Medicare amount.
- The law prohibits a hospital from collecting more than the equivalent Medicare amount.

Physician care

The law requires FEP to base our payment and the member's applicable coinsurance or copayment on:

- An amount set by Medicare and called the "Medicare-approved," or
- The actual charge if it is lower than the Medicare-approved amount.

Medi-Pak® Advantage

HMO plan referrals

Effective January 1, 2020, Health Advantage Medi-Pak Advantage HMO plans will require a physician referral prior to the member receiving services from a specialist. Referrals empower all of our physician partners to better coordinate care and mitigate low-value services.

Referrals submitted prior to claims submissions will generate overrides in the claims processing system, which will allow for specialists' claims to be processed. If a referral is not in place prior to services being rendered, the claim will pend for manual review. If a determination is made that no referral is on record, the claim will be denied.

Our referral process is intended to be the least administratively burdensome referral process in Arkansas. We look to our physician partners and their staff for feedback on how we can make this process as successful as possible. More details will be shared throughout the year in future communication.

New member ID numbers and cards

New member ID numbers and cards coming for Arkansas Blue Cross Medicare Supplement members.

Medi-Pak Supplement members will be receiving new member ID numbers for 2020.

How will this affect members' care?

Members will use this new ID card starting on January 1, 2020, when they need medical care. The new member ID card will not change their coverage or benefits.

How will this affect providers?

Providers will need to collect member's new ID number. Providers can use the new or previous member ID number when filing claims, but the new ID number is preferred.

When will new Medicare Supplement member ID Cards be mailed out?

Members will begin receiving new ID cards starting in December 2019. A letter will go out to members with the ID card explaining why they are receiving the new card and what actions to take.

Reminder on billing Qualified Medicare Beneficiaries

Medicare providers are prohibited by federal law from billing Qualified Medicare Beneficiaries for Medicare deductibles, 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 who are enrolled in Medi-Pak® Advantage to administer their Medicare benefits would 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 billing 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.

Requirements for outpatient observation care

In compliance with the Centers for Medicare and Medicaid Services (CMS) Medicare Outpatient Observation Notice (MOON), Arkansas Blue Cross and Blue Shield requires all acute care and critical access hospitals to provide written notification and an oral explanation of the notification to patients receiving outpatient observation services for more than 24 hours. For Medi-Pak® Advantage members, observation stays require any pre-authorization or pre-notification requirements.

The notice should explain the following using contemporary language:

- The patient is classified as outpatient
- Cost-sharing requirements
- Medication coverage
- Subsequent eligibility for coverage for services furnished by a skilled nursing facility
- Advise patients to contact their insurance plan with specific benefit questions

The notice and accompanying instruction are available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

HEDIS® News

Breast cancer screening

Remind your eligible patients to get mammograms every two years

One in eight women in the United States will be diagnosed with breast cancer in her lifetime, making it the second-most-common cancer in women. You play an integral role in early detection by recommending regular screenings to your patients. Early detection through regular screening is key to a better outcome for your patients.

The Healthcare Effectiveness Data and Information Set (HEDIS®) Breast Cancer Screening measure is used by the Centers for Medicare & Medicaid Services (CMS) as a star rating measure to drive improvements in patient health. CMS and HEDIS guidelines recommend that routine mammogram screenings are completed every 24 months for women ages 50 to 74.

The National Committee for Quality Assurance (NCQA) now allows patients to be excluded from the Breast

Cancer Screening HEDIS star quality measure due to advanced illness and frailty. They acknowledge that measured services most likely would not benefit patients who are in declining health.

Review the Breast Cancer Screening tip sheet to learn more about this HEDIS measure, including information that should be documented in a patient's medical record, information that should be included in claims, and tips for talking with patients.

Colorectal cancer screening

Remind your patients of the importance of a colorectal cancer screening

According to the American Cancer Society, colorectal cancer is the third-most-common cancer diagnosed in both men and women in the United States. Your patient may be under the assumption that a colonoscopy is the only way to test for colorectal cancer. Talk to your patients about the importance of early detection and the types of tests available, including those that are non-invasive.

There are many screenings available for patients to choose from, and it is important for providers to document the type of screening performed or any exclusions in the patient's medical record. Exclusions for this measure have changed to include advanced illness and frailty of the patient.

View the Colorectal Cancer Screening tip sheet to learn more about the measure, information to include in a patient's record, CPT codes that should be included in claims, and tips for talking with patients.

Medication reconciliation post-discharge

Medication reconciliation post-discharge is critical to patient safety and care coordination efforts.

Collaboration is a key component of medication reconciliation. Communication between medical, nursing, ambulatory and pharmacy staff involved in the patient's care and the patient, their caregiver or family members is vital for its success.

Medication reconciliation is about obtaining the most accurate list of patient medicines, allergies and adverse drug reactions and comparing this with the medications and documented allergies and adverse drug reactions listed in the outpatient medical record. Any discrepancies are then documented and reconciled.

View the Medication Reconciliation Post-Discharge tip sheet to learn more about when the process should be completed, information to include in a patient's record, Current Procedural Terminology (CPT) codes that should be included in claims and tips for talking with patients about this important topic.

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