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## 2017 open enrollment please use AHIN

2017 Open Enrollment Periods will begin on October 1, 2016, and runs through January 31, 2017. Due to the anticipated enrollment of many new members and the renewal of current members effective on the same dates, we are expecting extremely high call volume through March 1, 2017. Arkansas Blue Cross and Blue Shield strongly encourages physician and other health care professional offices and facilities to use AHIN (Advanced Health Information Network) for verifying eligibility, benefits, and claims status. AHIN displays information on benefits that should assist providers when scheduling appointments, checking eligibility and benefits. If a provider requires proof of coverage for their records, they may copy the screen to their files or print a paper copy.

Arkansas Blue Cross is planning and staffing to answer a higher call volume, but there may be times when call volumes spike and exceed our ability to answer every call. Because Arkansas Blue Cross recognizes how valuable our provider's time is, we want to remind our medical providers that AHIN uses the same information available to our customer service representatives and is continually updated.





# Benefit changes for cervical cancer screenings

In 2013, the U.S. Preventive Services Task Force (USPSTF) determined there was no evidence indicating that healthy women needed to be screened annually for cervical cancer. This change is supported by a broad coalition of medical specialty societies, including the American Cancer Society, the American College of Physicians and the American Congress of Obstetrics and Gynecology.

Effective January 2016, these recommendations replaced cervical screening guidelines for all members of Arkansas Blue Cross and Blue Shield and its family of companies, unless noted below.

Cervical Screening Policy Effective January 1, 2016	
Age	Recommendation/Benefit
Under 21	No screening
21-65	Pap test every three years
<b>OR</b>	
30-65	Pap test and co-testing for HPV every five years
65 and older	No screening
A Pap test is not necessary for women who have had a hysterectomy with removal of cervix for a benign disease.	

## Exceptions

These recommendations do not apply to women who:

- Are at high risk for cervical cancer because they:
  1. Have had in-utero exposure to diethylstilbestrol (DES)
  2. Are immunocompromised (such as those who are HIV positive)
- Are being followed for an abnormality on a Pap test.

In these situations the test would be considered diagnostic and would not be covered under preventive services.

## How does this change affect coverage?

Our medical policy regarding these screenings changed on January 1, 2016, and our coverage will change on January 1, 2017.

If a woman is between the ages of 21-65 and received a Pap test as a screening service in 2016, she will not have 100 percent preventive coverage of another screening until three years from the date of her last screening. If a doctor thinks a test is needed for health reasons, it will be covered as a diagnostic test (not a screening), which may require a copayment. If she had a Pap test last year, and an HPV test, she will not have coverage for screening purposes for five years from the date of her last screening.

Many doctors began switching patients to this schedule in 2013 when the recommendation was announced by the USPSTF. Arkansas Blue Cross reviewed the information from the USPSTF thoroughly before determining that our medical policy should reflect the recommendation.



# Claims incurred during the credentialing process

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

In addition, once a physician's application has been approved through the payer's credentialing process, Act 1232 requires a physician's network participation effective date to be back dated to the

day the payer received a completed application. Arkansas Blue Cross and its family of companies apply this rule to physicians and non-physician providers.

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

Act 1232 offers protection to physicians against unacceptable credentialing wait times. In addition, Arkansas Blue Cross has been able to provide compliance to these

requirements. As a result, Arkansas Blue Cross, USAble Corporation and Health Advantage have enacted a policy effective immediately that we will **not** adjust claims from providers who file their claims during their credentialing process. In addition, our members cannot be billed and held responsible for more than their applicable in-network deductible, copay and/or coinsurance amounts. Again, we ask providers to hold your claims until you receive our letter indicating full network participation.

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

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## Claims Xten software updates

Updates to the Claims Xten (CXT) claims auditing software implementation, scheduled for this fall, will be posted on AHIN for all lines of business. CXT uses CPT coding criteria and protocol when checking billing information submitted on claims. For more information on CXT, see page 8 in the June 2016 edition of Providers' News found at arkansasbluecross.com.



## CPC+

CMS launches largest-ever multi-payer initiative to improve primary care in America

New Affordable Care Act initiative, designed to improve quality and cost, gives doctors and patients more control over health care delivery (<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html>)

### Highlights:

- Successor to CPCi
- 5 year project (2016 is the only enrollment year)
- 2 tracks for clinics to choose from
- PMPM payments continue, but new addition of incentive payments (with claw-back based on quality)

## Important Dates:

- **August 1 -September 15, 2016:** Practice applications accepted
- **October:** Selected practices notified
- **January 1, 2017 - December 31, 2021:** CPC+

## Arkansas Patient-Centered Medical Home portal

The Arkansas Patient-Centered Medical Home program uses a secure electronic portal on the AHIN website for documentation and reporting. The user-friendly portal allows clinics to streamline PCMH tasks with their workflow. Each clinic designates access rights to the portal among their staff. The portal includes: **patient panels, risk scores, aligned patients, activity and metric requirements and status, PCMH quarterly reports and PCMH resources.**

The portal is located at: [secure.ahin-net.com](http://secure.ahin-net.com)

## CPC+ Practice Eligibility Criteria:

### Track 1

- Practice structure and ownership information;
- Use of CEHRT;
- Payer interest and coverage;
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities.

### Track 2

- Practice structure and ownership information;
- Use of CEHRT;
- Payer interest and coverage;
- Existing care delivery activities must include: assigning patients to provider panel, providing 24/7 access for patients, and supporting quality improvement activities, while also developing and recording care plans, following up with patients after emergency department (ED) or hospital discharge, and implementing a process to link patients to community based resources.
- Letter of support from health IT vendor that outlines the vendor's commitment to support the practice in optimizing health IT.

