Providers' News

Arkansas BlueCross BlueShield

To: All Providers

From: Provider Network Operations

Date: December 12, 2001

Please Note: This newsletter contains information pertaining to Arkansas Blue Cross Blue Shield (ABCBS), a mutual insurance company, its wholly owned subsidiaries and affiliates. This newsletter does not pertain to Medicare. 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.

What's Inside?

Attachments:

Correction to September 2001 Newsletter Regarding Transplant Network:

ABCBS previously published an article regarding transplants. The September 2001 Provider Newsletter stated that "**ALL** transplants required prior approval" which was incorrect. All transplants with the **exception** of kidney and cornea require prior approval. Kidney and cornea transplants do not require prior approval.

Allergen Immunotherapy Coding:

Codes 95115 to 95180 include the professional services necessary for allergen immunotherapy. Office visit codes should not be used with allergen immunotherapy codes unless a separate identifiable service is rendered at that time.

When there is documentation of a separate identifiable service with an allergy immunotherapy code, the E/M service should be billed either with modifier 25 or with a separate diagnosis.

Anesthesia Update:

Effective January 02, 2002, the conversion factor for anesthesia will be increased from $34.00 per unit to $42.00 per unit.

Arkansas State Employees (ASE) Benefit Changes:

Effective January 01, 2002 the following benefit changes will apply to the Arkansas State Employees.

Health Advantage HMO and POS In-Network Benefits:

- Primary Care Physician (PCP) Office Visits: $20 Copayment.
- Specialist Office Visits: $25 Copayment.
- In-Network Out-of-Pocket Limit: $1,000 (individual) $1,500 (family).
- In-Network Hospital Inpatient Services: $250 Copayment and 10% Coinsurance.
- In-Network Out Patient Facility Services: $100 Copayment and 10% Coinsurance.
- In-Network Out Patient and In-Patient Physician Services: 10% Coinsurance.
- Home Health Nurse Visits: 120 Visits per year and 0% Coinsurance.
- Home IV Drugs/Solutions/Supplies: 10% Coinsurance.
- Physical, Occupational, Speech Therapy, Cardiac Rehabilitation and Chiropractic Services: 60 Visits per year (combined) and 20% Coinsurance.
- OB Physician Services: 10% Coinsurance (Applicable copay applies to initial visit only).
- OB In-patient Services: $250 Copayment and 10% Coinsurance.
- Routine Vision Exams: $25 Copayment.
- Preventive Dental Services: $25 Copayment.
- POS Out-of-Network Annual Deductible: $500 (individual) $1,000 (family).
- POS Out-of-Network Coinsurance: 30%.
- POS Out-of-Network Out-of-Pocket Limit: $4,000 (individual) $8,000 (family).
- POS Out-of Network Inpatient Services: Deductible and 30% Coinsurance.
- POS Out-of-Network Out Patient Services: Deductible and 30% Coinsurance.
- Mental Health/Substance Abuse Benefits: Not Covered by Health Advantage.
- Routine Maternity Services for Dependent Children: Not a Covered Benefit.

Arkansas Blue Cross and Blue Shield Benefits:

- In-Network Deductible: $500 (individual) $1,000 (family)
- In-Network Coinsurance: 20%
- In-Network Annual Out-of-Pocket Limit: $2,000 (individual) $4,000 (family)
- In-Network Lifetime Maximum: None
- Physical, Occupational, Speech Therapy, Cardiac Rehabilitation and Chiropractic Services: 60 Visits per year and 20% Coinsurance
- Home Health/Nurse Visits: 120 Visits per year and 20% Coinsurance
- Home IV Drugs/Solutions/Supplies: 20% Coinsurance
- Out-of-Network Deductible: $750 (individual) $1,500 (family)
- Out-of-Network Coinsurance: 30%
- Out-of-Network annual Out-of-Pocket Limit: $2,500 (individual) $5,000 (family)
- Out-of-Network Lifetime Maximum: $1,000,000
- Mental Health/Substance Abuse Benefits: Not Covered by Blue Cross
- $500 Supplemental Accident Endorsement (SAE): Not a Covered Benefit
- In-Vitro Fertilization: Not a Covered Benefit
- Routine Maternity Care for Dependent Children: Not a Covered Benefit

BlueChoice® (Health Advantage) Open Access Point Of Service Plan:

The following is a brief description of the new Health Advantage **BlueChoice®** Open Access Point of Service Plan. The Open Access POS plan is responding to members' request for a low priced HMO/POS product.

