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PROVIDERS' NEWS

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

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Good Friday
Friday, April 15

Memorial Day
Monday, May 30

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

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PROVIDERS' NEWS

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Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Arkansas Blue Cross and Blue Shield

Availity® is faster for checking eligibility & benefits

Healthcare providers and clinic staff who call Arkansas Blue Cross Customer Service to **check eligibility, benefits and claims status** have an **online option** that can help them get those answers much faster – the Availity Essentials portal.

The Availity Essentials portal (https://www.availity.com/arkansasbluecross) gives providers access to real-time information that is identical to that used by phone-based Customer Service representatives and can be accessed in seconds, around the clock. This allows healthcare providers and staff to quickly obtain the information they need to efficiently serve their patients.

Providers are encouraged to call to check eligibility/benefits, etc., only if they have difficulty accessing Availity. Providers also should be aware that eligibility/benefits calls will be given lower priority than calls from members and may incur longer wait times.

For **prior authorization information**, providers should check **AHIN** (https://secure.ahin-net.com/ahin/Session/logon), which also is available 24/7.

Healthcare providers and staff who have issues accessing the Availity platform should call

1-800-282-4548 (or **1-800-AVAILITY**) – 7 a.m. to 7 p.m. Central Time.

We appreciate the cooperation of healthcare providers and their staffs as we work together to serve the people who trust us for their health coverage.

New Availity® functions coming soon

The teams at Arkansas Blue Cross and Blue Shield and Availity® continue to work to create additional functionality on the Availity Essentials portal similar to what you have used in AHIN. Provider data management functions will be the next transition from AHIN to Availity.

These functions include:

- Adding new provider applications to an existing clinic.
- Adding or terminating a provider from an existing clinic or group.
- Recredentialing for all professional providers.
- Updating provider data.

Please continue to monitor the Availity Payer Space News & Announcements for updates.

You will need to maintain your AHIN access and continue to complete the needed provider enrollment, updates and recredentialing on AHIN until full transition of these functions have been made to Availity.

The **Health Information Network** section on the Arkansas Blue Cross website is a helpful resource which lists current Availity and AHIN access as well as how to register for Availity and AHIN.

Consolidated Appropriations Act – Update provider directory information

The Consolidated Appropriations Act (CAA) effective January 1, 2022, requires providers to update directory information and provide refunds to enrollees if out-of-network costs are inappropriately applied (in certain circumstances).

In order to ensure accurate provider directory information, the CAA requires group health plans and issuers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days. A**ccordingly, it is very important that healthcare providers respond in a timely manner to Arkansas Blue Cross and Blue Shield when we inquire about their provider information. This includes attesting to the information's accuracy to avoid possible network termination from our provider networks due to noncompliance with the requirements of the law.**

At this time about half of the provider data profiles that are being sent to providers for verification are being ignored by the provider community. **This law requires providers to respond to these requests every 90 days that they are distributed.**

We appreciate your help complying with our requests as we navigate the new CAA requirements together.

COVID-19 update for members covered by Arkansas Blue Cross and Blue Shield and Health Advantage (fully insured health plans)

Arkansas Blue Cross and Blue Shield and Health Advantage are committed to the safety and well-being of our members. Since the beginning of the COVID-19 public health emergency, we have been working closely with the state and federal government during the coronavirus outbreak to help our fully insured members get access to the care they need during the coronavirus outbreak.

Status of COVID-19 expanded benefits

At the outset of the COVID-19 public health emergency, Arkansas Blue Cross and Health Advantage temporarily extended a number of voluntary, expanded COVID-19-related benefits and suspended some of our normal practices.

Of course, those measures covered under federal mandates will remain in force until federal officials advise that they may be discontinued. Officials have announced the federal mandate will continue **through April 15, 2022**.

Please note: *Decisions about coverage changes for members of self-funded health plans served by BlueAdvantage Administrators of Arkansas or Health Advantage are made by the employers or plan sponsors who fund those self-funded programs. If you have questions about coverage, please call the number on the back of the health plan member ID card.*

Here is an updated rundown of the status of COVID-19-related benefits and measures:

- **Coverage (at no cost to our members) of COVID-19 diagnostic tests ordered by healthcare providers.**
  This applies to diagnostic testing services that meet primary coverage criteria for COVID-19 as defined by the Centers for Disease Control & Prevention (CDC) and are ordered by a healthcare provider.
- **Waiver of cost-sharing for medical services for our fully insured members whose primary diagnosis is COVID-19.**
  This includes COVID-19-specific visits to an in-network medical clinic, urgent care center and/or emergency room and inpatient treatment for which COVID-19 is the primary diagnosis.
- **Suspension of prior authorization for inpatient hospital admissions and outpatient procedures at hospitals and ambulatory surgery centers.**
  Prior authorizations for inpatient hospital admissions and outpatient procedures at hospitals and ambulatory surgery centers have been temporarily suspended.

The federally mandated measures for COVID-19 services (e.g., concerning COVID testing and COVID vaccines) will remain in force until the public health emergency is terminated by the federal government. When the termination date for the public health emergency is known, Arkansas Blue Cross will notify healthcare providers 90 days in advance of the measure being discontinued.

If you have questions about the status of COVID-19-related benefits and related member cost-sharing, please contact your Arkansas Blue Cross network development representative.

Thanks for your continued commitment to serve our members with excellent healthcare and effective utilization of their health benefits.

New process for medical transports

Arkansas Blue Cross and Blue Shield has engaged Alacura Medical Transportation to provide medical transport network development and patient transport coordination services on behalf of our members.

In the past, Arkansas Blue Cross simply maintained a benefit cap (a maximum allowable amount) on billed medical transport services and has not maintained a formal transportation network, as is done for other healthcare providers and medical services.

However, recent legislation – the Consolidated Appropriations Act of 2021 (CAA) – has prompted us (effective **January 1, 2022**) to establish a formal medical transport network.