Because Arkansas Blue Cross and Blue Shield collaborates with the state Medicaid PCMH program, the PCMH portal is housed in the same location with similar access points. Both programs are found under the APII (Arkansas Health Care Payment Improvement Initiative) tab on the top tool bar.

For those currently enrolled in the program, here are some significant dates:

Activity Description	Scheduled Date
Six-month scheduled site visits	September
Early care-plan selection announcement	October 3-14
PCMH open enrollment	October 1-December 1

*Open enrollment is October 1 through December 1 for those who wish to enroll in the Arkansas Blue Cross 2017 program. Stay tuned for future alerts on AHIN.*



# Discontinue altering total charge to \$.01 to bypass edits

Effective October 16, 2016, with BlueCard (Arkansas Blue Cross and Blue Shield and its affiliates, Preferred Payment Plan; Arkansas' FirstSource® PPO; True Blue PPO; and Health Advantage HMO Networks) will Allow Zero Total Charge and Zero Service Charge on Professional and Institutional submission of claims. Providers should discontinue the practice of altering their total charge zero professional claims to reflect \$.01 to bypass edits.

This enhancement will increase the Host Plan's ability to transmit a claim while maintaining the integrity of the claim submitted from the provider. In addition, Host Plans will have access to encounter type claims that their providers file for consideration in Value-Based Programs. It also supports the Blue strategic priority of improved efficiency and cost management.

**Institutional Outpatient (Claim Type of 12)**  
Medicaid Request for Anticipated Payment (RAP) claims will be included in the bypass logic, allowing the Total Charge to be zero. This change accommodates Medicaid RAP

claims requiring that the Total Charge be zero and Par/Host Plans being prevented from creating a valid claim due to existing edit.

All outpatient claims will allow for the service line local rate to be greater than charge, which accommodates new pricing methodologies for outpatient services that base the price/allowance on the service rather than the charge.

**Professional (Claim Type of 20)**  
All professional claims will be allowed to have a Total Charge equal to zero when the Pricing Method is equal to "01 – Charges." This change ensures that on encounter type claims the Host Plan can pass information accurately on the claim. It also will prevent providers or Host Plans from adjusting the total charge to \$.01 to accommodate HEDIS requirements (must pass all claims) and also prevent errors for altering the claim.

**Institutional Inpatient (Claim Type of 11)**  
There are no changes for this type of claim with this enhancement.

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## Inpatient DRG changes effective January 1, 2017

October 1, 2015, Medicare converted from ICD-9 to ICD-10 diagnosis and procedure codes. To reduce filing issues for providers during this conversion, Arkansas Blue Cross and Blue Shield recognized the date Medicare used to change from ICD 9 to ICD 10 diagnosis and procedure codes for coding of inpatient

claims. This change also included using the DRGs and weights that were effective for Medicare on that date. The transition to ICD 10 has been successfully completed.

Please note that for the fiscal year starting January 1, 2017, ABCBS will once again begin using January 1st of each

calendar year to begin using the DRGs and corresponding weights effective for Medicare the previous October 1st. (Example: The DRG's and weights effective January 1, 2017 are equal to the F.Y. 2017 DRG case weights that are effective for Medicare on October 1, 2016)



# Infertility services policy

Arkansas Blue Cross and Blue Shield and its affiliates and subsidiaries have a coverage policy for infertility services. Infertility services are contract-specific benefits and only apply to services performed on the covered member. Please note that some contracts have infertility benefits and some do not. Even when the contract has infertility benefits available, no infertility-related services are eligible for benefits when: (1) the covered person or the covered person's spouse has undergone a voluntary sterilization at any point in their medical history, (2) the infertility is the result of natural age-related hormone reduction (i.e., postmenopausal or 45 years of age or older), (3) when a surrogate is used or (4) when the covered person has had three live births by any means.

For purposes of the policy, the definition of infertility is as follows: A covered person and spouse are unable to conceive after at least one (1) year of regular unprotected vaginal sexual intercourse, when the wife is less than 36 years of age, OR at least six (6) months of regular unprotected vaginal sexual intercourse when the wife is 36 years of age or older; or a covered person has a medically documented inability to conceive due to at least one of the following:

1. Stage 4 surgically treated endometriosis;
2. Exposure in utero to diethylstilbestrol, commonly known as DES;
3. Fallopian tube blockage or removal with documentation of patency of one fallopian tube, not as a result of voluntary sterilization;
4. Untreatable, abnormal male factors contributing to infertility, not as a result

- of voluntary sterilization;
5. Cervical factor infertility;
6. Vaginismus preventing intercourse;
7. Anovulatory females who have failed to conceive after a six-month trial of ovulation induction with timed intercourse under the supervision and monitoring of a physician; or
8. Absence or abnormality of uterus that precludes conception with evidence of intact ovarian function.

Arkansas Blue Cross and Blue Shield requires prior authorization for all infertility-related services. Coverage policy #2014008 includes very specific coverage criteria for infertility diagnostic testing, artificial insemination and in-vitro fertilization services. Prior authorization requires medical record documentation verifying that all of the coverage criteria are met.

For assisted reproductive technology (in-vitro fertilization) services, the member and the member's spouse must have a history of unexplained infertility of at least two years or the member or the member's spouse have infertility associated with one or more of the following medical conditions and where appropriate other less invasive therapies have failed (for example intrauterine insemination):

1. Stage 4 surgically treated endometriosis; or
2. Exposure in utero to diethylstilbestrol, commonly known as DES; or
3. Blockage or removal of one or both fallopian tubes, not as a result of voluntary sterilization; or
4. Untreatable, abnormal male factors contributing to infertility, not as a result

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### Infertility services policy (Continued from page 6)

- of voluntary sterilization; or
- 5. Cervical factor infertility; or
- 6. Vaginismus preventing intercourse; or
- 7. Anovulatory females who have failed to conceive after a six-month trial of ovulation induction with timed intercourse under the supervision and monitoring of a physician; or
- 8. Absence or abnormality of uterus that precludes conception with evidence of intact ovarian function.