The **BlueChoice®** Open Access Point of Service (OAPOS) is an innovative plan that is a hybrid of a traditional HMO coverage and POS benefits. Preventive and routine services with copayments for primary care physicians and for episodic services provided by in-network specialty physicians and hospitals with copayments, deductibles, and coinsurance available without a referral from a Primary Care Physician. Product features include the following:

- **Open Access –** This means that members have the choice in health care providers for accessing their health care benefits from Health Advantage. The choice of any in-network provider without going through the primary care physician for referral, to receive the highest level of benefits, which are under the In-network Benefit Program. Members have another option of using out-of-network providers and receiving the out of network level of benefit coverage.

- **Important Notice to In-Network Specialists –** The member ID card will indicate **Open Access**, therefore no referral number on your claim form is necessary for in-network benefits.

- **In-network Deductible –** Options include no deductible, $250 in-network deductible and a $1,000 in-network deductible is available. The in-network deductible is applied to specialty care physician services, hospital services, maternity services, rehabilitation, home health, SNF, etc., services. This deductible for in-network services is applied after the member pays the applicable copayment for the services.

- **Copayments –** Depending on service, Physician copayment options are $25 and $35, the inpatient admission copayment is $500 and the outpatient facility copayment is $100. Benefit determination requires that copayments are always subtracted first, then deductible and then coinsurance.

- **Preventive Services –** The primary care physician services are not subject to deductible.

- **Emergency Services –** $100.00 copayment and coinsurance and are not subject to deductible.

- **Coinsurance –** The in-network options are 20% and 30%.

- **Out-of-Network –** Out-of-network services are applied after a deductible. The deductible options are $1,000, and $2,000. There is no out-of-pocket limit for out-of-network services.

CPT Code 97010 - Changes:

The Relative Value Units (RVU) for hot and cold packs were bundled into the RVU's for all other physical therapy codes and E&M codes (Federal Register, Friday, November 22, 1996, page 59499). ABCBS will no longer allow separate payment for CPT 97010 effective January 1, 2002.

CPT Code 97535 – Billing with Chiropractic Manipulation Therapy Codes

CPT Code 97535 was introduced into CPT in 1996. Described as self-care/home management training [e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment] direct one-on-one contact by provider, each 15 minutes.

The *CPT Assistant*, September 1996 (page 7) describes the vignette for CPT Code 97535:

> "The patient is a 65-year-old woman recently discharged from the hospital with a diagnosis of CVA resulting in a right hemiparesis. The patient lives alone and wants to be able to remain in her home. The initial evaluation has revealed performance deficits in bathroom activities and meal preparation. At the home site, the therapist recommends and sets up the proper adaptive equipment in the bathroom, so the patient can safely transfer to toilet and bathtub by using compensatory techniques.
>
> In the kitchen, the therapist teaches and observes meal preparation using one-handed techniques and special adaptive equipment. The therapist must assure that the patient's functional level is sufficient to perform necessary self-care and home management activities within safe limits (e.g., picking items off the floor, lifting pots from stove, reaching items in cupboards, opening drawers)."