That's where Alacura comes in. Alacura's expertise is in developing medical transport networks for rotary, fixed-wing and ground ambulance services and working daily with medical professionals to quickly determine the most medically appropriate and cost-efficient mode of transport for each patient's individual situation. Alacura is a nationally recognized player in this field and is working to perform medical transport-related services for a dozen other Blue Cross Blue Shield Association affiliates and another 11 major health plans.

Under this new medical transport benefit, Alacura will operate a **medical transport transfer center** for Arkansas Blue Cross members that will be available 24 x 7 x 365.

Alacura will develop relationships with medical transport decision-makers at healthcare facilities – notifying them to call Alacura when a transport is needed. In addition, Alacura will proactively reach out to inquire about potential air transports.

Alacura will work in real time with healthcare professionals directly involved in each case to rapidly – often within seconds – agree upon and arrange the most appropriate transport mode. This service will not replace calling 911 for local emergency medical services.

Medical transport and healthcare facilities may contact Alacura to coordinate transportation or for general information at **1-844-4ALACURA** (**1-844-425-2287**). Additional information can also be found at **www.alacura.com**.

Healthcare providers who have questions about the new medical transport process may contact their assigned Arkansas Blue Cross representative.

Alacura Medical Transportation is not affiliated with Arkansas Blue Cross and Blue Shield or with the Blue Cross and Blue Shield Association and is an independent company that provides medical transport network management and medical transport coordination services for Arkansas Blue Cross and its members.

Trend Health Partners

Later this year, Arkansas Blue Cross and Blue Shield and its subsidiaries will begin rolling out a new credit balance reconciliation and recovery service with Trend Health Partners. The service is designed to assist our provider partners in researching and resolving outstanding credit balances and to reduce the administrative burden on facility staff. Through this initiative, Arkansas Blue Cross will provide access to a range of vendor-based solutions including an innovative software platform and skilled professional services to aid in credit balance resolution specific to our members.

These services support the provider's administrative team by managing credit balances on the facility's books while resolving potential overpayments in real time with Arkansas Blue Cross and allowing more efficient use of valuable resources.

Be watching for more information as we prepare to launch these innovative services.

USAble MCO frequently asked questions and common concerns about workers' compensation

The USAble MCO leases our True Blue PPO network to insurance carriers and self-insured employers. Payment for worker's compensation claims is set out by regulation. Payments must be the lesser of the provider's usual charge, the maximum fee calculated according to the Arkansas Workers' Compensation Commission (AWCC) Official Fee Schedule, or the MCO/PPO contracted price (True Blue PPO).

In specific extraordinary services, a greater fee may be allowed up to 150% of the fee schedule. We would note that for USAble MCO customers, the payment is the same True Blue PPO price that facilities or other providers are

paid on commercial health claims. Workers' compensation payers are required to date stamp bills, and any clean claim/properly submitted bill must be paid within 30 days of receipt.

Facilities should understand that with the exception of radiology and lab codes, there is no Arkansas Workers' Compensation Commission (AWCC) state fee schedule for outpatient facility charges. That being said, the rate paid to facilities for most workers' compensation outpatient services on is a PPO negotiated rate. For USAble MCO customers, this would be pricing from the True Blue PPO.

It is important to note that there is a provider outpatient fee schedule on the AWCC website. This **fee schedule** may **not** be used in calculating facility reimbursement for outpatient claims.

Reports and notes

Just as in commercial health insurance billing, reports and notes will be required if procedure is not listed in the Medicare Resource Based Relative Value Scale (RBRVS). In this case, the AWCC has not assigned a maximum fee and requires a written description. For USAble MCO customers, these codes will be paid per network customization percentage. This is the same method that is used for commercial health claims.

In workers' compensation claims, a provider is required to furnish the payer with a narrative medical report for the initial visit and may bill for the report. Medical reports are billable at the rate of

- $40.00 for the initial report (WC101)
- $11.00 for subsequent reports (WC102)
- $28.00 for the final report (WC103)

Preauthorization

The current guidelines issued from the Arkansas Worker's Compensation Commission [AWCC] require **certain procedures** receive preauthorization prior to rendering those services.

Preauthorization services **would be required** for the following procedures:

- Nonemergency hospitalizations
- Transfers between facilities
- Outpatient facility services exceeding $1,000 billed by a provider for a single date of service.
- Most outpatient surgeries
- Most MRIs
  - MR arthrograms (MRI after arthrogram)
  - Myelograms
  - ESIs (depending on location of service)

Services that typically do not require preauthorization services:

- Venograms
- Bone scans
- Arthrograms
- CT scans

- Ultrasounds
- EMG/NCV studies

Denials

A denial decision for payment for any type of health care services and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury, shall only be made by an Arkansas certified private review agent. Upon emergency admission, notice must be given to the carrier **within 24 hours** or for the next business day.

If you have further questions, please call Ann Shelnutt at 501-378-2333 or Becky Foreman at 501-378-2332.