Additionally, in vitro fertilization procedures must be performed by a physician who is board-certified in reproductive endocrinology and infertility. NOTE: Related procedures (for example lab tests, ultrasounds) may be performed by a provider in consultation with the board-certified or the IVF experienced physician.

Up to six cycles\* of intrauterine or intracervical insemination meets member benefit certificate primary coverage criteria when the member or member's spouse has a medically documented inability to conceive due to at least one of the following:

- 1. Surgically treated endometriosis; or
- 2. Blockage or removal of one or both fallopian tubes, not as a result of voluntary sterilization; or
- 3. Untreatable, abnormal male factors contributing to infertility, not as a result of voluntary sterilization (for example untreatable retrograde ejaculation, untreatable penectomy, refractory erectile dysfunction), or
- 4. Evidence of discordance for a sexually

- transmitted disease carriage (for example human immunodeficiency virus [HIV], hepatitis B or C)
- 5. Cervical factor infertility; or
- 6. Vaginismus preventing intercourse; or
- 7. Anovulatory females who have failed to conceive after a six-month trial of ovulation induction with timed intercourse under the supervision and monitoring of a physician; or
- 8. Unexplained infertility in the member or member's spouse after at least one year of regular unprotected vaginal sexual intercourse. (Note: Unexplained infertility is defined as no detected abnormalities identified from standard infertility diagnostic testing).

Contraindications include: active cervical, uterine, or pelvic infection; absence of uterus; bilateral fallopian tube obstruction or absence; bilateral absence of ovaries; or other known causes of complete anovulation.

If conception does not occur after the initial six cycles\* of intrauterine or intracervical insemination, up to six additional cycles may be eligible for benefits.

For details on coverage criteria for infertility diagnostic testing and further details related to infertility services, please refer to the coverage policy #2014008 on the Arkansas Blue Cross website under the "Coverage Policy" page under the "Doctors and Hospitals" tab at [arkansasbluecross.com/members/other\\_links/coverage\\_policy.aspx](http://arkansasbluecross.com/members/other_links/coverage_policy.aspx).



# Provider third party liability or subrogation

Arkansas Blue Cross and Blue Shield would like to provide the following notice regarding applicable claims filing policies and procedures of Arkansas Blue Cross and its affiliate, Health Advantage, in situations in which a third party or their liability carrier are responsible for the injuries an Arkansas Blue Cross or Health Advantage member sustains (generally referred to for shorthand convenience as “Third Party Liability” or “Subrogation” matters).

These policies and procedures have been in place for many years but are being restated for emphasis due to increasing Third Party Liability or Subrogation activities of some providers. Providers are reminded that their network participation agreements obligate them to comply with all claims filing policies and procedures, including those published in Providers’ News.

1. Arkansas Blue Cross and Blue Shield and Health Advantage encourage providers to file all claims, rather

than holding such claims to pursue Third Party Liability or Subrogation. Filing the claim allows quick provision of any available health plan or insurance contract benefits to our members, and provides the fastest payment to providers.

2. Although filing of claims is strongly encouraged and preferred, Arkansas Blue Cross and Health Advantage provider contracts do not require that claims be filed with them, and recognize that state law specifically grants a lien to providers for Third Party Liability (i.e., providers can claim a part of any third party recovery the member may otherwise seek or be entitled to recover).

3. While Arkansas Blue Cross and Health Advantage understand this state lien law, and do not purport to change or challenge it, Arkansas Blue Cross and Health Advantage do require as an express term of their network participation agreements that participating providers must not

pursue the member for any amounts in excess of the Arkansas Blue Cross or Health Advantage payment (“Excess Amounts”) although participating providers may collect applicable member deductible, coinsurance or copayments. This means that while a provider can go after the third party or their carrier without violating their network participation agreement, the provider cannot attempt to recover “Excess Amounts” from the member. Any attempt to bill the member or collect against the member or their assets for Covered Services will be deemed a violation of the network participation agreement.

4. Providers are reminded that network participation agreements impose a 180-day timely filing requirement for all claims, and expressly bar collection – either from Arkansas Blue Cross or Health Advantage or the member – on claims not filed within 180 days. Thus, if a provider elects not to file a claim

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in favor of exclusively pursuing Third Party Liability or Subrogation, if that effort causes a delay in filing the claim past the 180-day filing deadline, providers cannot thereafter bill either the member or Arkansas Blue Cross or Health Advantage for any amount on such claims.

5. Providers are also reminded that while they may elect not to file a claim, members may still file the claim with Arkansas Blue Cross Provider “Third Party Liability” or “Subrogation” Activities and Member Claims or Health Advantage based on the provisions of their member certificate or evidence of coverage. If the member files a claim that a provider has withheld, Arkansas Blue Cross or Health Advantage will attempt to develop and process that member-submitted claim. Providers are contractually obligated in such circumstances to provide to Arkansas Blue Cross and Health Advantage information needed to evaluate and process the claim. Any payments determined due on such claims will be paid to the provider. Providers may not decline to accept the Arkansas Blue Cross or Health Advantage payment in such situations. If a provider does breach the participation agreement by declining to accept payment, Arkansas Blue Cross or Health Advantage will then make payment to the member. In either case, whether the payment is accepted or declined, and whether payment is made to the provider or the member (following provider refusal to accept), the provider cannot pursue collection against the member for excess amounts.
6. Arkansas Blue Cross and Health Advantage do not take a position regarding a provider’s option to (a) file claims and receive the Arkansas Blue Cross or Health Advantage payment and also (b) pursue Third Party Liability or Subrogation for the remaining portion of their bills (the Excess Amounts). The only interest for Arkansas Blue Cross and Health Advantage is in ensuring that providers understand that once they become a participating provider in these networks, they cannot pursue the member for amounts beyond the Arkansas Blue Cross or Health Advantage payments.
7. To the extent that any of the preceding rules of network participation have not been clearly understood or interpreted by any provider or party, this Providers’ News article shall be deemed to constitute notice of an amendment to the network participation agreement of Arkansas Blue Cross and Health Advantage participating providers.
8. With respect to Arkansas’ FirstSource® PPO and True Blue PPO networks of US Able Corporation, the same policies and procedures as referenced above shall apply, with the only variation being that US Able Corporation is not a payer of any claims of self-funded groups that access these networks; accordingly, payment of all such self-funded group claims is always subject to funding and direction of the employer sponsor as Plan Administrator of such plans.