The chiropractic manipulation codes (CPT Codes 98940, 98941, 98942, and 98943) were introduced in 1997. The *CPT Assistant*, January 1997 (pages 7-8), describes these new codes:

> "The complete service of Chiropractic manipulation requires a certain amount of pre-service and intra-service work that is included as part of the service. This evaluation and management is necessary to determine not only what specific work will be necessary, but also to determine the effectiveness of the service being provided.
>
> Pre-service work includes reviewing previously gathered clinical data (including an initial or interim history, reviewing the problem list, pertinent correspondence or reports, and other important

findings and prior care), review of imaging and other test results, test interpretation, and care planning.

Intra-service work includes an interactive patient reassessment (i.e., determining the current status, determining indicators/contraindications, assessing the change in condition, evaluating any new complaints, correlating physical findings, and coordinating and modifying the current treatment plan).

Also included in the intra-service work are a number of manipulations and post adjustment assessments that are necessary in order to adequately treat the ailment presented. This work is inherently included as part of the Chiropractic Manipulative Treatment service and would not be coded separately."

CPT Code 97535 is included in the payment for CPT Codes 98940, 98941, or 98942 unless the patient's chart indicates a level of work described in the vignette for CPT Code 97535 was performed.

CPT Modifier 78:

Effective April 1, 2002, services submitted with modifier 78 will be reimbursed at 70% of the usual allowance for the procedure. Per the CPT manual, modifier 78 is used to indicate a service performed by returning to the operating room for a related procedure during the postoperative period.

Federal Employees Program (FEP) Overview of Benefit Changes:

Introduction:
The Federal Employee Program, also known as the Blue Cross and Blue Shield Service Benefit Plan, provides health insurance benefits for retired and active federal employees and their dependents throughout the United States and internationally.

In Arkansas, the Arkansas Blue Cross and Blue Shield (ABCBS) Federal Employee Program provides health care coverage to nearly 50,000 members. Claims for services received by FEP members in Arkansas should be filed with ABCBS, even if the member resides in another state.

The FEP Service Benefit Plan still offers 4 types of coverage. You can distinguish the type of coverage a person has by the enrollment code located on the front of the identification card.

	Standard Option	Basic Option
Enrollment code	104-Individual	111- Individual
Enrollment code	105- Family	112- Family

New Plan Options:
Effective January 1, 2002, High option is merging with Standard Option. We will introduce a Basic Option in 2002. Basic Option is a lower-priced health plan alternative. This new benefit package has been specially designed based on comments we received from federal employees and in recognition of the need for more affordable health plan choices in today's economic environment.

Basic Option is an in-network only benefit program. Preferred Providers can continue to see FEP patients as they do today. To receive benefits, members who enroll in Basic Option must seek care from a Preferred provider.

FEP Standard Option members have access to the ABCBS participating providers and ABCBS FirstSource preferred providers. FEP Basic Option members have access to only ABCBS FirstSource preferred providers.

FEP - Basic Option Benefits:

1. Basic Option program is an in-network only benefit program. Members who enroll in Basic Option must seek care from a Preferred provider for benefits to be paid. Preferred providers currently eligible under Standard Option are considered covered in Basic Option. Preferred Chiropractors are also considered covered providers in Basic Option.

2. No referrals required.

3. No Calendar year deductible.

4. $20 Copayment for primary care physicians. Primary Care Physician includes Internal Medicine, Family Practice, General Practice, Pediatricians, and Obstetricians/Gynecologists.

5. $30 Copayment for Specialists visits.

6. $100 Copayment per surgery for surgical services by a physician.

7. Preventive Care/Well Child Care covered for physical exams, cancer screenings and immunizations for adults; well child care for children up to age 22 in full after $20 PCP or $30 Specialist visit copayment.

8. Preferred provider preventive dental coverage $20 copayment for 2 exams, x-rays, cleanings per year, and sealants for children up to age 16.

9. Preferred Chiropractic care $20 copayment for chiropractic spinal manipulation, up to 20 annual.

10. Inpatient Hospital Benefits: Precertification is required for all inpatient admissions except for maternity. Preferred providers $100 per day copayment up to the maximum of $500.