Coverage Policy manual updates

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

Policy ID	Policy Name
1997054	Bone Mineral Density Study
1997066	Periurethral Bulking Agents for the Treatment of Urinary and Fecal Incontinence
1997088	Hyperbaric Oxygen Pressurization (HBO)
1997113	Immune Globulin, Intravenous and Subcutaneous
1997128	Leuprolide (Lupron)
1997169	Photochemotherapy (PUVA)
1997210	Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy Gamma Knife Surgery, Linear Accelerator, Cyberknife, TomoTherapy
1997233	Spinal Decompression Therapy (Internal Disc Decompression Therapy, Spinal Distraction Therapy) Using Motorized and/or Computerized Traction
1998076	Meniscal Allograft Transplantation and Synthetic Meniscal Implants
1998109	Chimeric Antigen Receptor Therapy for Hematologic Malignancies (CAR-T)
1998114	Pulmonary Rehabilitation
1998137	Genetic Test: Alzheimer's Disease
1998141	Quantitative Sensory Testing
1998144	Pulmonary Arterial Hypertension, Infusion and Selected Inhalation therapy
2000001	PET or PET/CT for Colorectal Cancer
2000002	PET or PET/CT for Non-Hodgkins Lymphoma and Leukemia
2000003	PET or PET/CT for Melanoma
2000023	PET or PET/CT for Head and Neck Malignant Disease
2001009	Non-Implantable Insulin Infusion Devices, Hybrid Insulin Infusion Devices, and Continuous Glucose Monitoring Devices
2001012	Laser or Radiofrequency Treatment, Chronic Back Pain
2001028	Magnetic Resonance Imaging (MRI), Breast
2001035	PET or PET/CT for Prostate Cancer
2001036	PET or PET/CT for Breast Cancer
2001037	PET or PET/CT for Ovarian Cancer

Policy ID	Policy Name
2001038	PET or PET/CT for Pancreatic Cancer
2001039	PET or PET/CT for Neuroendocrine Tumors
2001040	PET or PET/CT for Testicular Germ Cell Cancer
2002002	Genetic Test: Azothiaprine, 6MP Sensitivity,Genotyping & Phenotyping (TPMT) (NUDT15)
2002008	Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon
2002015	PET or PET/CT for Carcinoma of Unknown Primary (CUP)
2002029	Implantable Bone Conduction Hearing Aids
2003015	Intensity Modulated Radiation Therapy (IMRT)
2003055	Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric Disorders
2004007	Radiofrequency Ablation, Renal Tumors
2004017	Genetic Test: Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer
2004024	PET or PET/CT for Thyroid Cancer
2004029	Genetic Test: Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients With Breast Cancer (Oncotype DX®, EndoPredict, the Breast Cancer Index and Prosigna, Mammaprint and BluePrint)
2005007	PET or PET/CT for Cervical Cancer
2005008	PET or PET/CT for Pleural Mesothelioma
2005010	Cardiac and Coronary Artery Computed Tomography, CT Derived Fractional Flow Reserve and CT Coronary Calcium Scoring
2005033	PET or PET/CT for Primary Central Nervous System Cancer (Malignant Brain and Spinal Cord Tumors)
2008012	Radiation Therapy, Proton Beam or Helium Ion Irradiation
2009004	Biochemical Markers, Alzheimer's Disease
2009019	Sleep Apnea, Testing
2009036	Intensity Modulated Radiation Therapy (IMRT), Breast
2009049	Platelet-Rich Plasma (Autologous Growth Factors)
2010017	Aqueous Shunts and Devices for Glaucoma
2011008	Left Atrial Appendage, Closure Device, Percutaneous
2011024	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: TOBACCO USE, SCREENING, COUNSELING AND INTERVENTIONS
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
2011045	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: COLORECTAL CANCER SCREENING
2011066	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: OVERVIEW
2011069	PET or PET/CT for Anal Carcinoma
2011074	PET or PET/CT for Gastric Cancer
2011077	Transcatheter Aortic Valve Implantation
2012003	Genetic Test: Molecular Markers in Fine Needle Aspirates of the Thyroid
2012006	Genetic Test: X-Linked Opitz G/BBB Syndrome, MID1 Mutation Testing
2012009	Skin and Soft Tissue Substitutes, Bio-Engineered Products
2012022	PET or PET/CT for Urological Cancers

Policy ID	Policy Name
2012024	PET or PET/CT for Cancers of the Thymus, Heart, and Mediastinum
2012025	Biomarkers for Liver Disease
2012027	PET Scan for Multiple Myeloma, Plasmacytoma
2012056	PET or PET/CT for Histiocytic Neoplasms (eg Pulmonary Langerhans Cell Histiocytosis)
2012058	PET or PET/CT for Small Cell Lung Cancer
2012065	Laser Interstitial Thermal Therapy for Neurological Conditions
2013002	PET or PET/CT for Hodgkin's Lymphoma
2013005	Sacroiliac Joint Fusion, Minimally Invasive
2013008	PET or PET/CT for Soft Tissue Sarcoma, including Gastrointestinal Stromal Tumor (GIST)
2013023	PREVENTIVE SERVICES FOR NON-GRANDFATHERED (PPACA) PLANS: HEPATITIS C VIRUS SCREENING
2013034	Peroral Endoscopic Myotomy (POEM) for Treatment of Esophageal Achalasia
2013035	Genetic Test: Whole Exome and Whole Genome Sequencing
2013047	Navigated Transcranial Magnetic Stimulation
2015002	Mutation Molecular Analysis for Targeted Therapy in Patients With Non-Small-Cell Lung Cancer
2015005	Genetic Test: Pharmacogenetic Testing for Pain Management
2015007	Laboratory Tests for Chronic Heart Failure and Heart and Kidney Transplant Rejection
2015014	Amniotic Membrane and Amniotic Fluid Injections
2015034	Telehealth
2015035	Sleep Apnea, Minimally Invasive Surgical Treatment
2016001	Multispectral Digital Skin Lesion Analysis (MSDSLA) (e.g., MelaFind®)
2016003	Omalizumab (Xolair)
2016004	Lab Test: Identification of Microorganisms Using Nucleic Acid Probes
2016010	Mepolizumab (Nucala)
2016016	Atezolizumab (Tecentriq®)
2016022	PET or PET/CT for Uterine Cancer
2017004	Asfotase alfa (Strensiq®)
2017006	Bevacizumab (Avastin™) for Oncologic Indications
2017009	Denosumab (XGEVA™ and Prolia™)
2017031	Dupilumab
2018008	Reslizumab (Cinqair)
2018009	Benralizumab (Fasenra)
2018011	PET or PET/CT for Penile, Vaginal, and Vulvar Cancer
2018012	PET or PET/CT for Bone Cancer
2018030	Site of Care or Site of Service Review
2019005	Pembrolizumab (KEYTRUDA®)
2019009	Romosozumab-aqqg (Evenity®)
2020001	Adoptive Immunotherapy
2020005	Self-Administered Medication
2020007	Eptinezumab-jjmr (VYEPTI™)
2020023	Bimatoprost (Durysta™)
2020029	Covid-19 Monoclonal Antibody Therapy
2020030	Alglucosidase alfa (Lumizyme™)
2021004	PET or PET/CT for Cancer Surveillance and Other Oncologic Applications
2021024	White Blood Cell Growth Factors (Colony Stimulating Factors)