# Updates to the network credentialing standards – DEA certificate standard

Effective October 1, 2016, the network credentialing standards applicable to all individual network participants and applicants for the Preferred Payment Plan, Medi-Pak® Advantage PFFS, Medi-Pak® Advantage LPPO, Medi-Pak® Advantage HMO, Arkansas' FirstSource® PPO, True Blue PPO, and Health Advantage HMO Networks will be updated in section C, Drug Enforcement Agency (DEA) to effect the following significant changes in the DEA certificate standard:

- Recognition that primary care physicians (PCPs), and advanced practice registered nurses and physicians assistants who collaborate with PCPs, but who do not prescribe or intend to prescribe controlled substances no longer have to obtain a DEA certificate as a condition of network credentialing and participation.
- Clarification that any practitioner who does prescribe or intends to prescribe controlled substances must maintain a DEA certificate in good standing as a condition of network credentialing and participation.
- A new requirement that practitioners who hold a DEA certificate must enroll in the Arkansas Prescription Monitoring Program (AR PMP).
- New provisions detailing the ineligibility period applicable to any practitioner whose DEA certificate is subject to a disciplinary action.

Special Note on the Prescription Monitoring Program procedures and extended compliance deadline:

Registration for the Prescription Monitoring Program is free and takes about five

minutes. The registration page can be found at: [arkansaspmp.com/practitioner-/-pharmacist/](http://arkansaspmp.com/practitioner-/-pharmacist/).

Current participating providers will have until April 1, 2017, to complete enrollment in the AR PMP in order to be in compliance with the network credentialing standards. Non-compliance with the revised DEA Certificate Standard could prompt the networks to take additional action, up to and including network termination.

The following is the revised language for the DEA Certificate Standard, effective October 1, 2016:

## **DEA and Arkansas Prescription Monitoring Program**

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 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 is subject to any action (as hereinafter defined) shall lose eligibility to participate in the networks for the longer of (a) 365 days or (b) the date that the networks determine, in their sole discretion, that the conditions leading

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Updates to the network credentialing standards - DEA certificate standard (Continued from page 10)

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 certificate, including but not limited to any arrangement whereby the practitioner agrees to a surrender, restriction, limitation, suspension or revocation of the DEA 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 certificate may be utilized to legally prescribe medications, or the length of time that the DEA certificate may be utilized without further review or approval from any government agency or disciplinary board or program.

Any practitioner whose DEA certificate is subject to any action must give written notice of the same to the networks 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 networks recognize one exception under which a practitioner who has been subject to an action may, in the judgment of the networks, remain eligible for network participation and not be excluded from the networks 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 networks 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 networks’ members, as determined in the networks’ sole discretion.

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## Reminder: Annual compliance training requirements

As previously posted in the June 2016 *Providers’ News*, **annual compliance training requirements must be completed by 12/31/2016**. Arkansas Blue Cross and Blue Shield is required by the Centers for Medicare and Medicaid Services to develop and maintain a compliance program and ensure annual compliance training is satisfied by our first-tier, downstream and related entities (FDRs) and delegated entities (DEs). General compliance training must occur within 90 days of initial hiring and annually thereafter. The annual training can be completed any time between January 1-December 31 in the contract year. CMS training courses are available, at no charge, on the CMS Medicare Learning Network® (MLN): <http://www.cms.gov/MLNProducts>.



# Coverage policy manual updates

Since December 2015, policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. The next two pages of this newsletter highlights the additions and updates. To view entire policies, access the coverage policies located our website at [arkansasbluecross.com](http://arkansasbluecross.com).

Policy ID#	Policy Name
1998105	Transplant, Lung and Lobar Lung
2001009	Glucose Monitoring, Continuous
2002029	Implantable Bone Conduction Hearing Aids
2006032	Interspinous and Interlaminar Stabilization/Distracton Devices (Spacers)
2011011	Preventive Services For Non-Grandfathered (PPACA) Plans: Abdominal Aortic Aneurysm Screening
2011013	Preventive Services For Non-Grandfathered (PPACA) Plans: Aspirin To Prevent Cardiovascular Disease In Adults
2011015	Preventive Services For Non-Grandfathered (PPACA) Plans: High Blood Pressure Screening In Adults
2011021	Preventive Services For Non-Grandfathered (PPACA) Plans: Cervical Cancer Screening
2011023	Preventive Services For Non-Grandfathered (PPACA) Plans: Hypothyroidism Screening In Newborns
2011028	Preventive Services For Non-Grandfathered (PPACA) Plans: Phenylketonuria Screening In Newborns
2011029	Preventive Services For Non-Grandfathered (PPACA) Plans: Dental Caries Prevention In Preschool Children
2011031	Preventive Services For Non-Grandfathered (PPACA) Plans: Osteoporosis Screening In Women
2011032	Preventive Services For Non-Grandfathered (PPACA) Plans: Sexually Transmitted Infections (Stis), Behavioral Counseling For Prevention
2011033	Preventive Services For Non-Grandfathered (PPACA) Plans: Visual Impairment Screening In Children
2011035	Preventive Services For Non-Grandfathered (PPACA) Plans: Gonorrhea Prophylaxis, Newborn Ophthalmic
2011041	Preventive Services For Non-Grandfathered (PPACA) Plans: Folic Acid For Prevention Of Neural Tube Defects
2011064	Viscocalostomy And Canaloplasty
2011066	Preventive Services For Non-Grandfathered (PPACA) Plans: Overview
2012018	Preventive Services For Non-Grandfathered (PPACA) Plans: Skin Cancer, Behavioral Counseling For Prevention