Policy ID	Policy Name
2021034	Rituximab (Rituxan) and Biosimilars – Non-Oncologic Indications
2021036	Iobenguane I 131 (Azedra®)
2021040	Amivantamab-vmjw (Rybrevant™)
2021041	Avalglucosidase alfa-ngpt (Nexviazyme)
2021042	Aducanumab (Aduhelm)
2021046	Trilaciclib (Cosela)
2022001	Efgartigimod (e.g., Vyvgart)
2022002	Plasminogen [Ryplazim]
2022003	Cabotegravir ER inj susp (e.g., Apretude)
2022004	Cryoablation for Chronic Rhinitis

Medical specialty medications prior approval update

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

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

Drug	Indication	Benefit
Abecma (idecabtagene vicleucel)	Multiple Myeloma	Medical
Adakveo (crizanlizumab-tcma)	Sickle cell disease	Medical
Aldurazyme (laronidase)	MPS I Hurler syndrome	Medical
Apretude (cabotegravir)	Pre-exposure prophylaxis	Medical
Arcalyst (rilonacept)	CAPS DIRA Recurrent pericarditis	Medical
Benlysta (belimumab)	Systemic lupus erythematosus Lupus nephritis	Medical
Berinert (c1 esterase, inhib, human)	Hereditary angioedema	Medical
Breyanzi (lisocabtagene maraleucel)	Large B-cell lymphoma	Medical
Brineura (cerliponase alfa)	CLN2 disease	Medical

Drug	Indication	Benefit
Cabenuva (cabotegravir & rilpivirine)	HIV	Medical
Cablivi (caplacizumab-yhdp)	Thrombocytic thrombocytopenia	Medical & Pharmacy
Cinqair (reslizumab)	Severe asthma	Medical
Cinryze (c1 Esterase, inhib, human)	Hereditary angioedema	Medical
Crysvita (burosumab – twza)	Hypophosphatemia Tumor induced steomalacia	Medical & Pharmacy
Duopa (levodopa-carpidopa intestinal gel)	Parkinson's	Medical
Durysta (bimatoprost)	Open-angle glaucoma Ocular hypertension	Medical
Elaprase (idursulfase)	MPS II Hunter syndrome	Medical
Elzonris (tagraxifusp-erzs)	BPDCN	Medical
Enspryng (satralizumab-mwge)	NMOSD	Medical & Pharmacy
Evenity (romosozumab-aqqg)	Severe Osteoporosis	Medical
Evkeeza (evinacumab-dgnb)	Homozygous familial hypercholesterolemia	Medical
Fabrazyme (agalsidase beta)	Fabry disease	Medical
Fasenra (benralizumab)	Mod to severe asthma	Pharmacy
Firazyr (icatabant acetate)	Hereditary angioedema	Pharmacy
Gamifant (emapalumab-lzsg)	Hemophagocytic lymphohistiocytosis	Medical
Givlaari (givosiran)	Acute hepatic porphyria	Medical
Haegarda (c1 esterase, inhib, human)	Hereditary angioedema	Pharmacy
Ilaris (canakinumab)	Periodic fever syndrome Still's disease	Medical & Pharmacy

Drug	Indication	Benefit
Kalbitor (ecallantide)	Hereditary angioedema	Medical & Pharmacy
Krystexxa (pegloticase)	Gout	Medical
Kymriah (tisagenlecleucel)	Cancers	Medical *Reviewed by Transplant Coordinator
Lemtrada (alemtuzumab)	Multiple Sclerosis	Medical
Lumizyme (alglucosidase alfa)	Pompe Disease	Medical
Lutathera (lutetium Lu 177 Dotatate)	Neuroendocrine tumors	Medical
Mepsevii (vestronidase-Alfa)	MPS VII Sly syndrome	Medical
Myalept (metreleptin)	Lipodystrophy	Pharmacy
Nagalzyme (galsulfase)	MPS VI Maroteaux-Lamy syndrome	Medical
Nucala (mepolizumab)	Mod to severe asthma	Pharmacy
	Hypereosinophilic syndrome	
Oxlumo (lumasiran)	Primary hyperoxaluria	Medical
Reblozyl (luspatercept)	Beta thalassemia	Medical
	Myelodysplastic syndrome	
Ruconest (c1 esterase, inhib, recombinant)	Hereditary angioedema	Medical
Ryplazim (plasminogen)	Plasminogen deficiency type 1	Medical
Saphnelo (anifrolumab-fnia)	System lupus erythematosus	Medical
Soliris (eculizumab)	PNH	Medical
	aHUS	
	Myasthenia Gravis	
	NMOSD	
Spinraza (nusinersen)	Spinal muscle atrophy	Medical
Spravato (esketamine)	Treatment resistant depression	Pharmacy
	Major depressive disorder with suicidality	

Drug	Indication	Benefit
Stelara (ustekinumab)	Crohn's disease	Medical & Pharmacy
	Plaque psoriasis	
	Psoriatic arthritis	
	Ulcerative colitis	
Strensiq (asfotase alfa)	Hypophosphatasia	Pharmacy
Takhzyro (lanadelumab)	Hereditary angioedema	Pharmacy
Tecartus (brexucabtagene autoleucel)	Mantle cell lymphoma	Medical
Tepezza (teprotumumab)	Thyroid eye disease	Medical
Ultomiris (ravulizumab-cwyz)	PNH	Medical
Uplizna (inebilizumab)	Neuromyelitis optica spectrum disorder	Medical
Vimizim (elosulfase alfa)	MPS IV Morquio A	Medical
Vyvgart (efgartigimod alfa-fcab)	Myasthenia gravis	Medical
Yescarta (axicabtagene ciloleucel)	Cancers	Medical *Reviewed by Transplant Coordinator
Xolair (omalizumab)	Mod to severe asthma	Pharmacy
	Urticaria	
Zolgensma (onasmnogene abeparvovec-XIOI)	Spinal muscle atrophy	Medical
Zulresso (brexanolone)	Postpartum depression	Medical

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 501-210-7051 for BlueAdvantage members. For all other members, the appropriate fax number is 501-378-6647.