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Coverage policy manual updates (Continued from page 12)

Policy ID#	Policy Name
2012021	Preventive Services For Non-Grandfathered (PPACA) Plans: Intimate Partner Violence; Screening In Women
2012027	Pet Scan For Multiple Myeloma, Plasmacytoma
2012036	Preventive Services For Non-Grandfathered (PPACA) Plans: Anemia, Screening In Infants, Children And Adolescents
2012037	Preventive Services For Non-Grandfathered (PPACA) Plans: High Blood Pressure, Screening In Infants, Children And Adolescents
2012040	Preventive Services For Non-Grandfathered (PPACA) Plans: Congenital/Inherited Metabolic Disorders & Hemoglobinopathy, Screening In Newborns
2012041	Preventive Services For Non-Grandfathered (PPACA) Plans: Pregnancy Screening, Sexually Active Females Without Contraception, Late Menses Or Amenorrhea
2012042	Preventive Services For Non-Grandfathered (PPACA) Plans: Media Use By Children & Adolescents, Screening & Counseling
2012046	Preventive Services For Non-Grandfathered (PPACA) Plans: Well-Child Visits, Newborn, Infant, Children, Adolescents & Ages 18-21
2013015	Treatment Of Varicose Veins/Venous Insufficiency
2014020	Preventive Services For Non-Grandfathered (PPACA) Plans: Lung Cancer Screening
2016003	Omalizumab (Xolair)
2016005	Anti-PD-1 (programmed death receptor-1)Therapy (Pembrolizumab)(Nivolumab)
2016012	Daratumumab (Darzalex)
2016013	Eculizumab (Soliris)
2016014	Genetic Test: Use of Common Genetic Variants (Single Nucleotide Polymorphisms) to Predict Risk of Nonfamilial Breast Cancer
2016015	Alemtuzumab (Lemtrada)
2016016	Atezolizumab (Tecentriq)
2016017	Radium Ra 223 dichloride for Symptomatic Osseous Metastatic Prostate Cancer (Xofigo®; Ra 223)
2016018	Natalizumab (Tysabri)
2016019	Short Tandem Repeat Analysis for Specimen Provenance Testing (know error® system)
2016020	Dry Needling of Myofascial Trigger Points



# HHS finalizes rule to improve health equity and reduce healthcare disparities

The Department of Health and Human Services (HHS) published a final rule to implement Section 1557 of the Affordable Care Act (ACA). This newly effective regulation relates to nondiscrimination and meaningful access that must be implemented by October 18, 2016.

Individuals are protected from discrimination in healthcare on the basis of race, color, national origin, age, disability and sex, including discrimination based on pregnancy, gender identity and sex stereotyping.

The law also enhances language assistance for people with limited English proficiency. Additionally, it requires reasonable accommodations to help ensure effective communications and services to individuals with disabilities.

These provisions incorporate current federal non-discrimination law and policy and apply only to covered entities and extend to their employee health benefit programs.

## What does this regulation cover?

- Prohibits discrimination on the basis of sex identity or disability
- Requires that meaningful access be

provided to individuals with limited English proficiency

- Requires notices and multi-language taglines be included with all significant documents, websites and other materials related to member benefits
- Ensures effective communication with and accessibility for individuals with disabilities
- Implements a grievance process for civil rights complaints

## Who is impacted by this Act?

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS administers
- Health Insurance Marketplaces and all plans offered by companies that participate in those Marketplaces (including premium tax credits, cost sharing reductions through a federally-facilitated marketplace or Medicare A, C and D, Medicaid and other federal HHS dollars)

For more information on how this may impact you as a healthcare provider and your employees, visit <http://www.hhs.gov/sites/default/files/section1557-training-slides.pdf>



# Testing for drugs of abuse

Arkansas Blue Cross and Blue Shield has a Coverage Policy addressing Testing for Drugs of Abuse or Drugs at Risk of Abuse including Controlled Substances (Policy #2009013). This policy requires a positive precedent qualitative drug screen for each specific drug prior to quantitative drug testing. A screening test billed with either CPT codes 80300 or 80301 or new HCPCS codes G0477 or G0478 will be required before quantitative or definitive testing codes will be allowed. Please note that Arkansas Blue Cross considers the testing captured by billing of HCPCS G0479 and CPT 80302-80304 to be more extensive and complex testing than is required for screening and therefore does not meet primary coverage criteria and is not medically necessary.

The coverage criteria outlined in policy 2009013 is as follows:

## **Meets Primary Coverage Criteria Or Is Covered For Contracts Without Primary Coverage Criteria.**

Quantitative or definitive testing (80320-80377 or G0480-G0483) for specific drugs of abuse or drugs at risk of abuse including controlled substances meets member benefit certificate primary coverage criteria only when a precedent qualitative drug screen (80300-80301 or G0477-G0478) has been positive for the specific drug. For cases in which a specific drug test is performed in the absence of a positive drug screen, medical records should be submitted to justify the exception (e.g., in the event of an unexpected negative test where medication diversion may be expected).