Standard formulary changes effective April 1, 2022

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

Drug	Change	Formulary Alternatives
GEMTESA TAB 75MG	Adding Drug	
HAEGARDA INJ	Adding Drug	
Azithromycin Powder 1GM	Move to Non-Preferred Drug Tier	
BYSTOLIC TAB all strengths	Move to Non-Preferred Drug Tier	generic now available - Nebivolol
Entacapone/Levodopa/Carbidopa all strengths	Move to Non-Preferred Drug Tier	
DUREZOL 0.05% OPHTHALMIC SOLUTION	Move to Non-Preferred Drug Tier	
Methoxsalen Cap 10MG	Move to Non-Preferred Drug Tier	
SUTENT CAP all strenghts	Move to Non-Preferred Drug Tier	
Adapalene Pad 0.1%	Not Covered	Use other adapalene topical generics, benzoyl peroxide, clindamycin gel, clindamycin solution, clindamycin- benzoyl peroxide, erythromycin solution, erythromycin- benzoyl peroxide, tretinoin
Albuterol Inhaler HFA 200	Not Covered	Use albuterol sulfate CFC-free aerosol (except NDC 66993001968), levalbuterol tartrate CFC-free aerosol
Butalbital/APAP TAB 25-325MG, Butalbital/APAP CAP 50-300MG, VTOL LQ SOL	Not Covered	Use diclofenac sodium, ibuprofen, naproxen (except CR, susp)
CapsFenac Pak, Capsinac, Diclofex DC, DicloHeal-60, Iclofenac CP, Kapzin DC, Pennsaicin, Sure Result DSS Premium Pack, Ziclopro	Not Covered	Use diclofenac sodium, diclofenac sodium gel 1%, diclofenac sodium solution, ibuprofen, meloxicam tablet, naproxen naproxen (except CR, susp)
Ciprofloxacin-Fluocinolone (otic)	Not Covered	Use ciprofloxacin-dexamethasone, ofloxacin otic
Desonide Gel 0.05%, DESRX GEL 0.05%	Not Covered	Use desonide (except desonide gel), hydrocortisone
Doxycycline Hycalate tab 75MG, 80MG, 150MG DR	Not Covered	Use doxycycline hyclate 20 mg, doxycycline hyclate capsule, minocycline, tetracycline
DYMISTA SPRAY	Not Covered	Use azelastine-fluticasone, flunisolide, fluticasone, mometasone
EPANED 1MG/ML SOLUTION	Not Covered	Use enalapril, fosinopril, lisinopril, quinapril, ramipril
MYRBETRIQ	Not Covered	Use generics GEMTESA, TOVIAZ
NUEDEXTA CAP 20-10MG	Not Covered	Consult doctor for preferred alternatives

Drug	Change	Formulary Alternatives
Peg 3350-electrolytes (generics for Moviprep only)	Not Covered	Use peg 3350-electrolytes (except generics for MOVIPREP), CLENPIQ
Prednisolone Solution (10MG/5ML, 20mg/5ml)	Not Covered	Use dexamethasone, hydrocortisone, methylprednisolone, prednisolone solution (except prednisolone solution 10 mg/5 mL, 20 mg/5 mL), prednisone

Requests for step therapy drugs for contracts subject to Act 97

Act 97 of the Arkansas legislature requires payors to provide an exigent request process for those drugs Arkansas Blue Cross Blue Shield identifies as subject to step therapy (e.g., as defined by the Act "a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition and that are medically appropriate for a patient are covered by a healthcare insurer or health benefit plan…."). **All drugs on the step-therapy list require prior approval.**

This law is applicable **only** to the following lines of business: **Arkansas Blue Cross and Blue Shield fully insured (Arkansas Blue Cross, Health Advantage, Blue Exchange) and specified governmental health plans (Arkansas State and Public School Employees).** The law is **not** applicable to other self-insured groups (including but not limited to Walmart, Tyson, Blue Advantage groups and/or FEP).

The law is applicable only to those drugs identified as step-therapy. Requests for drugs not on the step therapy list will be denied. The provider may submit a request for non-step therapy drugs as per usual process of drug/service requests.

Arkansas Blue Cross and Blue Shield maintains a list of these drugs updated quarterly:

- Drugs provided under medical benefit.