## **Does Not Meet Primary Coverage Criteria Or Is Not Medically Necessary For Contracts Without Primary Coverage Criteria.**

Quantitative or definitive testing (80320-80377 or G0480-G0483) for specific tests for drugs of abuse or drugs at risk of abuse including controlled substance, in the absence of a positive drug screen do not meet member benefit primary coverage criteria for effectiveness as such additional testing is not cost effective.

For members with contracts without Primary Coverage Criteria, Quantitative or Definitive testing (80320-80377 or G0480-G0483) specific tests for drugs of abuse or drugs of risk of abuse including controlled substance, in the absence of a positive drug screen, are considered not medically necessary and are not covered. Services that are considered not medically necessary are specific contract exclusions in most member benefit certificates of coverage.

The use of quantitative testing as a drug screen (80302-80304 or G0479) does not meet member benefit certificate primary coverage criteria that there be scientific evidence of effectiveness and such testing is not cost-effective.

For members with contracts without Primary Coverage Criteria, the use of quantitative testing as a drug screen (80302-80304 or G0479) is considered not medically necessary and is not covered. Services that are considered not medically necessary are specific contract exclusions in most member benefit certificates of coverage.



# Eculizumab (Soliris) medical coverage policy

Eculizumab is approved by the U.S. Food and Drug Administration for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) and atypical hemolytic uremic syndrome (aHUS). Arkansas Blue Cross and Blue Shield has established a medical coverage policy #2016013. The policy lists coverage criteria required for use in PNH and aHUS.

**ECULIZUMAB FOR THE TREATMENT OF ANY OTHER INDICATION IS NOT COVERED.**

Coverage criteria include:

## Paroxysmal Nocturnal Hemoglobinuria

Coverage for eculizumab for paroxysmal nocturnal hemoglobinuria (PNH) requires medical record documentation of:

1. PNH as documented by flow cytometry including the presence of PNH type III red cells or glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs); AND
2. Immunization with a meningococcal vaccine at least two weeks prior to administration of the first dose of eculizumab (unless the clinical record documents that the risks of delaying eculizumab outweigh the risk of meningococcal infection); AND
3. Either of the following: A) Hemoglobin less than or equal to 7g/dl, or the individual has symptoms of anemia and the hemoglobin is less than or equal to 9 g/dl; OR B) Documented history of a major adverse vascular event (MAVE) from thromboembolism.
4. Dosage Regimen:
  - 600 mg via 35 minute intravenous infusion every seven days for the first four weeks, followed by

- 900 mg for the fifth dose seven days later, then
- 900 mg every 14 days thereafter.

## **Atypical Hemolytic Uremic Syndrome (aHUS)**

Coverage for eculizumab for paroxysmal nocturnal hemoglobinuria (PNH) requires medical record documentation of:

### Initial Six-week Trial

1. A diagnosis of aHUS supported by the absence of Shiga toxin-producing *E. coli* infection; AND
2. Thrombotic thrombocytopenic purpura (TTP) has been ruled out (for example, normal ADAMTS 13 activity and no evidence of an ADAMTS 13 inhibitor), or if TTP cannot be ruled out by laboratory and clinical evaluation, a trial of plasma exchange did not result in clinical improvement; AND
3. Individual has been immunized with a meningococcal vaccine at least two weeks prior to administration of the first dose of eculizumab (unless the clinical record documents that the risks of delaying eculizumab outweigh the risk of meningococcal infection).

### Continuation

1. Documents clinical improvement is required after the initial trial (e.g., increased platelet count or laboratory evidence of reduced hemolysis).

A complete copy of the medical coverage policy can be accessed by selecting Coverage Policy at [arkbluecross.com/members](http://arkbluecross.com/members).



# Prior authorization of specialty pharmacy

Arkansas Blue Cross and Blue Shield requires prior authorization for omalizumab (Xolair) and mepolizumab (Nucala). These medications will only be available under the member's medical benefit and must be obtained through CVS Caremark. These drugs will not be available for reimbursement

through the physician's office.

Prior authorization requests with all necessary documentation may be faxed to 1-501-378-6647. The prior authorization form for requested services can be found on [arkansasbluecross.com](http://arkansasbluecross.com).

The member's prescription

will also need to be faxed to CVS/Caremark Attn: Katrina Lyles or Kay Cannon at 1-877-362-3924.

Authorized requests will be submitted to CVS Caremark for shipment to the member or provider's office as designated by the member.

## Attention AHIN clearinghouse customers

Notice of Medicare Changes Effective October 24, 2016, Novitas Solutions EDI will no longer support dial-up connectivity. EDI trading partners connecting to Novitas using a dial-up modem will be unable to connect for claim submission or for report retrieval. Dial-up trading partners must use another connectivity method for claim submission. Secure File Transfer Protocol (SFTP) is the approved communication method for claim submission and receiving data using a secure network. The SFTP connection must be purchased through an approved Network Service Vendor (NSV).

### What does this mean for you?

If you are currently sending claims directly to Medicare using a dial-up modem you must select another connectivity method. Or if you are using a billing service or clearinghouse currently using a dial-up modem they also will need to select another connectivity method.

If another method is not selected your claims will not be sent to Medicare and reports/remits will not be able to be retrieved.

### How do I determine the type of connectivity?

You will need to contact your software vendor if you are sending directly to Medicare and are not sure of the connection type. Or if you are using a clearinghouse it is important to contact them to ensure they have updated their connections to Novitas.

### Is AHIN a Network Service Vendor?

Yes, AHIN Clearinghouse is an approved NSV for Novitas. As a clearinghouse, AHIN offers claim submission and reporting, electronic remits and real-time eligibility for government and commercial payers. All or parts of services are available at a low monthly cost.