Policy ID#	Policy Name
2021033	Belimumab (Benlysta)
2020023	Bimatoprost (Durysta™)
2019012	Brexanolone (Zulresso™)
2016013	C 5 Complement Inhibitors (Eculizumab and Ravulizumab)
2020026	Canakinumab (Ilaris™)
2018002	Chemodenervation, Botulinum Toxins (Migraine headache requests only)
2020011	Crizanlizumab (Adakveo™)
2022001	Efartimod (Vyvgart) (new policy effective Jan 12, 2022)
2019013	Emapalumab-LZSG (Gamifant)
2020007	Eptinezumab-jjmr (VYEPTI™)
2021027	Evinacumab-dgnb (Evkeeza)

Policy ID#	Policy Name
2013032	Hereditary Angioedema (HAE), Prophylaxis and Acute Treatment (Chronic therapy only – Cinryze)
2009047	Hormone Pellet Implantation Hormone Replacement Therapy
1998161	Infliximab
1997153	Iron Therapy, Parenteral
2018023	Levodopa-carbidopa Intestinal Gel (Duopa) for Treatment of Advanced Parkinson's Disease
2021032	Lumasiran (Oxlumo)
2016018	Natalizumab (Tysabri)
2016021	Paliperidone Palmitate (Long-acting Injectables Invega Sustenna® & Invega Trinza)
2018027	Pegloticase (Krystexxa®)

Policy ID#	Policy Name
1998144	Pulmonary Arterial Hypertension, Pharmacological Treatment with Prostacyclin Analogues, Endothelin Receptors Antagonists, or Phosphodiesterase Inhibitors. Look at policy and id drugs
2018008	Reslizumab (Cinqair)
2008031	Rilonacept (Arcalyst)

Policy ID#	Policy Name
2021034	Rituximab (Rituxan) and Biosimilars – Non-Oncologic Indications
2019009	Romosozumab-aqqg (Evenity®)
2021006	Satralizumab-mwge (Enspryng™)
2021028	Ustekinumab (Stelara)
2015011	Vedolizumab (Entyvio) for Inflammatory Bowel Disease

- Drugs provided under pharmacy benefit – Please refer to member formulary. These will be handled through CVS Caremark.
- Drugs provided under medical benefit managed by AIM Medical Oncology – Please access AIM portal to submit request for these drugs.

Standard step therapy drug request

Standard step therapy requests should be submitted through the normal prior approval process. Standard step therapy requests will receive a response in 72 hours under regular business days (weekends and holidays excluded). Re-reviews and extended duration requests (up to 12 months) are permitted for standard requests. Standard step therapy requests for oncology drugs managed by AIM Medical Oncology should be submitted through the **AIM Portal**.

Exigent step therapy drug request

To submit a request for exigent step therapy drugs under the medical benefit, please complete the Exigent Step Therapy drug request form located on the Availity Alert and at **www.arkansasbluecross.com**.

Please note: A request for exigent step therapy drugs on weekends and holidays will require contact information for the requesting provider on weekends and holidays for any additional exigent information required. Absence of this information may result in denial if required information cannot be obtained.

All exigent step therapy drug requests are limited to 28 days. Further approval will require submission of a standard step therapy drug request for extended prior approval.

ARHOME & ACA members

Virtual prenatal and postpartum support program now available

Maven, a virtual prenatal and postpartum care program, is now available at no additional cost to Arkansas Blue Cross and Blue Shield and Health Advantage ARHOME and ACA members.

Maven's program supports women in between their in-person clinic visits. Maven's trusted care advocates take a relationship-driven approach to offer coaching and education on topics ranging from mental health support and birth planning to nutrition and breastfeeding. Members can video chat or message with OB-GYNs, pediatricians, lactation consultants and infant sleep coaches.

Maven supports expecting parents during pregnancy and postpartum and includes the following across each track:

- **Care advocacy**: Navigation to resources on the Maven platform as well as to high-quality, in-person care for medical and social needs; risk detection and proactive outreach to personalize support, drive healthy behaviors and improve outcomes.
- **Telehealth consultations**: Telehealth capabilities with virtual providers and professionals, acting in a coaching and education capacity.
- **Educational materials**: A library of articles and video content to educate and guide participants in their health journeys.
- **Content and community**: Clinically-approached, engaging content and virtual classes; live community forums moderated by Maven providers to ensure responses are clinically grounded.
- **Diverse coverage**: Culturally diverse and conscious providers that speak multiple languages.

Members can sign up on the **Maven website**.

We can also provide trifolds or posters for your office. Please contact Kimberly Brown (**kdbrown@arkbluecross.com**) if you would like further information.

Federal Employee Program (FEP)

AIM Specialty Health® to manage radiology utilization for Arkansas Blue Cross FEP

Notice of material amendment

Vendor will monitor use of diagnostic imaging, starting April 1

Arkansas Blue Cross and Blue Shield's Federal Employee Program (FEP) has engaged AIM Specialty Health®, to operate a new Radiology Utilization Management Program for that health plan's members, effective April 1, 2022.

As of that date, AIM will handle medical necessity review of diagnostic imaging services for FEP members.

AIM works with leading insurers and providers, through evidence-based practice initiatives, to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable.

For services that are scheduled to begin on or after April 1, 2022, all providers must contact AIM to obtain pre-service review for the following nonemergency modalities:

- Nuclear imaging (including myocardial perfusion imaging), cardiac blood pool imaging, infarct imaging and positron emission tomography (PET) myocardial imaging.
- Computed tomography (CT), including CT angiography, structural CT and quantitative evaluation of coronary calcification.
- Magnetic resonance imaging (MRI).
- Magnetic resonance angiography (MRA).
- Magnetic resonance spectroscopy (MRS).
- Functional MRI (fMRI).

How to submit a request for review:

Starting March 14, 2022, providers may begin submitting requests for review or verify order numbers, using one of the following methods:

- **Online**
  The fully interactive AIM ProviderPortal℠ is available 24/7 and processes requests in real-time, using clinical criteria. Register at the AIM Specialty Health provider portal.
- **By phone**
  Call AIM Specialty Health toll-free at 1-866-688-1449 (7 a.m. - 7 p.m. Central, Monday - Friday).

For more information:

- **Online**
  Providers may access Radiology Utilization Management Program resources on the AIM website. The AIM website also has more information about the program and provides access to useful information and tools such as order entry checklists and clinical guidelines.
- **By phone**
  Providers who have questions or observations may contact their designated Arkansas Blue Cross network development representative.

Arkansas Blue Cross and Blue Shield's Federal Employee Program greatly values the trusted healthcare providers that serve the members who depend on us for their health coverage, and we look forward to working with you and AIM to maintain a high standard of care.

Note: *Aim Specialty Health is an independent company that operates separately from Arkansas Blue Cross and Blue Shield and administers radiology utilization management services for the benefit of Arkansas Blue Cross Federal Employee Program members. Arkansas Blue Cross and Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.*

Magellan to manage specialty drugs for Federal Employees Program

Arkansas Blue Cross and Blue Shield's Federal Employee Program (FEP) has implemented a change in the way we manage certain specialty drugs that fall under the FEP medical benefit.

This new program is administered by Magellan Rx Management (Magellan Rx).

Providers should contact Magellan Rx to obtain prior authorizations for applicable drugs for FEP members for dates of service on or after March 1, 2022.

Providers will be able to complete the prior authorization process via the internet or by phone. Prior authorization will be required for the medical specialty drugs when they are administered in the following settings:

- Physician office (CMS Place of Service code 11)
- Patient homes (CMS Place of Service code 12)
- Outpatient facilities (CMS Place of Service codes 19 & 22)

Reference materials such as a **Frequently Asked Question (FAQ)** document and the list of affected drugs may be found on the **Specialty pharmacy - Arkansas Blue Cross and Blue Shield website**.

We appreciate your support to ensure that our members continue receiving high-quality and clinically appropriate care. If you have questions, please contact the provider service line at 800-482-6655.

FEP providers quality measure information

HEDIS Measure – Use of imaging Studies for Low Back Pain (LBP)

Use of Imaging Studies for Low Back Pain measure age has changed from 18-50 to 18-75 years. With the age expansion for this measure, we may have more members receiving imaging for low back pain. This may impact

our HEDIS scores if imaging for uncomplicated back pain is ordered within 28 days of diagnosis. Coding HEDIS exclusions for comorbid conditions for this measure, when applicable, provides you the following benefits:

- Allows measurement exclusions for members who are medically inappropriate for a given measure. As a result, your rates will be a more accurate representation of your performance.

HEDIS measure–cervical cancer screening

Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed. The HEDIS specs state we need to know the status of the cervix to be able to close the gap and/or exclude the member from the measure. The member continues to show up on the non-compliant list if the documentation states history of hysterectomy and does not say total, complete, radical, or hysterectomy with no residual cervix.

You may submit any of the following procedures to close this quality gap:

- Cervical cytology report within the last three years / cervical cytology with HPV report within the last five years.
- Chronic problem list with documentation of pap smear with or without HPV, including date and result.
- Any documentation of history of hysterectomy with no residual cervix – documentation must include the status of cervix – no residual cervix, cervical agenesis, or acquired absence of cervix.
  - Documentation of "complete, "total" or radical" hysterectomy (abdominal, vaginal or unspecified).
  - Documentation of "vaginal hysterectomy."
  - Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy."
- Progress note or consultation – notation of date and result of pap smear.
- Documentation of a "vaginal pap smear" in conjunction with documentation of hysterectomy.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Table 1: HEDIS Exclusion Value Sets – cervical cancer screening

HEDIS Exclusion Value Sets	HEDIS Value Set Codes	Conditions
Exclusions: ▪ Absence of Cervix	[Q51.5] Agenesis and aplasia of cervix	Absence of Cervix, Pressure Ulcers, Muscle Wasting, Atrophy, etc.
▪ Hysterectomy with No Residual Cervix	[Z90.710] Acquired absence of both cervix and uterus [Z90.712] Acquired absence of cervix with remaining uterus OUTC0ZZ, OUTC4ZZ, OUTC7ZZ, OUTC8ZZ CPT: 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570-58573, 58575, 58951, 58953, 58954, 58956, 59135	

HEDIS Measure–Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)

This measures the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

To Improve Your Score: Code for exclusions

- Educate patients on the lack of utility of antibiotics for viral infections and the impacts of overprescribing of antibiotics.
- Commit to an antibiotic stewardship program, and let your patients know why.
  For more information please contact Rochelle Nix, BSN, RN, CCM at rdnix@arkbluecross.com.
- Use simpler diagnostic language with patients: "Chest cold" instead of "bronchitis."
- If patients are insistent on antibiotics when not indicated, consider a delayed prescription where patients are instructed to wait three days to fill an antibiotic prescription if their symptoms do not improve.

Codes for exclusion conditions at any time during member's history

Coding HEDIS exclusions for comorbid conditions for this measure, when applicable, provides you the following benefits:

- Allows measurement exclusions for members who are medically inappropriate for a given measure. As a result, your rates will be a more accurate representation of your performance.
- Enhanced coding for the measures listed below may eliminate the need to produce patient medical records during HEDIS season – saves your staff time and your resources.

Table 2: HEDIS Exclusion Value Sets – comorbid conditions

HEDIS Exclusion Value Sets	HEDIS Value Set Codes	Conditions
Comorbid Condition History: ▪ HIV ▪ HIV Type 2	[B20] Human immunodeficiency virus [HIV] disease [B97.35] Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere [Z21] Asymptomatic human immunodeficiency virus [HIV] infection status	Hodgkin's Disease, Malignant Lymphoma, Tuberculosis, Cellulitis, Chronic Obstructive Asthma, etc.
Malignant Neoplasms	C00- C97, D00- D09, D37-D48	
Other Malignant Neoplasm of Skin	C43-C44	
Emphysema	J43.0, J43.1, J43.2, J43.8, J43.9	
COPD	J44.0, J44.1. J44.9, J41.0, J41.1, J41.8. J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9, J47.0, J47.1, J47.9	