Additional information on our clearinghouse services and pricing is available at AHIN Clearinghouse

Quick and easy clearinghouse online enrollment is located under Clearinghouse on the AHIN homepage.

Or contact us at (501) 378-2336, toll free (855) 822-2446 or [APSenrollment@ahin.net](mailto:APSenrollment@ahin.net)



# Did You Know?

The team at AHIN Professional services has extensive expertise across the Health Information Management (HIM) continuum affording us the ability and resources to provide comprehensive consulting services to healthcare providers. Our consulting services are designed to assist our clients with critical areas of coding and billing without breaking the bank. Some of our services include:

- Inpatient, outpatient and behavioral health coding audits
- Comprehensive RAC preparation including test audits and a subsequent plan to get you on the right track
- Denial management
- Charge master review
- Coding and documentation education
- Concurrent analysis of billing processes and identification of cycle impediments

Substantial benefits are derived from increasing an organization's ability to track projects and measure change. Giving statistical data to what otherwise may have been a blind spot helps bring awareness to areas of improvement and strengths. Data collection allows our team of consultants to diagnose billing inefficiencies or suggest other areas of improvement.

Contact AHIN Professional Services to help your office with today's challenging and complex billing and coding issues.

AHIN Professional Services  
Phone: 501-378-2446  
Email: [info@ahinservices.com](mailto:info@ahinservices.com)  
Web: [ahinservices.com](http://ahinservices.com)

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# Medicare Advantage - Stars Update

CMS Announces New Star Measures:

## Conducting Medication Reconciliation Post-Discharge (MRP)

Arkansas Blue Cross and Blue Shield will begin reimbursing providers who conduct medication reconciliation in the outpatient setting **within 30 days** of an inpatient discharge for Medi-Pak<sup>®</sup> Advantage members.

### Medication Reconciliation Post-Discharge Star Measure

This measure assesses patients age 18 and older who were discharged from an acute or non-acute inpatient stay between Jan. 1 and Dec. 1 of the measurement year. It looks at patients whose medications were reconciled from the date of discharge through 30 days after discharge (31 days total). Medication reconciliation is a review in which the discharge medications are reconciled with the most recent medication list in the outpatient record. It helps prevent adverse drug reactions and other medication-related issues that can occur after hospitalization. Medication reconciliation should be conducted by a prescribing practitioner, clinical pharmacist or registered nurse.

### Importance of Medication Reconciliation

Hospital admissions are often associated with unintentional discontinuation of medications for chronic conditions, and significant changes can occur to a patient's medication during hospitalization. The post-hospitalization follow-up visit provides an opportunity to address the condition that precipitated the hospitalization and to review the patient's medications. Conducting medication reconciliation after every discharge is an important step to ensure that medication errors are addressed and patients understand their new medications as well as medications that should no longer be taken.

### Medication Reconciliation Post-Discharge Reimbursement

**Effective September 1, 2016**, Arkansas Blue Cross and Blue Shield will reimburse providers who conduct medication reconciliation in the outpatient setting within 30 days of an inpatient discharge for Medi-Pak<sup>®</sup> Advantage members. When members are discharged from an inpatient stay, schedule a post-discharge office visit as soon as possible and perform medication reconciliation during the visit.

- The outpatient medical record must state that the “current and discharge medications were reconciled”
- Bill 1111F with the post-discharge office visit claim within 30 days of the discharge
- Medication reconciliation should be performed after every inpatient discharge

**1111F** is a reporting CPT 2 code which states, “Discharge medications reconciled with the current medication list in outpatient medical record.”

In addition to the reimbursement for the office visit, Arkansas Blue Cross will reimburse providers an additional \$10 for billing 1111F within 30 days of the patient's discharge.

(Continued on page 20)



## Hospitalization for Potentially Preventable Complications (HPC)

### About the Measure

The Hospitalization for Potentially Preventable Complications (HPC) measure evaluates patients age 67 and older with a diagnosis of an ambulatory care-sensitive condition (ACSC) that occurred during an inpatient visit. ACSCs are acute or chronic health conditions that can be managed or treated in an ambulatory setting.

Hospital inpatient data is used to assess the healthcare system as a whole, evaluating the quality of ambulatory care in preventing medical complications. This provides valuable information in determining how well a system of care helps older adults with chronic and acute conditions.

High rates of hospitalizations for ACSCs could indicate that members/patients aren't receiving high-quality ambulatory care. Because some complications are unavoidable, members with ambulatory care-sensitive conditions may be hospitalized. Measuring ACSC admissions can provide information for our healthcare providers that will help them improve outpatient care.

### What Providers Need to Know

Providers can manage and treat patients with ACSCs on an outpatient basis to help them avoid hospitalization. Older adults can develop serious complications as a result of hospitalization. Access to high-quality care, a focus on chronic disease self-management, appropriate care coordination and connection to community resources can reduce the chance that individuals with these chronic and/or acute conditions will develop complications resulting in hospitalization. To comply with Centers for Medicare & Medicaid Services (CMS) star reporting, Arkansas Blue Cross and Blue Shield will report member hospitalizations for ACSCs in accordance with HEDIS® specifications.

### Ambulatory Care Sensitive Conditions (ACSC) included in the Measure\*\*

Chronic ACSC	Acute ACSC
Diabetes, short & long-term complications	Bacterial pneumonia
Uncontrolled diabetes	Urinary tract infection
Lower extremity amputation (diabetics)	Cellulitis
Chronic obstructive pulmonary disease	Pressure ulcer
Asthma / Hypertension / Heart failure	

\*\* Exclusions apply. These include traumatic amputations, cystic fibrosis, congestive heart failure or hypertensive patients with a cardiac procedure or diagnosis of stage 1 to stage 4 kidney disease with a dialysis procedure, and patients who reside in a skilled nursing facility for 100 days or more during the measurement year.