HEDIS Exclusion Value Sets	HEDIS Value Set Codes	Conditions
Comorbid Conditions	A15.0 – A19.9, B44.81, D57.01 - D86.2, E84.0 – E84.9, J22 – J99, M05.10 - M35.02, O98.011 - O98.03, P27.0 - P27.9, Q25.45 - Q89.3	
Disorders of the Immune System	D80.0 – D89.9	
Competing Diagnoses: ▪ Pharyngitis	J02.0 – J03.91	
Competing Diagnoses	A00.00 – A69.9, B60.0 – B96.89, E83.2, H66.001 – H95.89, J01.00 – J39.9, K12.2, L01.00 – L98.3, M46.20 – M90.89, N10 – N77.1, Z20.2 – Z22.4	Infectious Diseases, Venereal Diseases, Otitis Media, Mastoiditis, Sinusitis, Pneumonia, Cellulitis, Pain Syndromes Bone Disorders, etc.
Members in hospice	CPT: 99377, 99378, HCPCS: G0182	

HEDIS®

Upcoming HEDIS® season medical record retrieval timeline

HEDIS® Medical Record Requests will be sent out to providers of our Medicare Advantage (MA), Arkansas Works (ACA), and FEP populations following the below timeline:

- February 1, 2022 – HEDIS® Medical Record Requests will be sent to providers for MA, ACA, & FEP populations.
- Estimated End date: April 15, 2022.

Requests for records will be processed by us here at Arkansas Blue Cross Blue Shield as well as and the following three vendors:

- Inovalon
- Optum
- CIOX

We do ask that you please respond to any records request within ten days of receipt.

If you have a preferred method for chart retrieval, please communicate this with one of our Network Development Representatives (NDRs) or applicable team:

MA: ABCBSMAQualityRecords@arkbluecross.com

ACA and FEP: EQRMMedicalRecords@arkbluecross.com

Please use the link below to find contact information specific to your location, along with other helpful contact information.

https://www.arkansasbluecross.com/providers/resource-center/network-development-reps

Medicare Advantage

Medicare Advantage COVID-19 Coverage Updates

Medicare Advantage COVID-19 Coverage Updates

Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO will continue to keep members and providers updated on the latest COVID-19 resources and support. It is important to provide you with a summary of new and extended benefits for treatment and testing-related services in conjunction with the extension of the national public health emergency until April 15, 2022.

2022 COVID-19 New Coverage Benefits

The following COVID-19 waivers and new benefits are extended through **April 15, 2022**, under CMS guidelines.

COVID-19 Vaccinations

Effective January 1, 2022, Medicare Advantage members will have no out-of-pocket costs for COVID-19 vaccinations under the benefit coverage. Vaccinations will now be covered at a $0 cost-share through April 15, 2022.

Monoclonal Antibody Treatment

Medicare Advantage members will have a $0 cost-share for all medically-appropriate monoclonal antibody treatment effective January 1, 2022.

COVID-19 Extended Coverage

COVID-19 Tests

Medicare Advantage members will continue to benefit from the COVID-19 test coverage at a $0 cost-share for all medically-appropriate tests ordered by a physician. This coverage applies to in-network and out-of-network tests.

COVID-19 Diagnosis Coverage

Medicare Advantage members who are diagnosed with COVID-19 are waived from being charged a copay when seen in the emergency room or in an office visit with their primary care physician.

Medicare Advantage members can also have certain prescription refill limits for specific prescriptions for managing chronic conditions when diagnosed with COVID-19. Those members receiving treatment at home with the diagnosis can also receive a waiver of cost-sharing for oxygen care.

Telehealth Coverage

Medicare Advantage members will continue to have increased access to Medicare Advantage telehealth services such as common office visits, mental health counseling and preventive health screenings.

Skilled Nursing Facility Waiver

Medicare Advantage members will also continue to benefit from the waiver extension for Skilled Nursing Facility Prior Authorizations for members transferring from acute inpatient stay.

Notification from the skilled nursing facility is still required for tracking and discharge planning purposes, to ensure the Medicare Advantage members have the services that they need as they transition back into the community.

This COVID-19 waiver will remain in effect through April 15, 2022, and applies to skilled nursing facilities only. Admission to long term acute Care hospitals and inpatient rehabilitation facilities will continue to require prior authorization.

Skilled nursing providers can contact Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO by calling 1-800-287-4188 or by faxing a facility notification to 1-816-313-3013.

2022 Medicare Advantage member verifications alert

For any questions, issues or concerns with 2022 Arkansas Blue Medicare and Medicare Advantage Health Advantage HMO members' medical eligibility, benefits and co-pay verifications, please call the provider service number 1-800-287-4188 which is also listed on the back of the Medicare Advantage member's identification card directly.

For Medicare Advantage **Dental** verifications, call Life & Specialty Ventures (LSV) directly at 1-888-224-5213.

For Medicare Advantage **Vision** verifications, call Vision Service Plan (VSP) directly at 1-800-877-7195.

Centers for Medicare and Medicaid Services (CMS) preclusion list

Effective January 1, 2019, CMS began releasing a monthly list of individual providers or entities that have been precluded from receiving payment for Medicare items, services, and Part D medications under the following two categories:

1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
2) Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Effective April 1, 2019, any Part D sponsor and/or Medicare Advantage Plan are required to deny payment for any pharmacy claim or health care item prescribed or furnished by an individual listed on the Preclusion List.

Please note that any provider or entity that falls on the preclusion list will be terminated and removed from the networks in accordance with the network participation agreement(s). There will be an option to appeal the network termination decision at time of notice or upon removal from the CMS preclusion list.

Additional resources and reference guide can be found on the **CMS website at Preclusion List**.

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 any Medicare Advantage plan to administer their Medicare benefits would have Medicare Advantage as their primary coverage and Medicaid as their 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 any Medicare Advantage plan and Medicaid.

Additional information about dual-eligible coverage is available under on the **Medicare Learning Network website**.

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 and no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.
- Beneficiaries for whom Medicare is either the primary or secondary payer.

For some Medicare Advantage members, observation stays have 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 his or her insurance plan with specific benefit questions.

The notice and accompanying instructions are available on the **CMS website**.