### Did You Know?

Many studies have shown a correlation between chronic conditions and depression. According to a World Health Organization study, health scores worsened when depression was a comorbid condition. That's why depression screening or referral to a behavioral health specialist can help improve health outcomes for patients with chronic conditions.

(Continued on page 21)



## Treating Patients with Rheumatoid Arthritis (RA)

It's important for providers to follow national guidelines when treating patients diagnosed with rheumatoid arthritis (RA) in order to prevent long-term damage and disability. Review of Arkansas Blue Cross and Blue Shield clinical quality data revealed that approximately 20 percent of Medi-Pak<sup>®</sup> Advantage members with RA aren't receiving the necessary disease modifying anti-rheumatic drug (DMARD) therapy.

### Why DMARD Therapy?

Several major studies have documented the benefits of aggressive early treatment for RA. DMARD therapy may increase the quality of life more effectively than other treatment strategies. The American College of Rheumatology recommends that all RA patients be prescribed a DMARD regardless of how active or severe their RA might be.

Appropriate DMARD treatment can potentially reduce a patient's disability by more than 60 percent. According to the American College of Rheumatology, correctly diagnosed RA patients should be treated with a DMARD unless indicated otherwise. Once an RA diagnosis has been made, all RA patients should be treated according to accepted clinical practice guidelines.

### Treatment Plan

Rheumatoid arthritis patients should receive at least one DMARD prescription each year and be referred to a rheumatologist. Keep in mind that patients receiving a DMARD should be regularly monitored for early detection and management of adverse events associated with a specific drug or biologic agent.

### Ensure Accurate Diagnosis and Coding

Patients' claims are sometimes coded inaccurately for RA when instead they may have joint pain or other signs and symptoms of similar conditions that must be addressed. A claim for RA shouldn't be submitted unless it's a confirmed diagnosis. Please note ICD-10 coding guidelines state the following:

- Don't code diagnoses using "uncertain" terms such as "*probable*", "*suspected*", "*questionable*", "*rule out*", or "*working diagnosis*". Instead, code conditions to the highest degree of specificity for the encounter, including signs, symptoms, abnormal test results or other reason for the visit.
- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis hasn't been established (confirmed) by the provider.



# CMS issues guidelines for online provider directories

The Centers for Medicare & Medicaid Services (CMS) is requiring all Medicare Advantage plans to provide its enrollees with the most up-to-date information regarding participating providers on their online provider directories. CMS has issued guidelines that all Medicare Advantage plans and participating providers must follow.

Under the new CMS program, Medicare Advantage plans must have regular, ongoing communications with providers to ascertain their availability and, more specifically, whether they are accepting new patients.

Plans are required to maintain accurate online provider directories by:

- Displaying all active participating providers
- Identifying providers whose practice is closed or providers not accepting new patients

- Updating online provider directories in real-time
- Communicating with providers monthly regarding their network status and information accuracy

Medicare Advantage plans are expected to require participating providers to inform the plan of any change to street addresses, phone numbers, office hours or any other change that can affect their availability. Medicare Advantage plans are also required to develop and implement a protocol to effectively address inquiries and complaints related to enrollees being denied access to a participating provider and make immediate corrections to their online provider directory.

In order to meet these CMS requirements, providers participating in the Medi-Pak® Advantage PFFS,

Medi-Pak® Advantage LPPO, and Medi-Pak® Advantage HMO plans are now required to maintain and updated their information with Arkansas Blue Cross and Blue Shield.

To assist providers, Arkansas Blue Cross is developing an information update screen on the AHIN website. Providers will be able to update information such as their status of accepting new patients, joining or terminating from an existing clinic, and their hours of service. On the AHIN provider detail page, providers will be able to update their patient restrictions under the network tab and update their office hours under the provider association tab. Reminders will also be published in subsequent editions of the Providers' News as well as monthly reminders on AHIN.



# Medi-Pak Advantage case management

Arkansas Blue Cross and Blue Shield Medical Management utilizes case management as a core function in meeting the needs of our members and your patients.

Case management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Case management is a collaborative process

which assesses, plans, implements and evaluates options and services to meet an individual's health needs. Case managers, in collaboration with the member's treating practitioners, provide education and coordination of services in an effort to help the member achieve optimal health outcomes and prevent complication of disease.

Arkansas Blue Cross Blue Shield can help your office by:

- Working collaboratively with the health care team

- Managing chronic disease
- Assisting with medication adherence
- Assisting with transition of care coordination
- Serving as member advocate in the administration of benefits
- Accessing community resources to improve health

Call us to refer your Medi-Pak Advantage patients for case management at 1-800-285-6658. We will be glad to assist you.

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# Medi-Pak Advantage quality improvement programs

In 2016 each Medi-Pak Advantage Health Plan has quality improvement programs that help you help members with Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Hypertension other chronic diseases to stay healthy and decrease unnecessary hospital readmissions and emergency department visits.

These programs can help

your patients and offer a number of services like facilitating follow-up with a provider and recommended screenings and tests. Additionally our program provides education about chronic conditions, medications and lifestyle modification that can improve the health of your patient. We have support groups in some areas of the state. Local care managers are there

as always to help you in navigating the health care system and understanding your benefits.

We have a team of care managers across the state. We are all working together with you to improve health in Arkansas. For more information about these programs call 1-800-285-6658.



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Editor: Suzette Weast • 501-378-2002 • FAX 501-378-2464 • [ProvidersNews@arkbluecross.com](mailto:ProvidersNews@arkbluecross.com)

## PLEASE NOTE

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield and its affiliated companies. The newsletter does not pertain to traditional Medicare. Traditional Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

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