11. Outpatient Hospital Benefits: $30 per day copayment per facility

12. Outpatient Accidental injury or medical emergency $50 per day copayment per facility.

13. Durable Medical Equipment 30% of ABCBS allowance.

14. Basic Option members preferred pharmacy network is smaller than the network for Standard Option. To find out if a pharmacy is preferred for Basic Option, you may call the Retail Pharmacy Program 1-800-624-5060.

15. There are three levels of benefits for prescription drugs.

    a) **Level 1** $10 copayment for generic.
    b) **Level 2** up to $25 copayment for formulary brand-name drugs.
    c) **Level 3** minimum $35 copayment after drug costs is more than $70 the member pays 50% of the drug costs for non-formulary brand name drugs.

    Please refer to the pharmacy chart (attachment page 13) indicating the copayment level for drugs. 34-day maximum supplies on initial prescription, up to 90 days for refills with 3 copayments. If the member uses a Non-Preferred pharmacy, the member will have to pay the full cost of the prescription. The Mail order Pharmacy program is not available for Basic Option members.

16. Provider must be in the Magellan Behavioral Health Network for benefits to be eligible. For Basic Option Mental Health Substance Abuse benefits, prior approval is required **before the first visit**. A treatment plan will be required for additional visits. Contact Magellan Behavioral Health 1-800-367-0406.

    a) $20 Office Visit Copayment. Prior approval is required before the first visit.
    b) $30 Copayment for intensive outpatient or partial hospitalization. Prior approval is required before the first visit.
    c) $100 Per Day up to $500 per admission. Precertification is required**. 1-800-367-0406.**

FEP - Standard Option Benefit Changes 2002:

1. Catastrophic Protection Benefit has been increased to $4,000 per contract for PPO expensed and $6,000 per contract for PPO and Non-PPO expenses.

2. Hospital Based providers benefits will be provided at Preferred level (90% of our allowance subject to the calendar year deductible) for covered services performed in preferred facilities by covered Non-preferred radiologist, anesthesiologist, certified registered nurse anesthetists, pathologist and emergency room physicians.

3. Additional Organ / Tissue Transplants will be provided for autologous stem cell support for amyloidosis. The clinical trials have been expanded to include non-myeloablative allogeneic stem cell transplants for chronic myelogenous leukemia, acute lymphocytic or non-lymphocytic i.e., myelogenous) leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced forms of myelodysplastic syndromes, multiple myeloma, chronic lymphocytic leukemia, early stage (indolent or non-advanced) small cell lymphocytic lymphoma, and renal cell carcinoma.

4. Additional Preventive Care services for chlamydial infection will be eligible for benefits with a routine diagnosis. V70.0

5. Mail Service Copayment for generic prescription drugs has been reduced to $10 and the copayment for brand-name prescription drugs has been increased to $35.

6. Ambulance Services rendered in connection with, and within 72 hours after, an accidental injury will be provided in full.

7. Dental Accidental injury will be provided for services related to dental accidental injuries only when treatment is started promptly and completed within 12 months of the accident.

8. Reminder for Standard Option Mental Health Substance Abuse benefits:
   Prior approval with a treatment plan is required before the ninth visit. Contact Magellan Behavioral Health 1-800-367-0406.

9. Standard Option members may obtain prescriptions through:

   a) **Mail Order Program:** The mail order program is for prescriptions requiring a 21-day or longer supply. The Mail Order Program phone number is 1-800-262-7890. Basic Option No Benefits for the Mail Order Program
   b) **Local Pharmacy:** Standard Option members may use a local Pharmacy. To obtain the highest benefit a preferred pharmacy must be used. To find out if a pharmacy is preferred, you may call the Retail Pharmacy Program 1-800-624-5060.

Fee Schedule Changes:

Effective September 1, 2001 the following updates have been made to the Arkansas Blue Cross Blue Shield Fee Schedule. Adjustments may be made to claims for services on or after September 1, 2001.

Code	Description	Office Allowance	Site of Service Allowance
Y9121	Aide, per visit	$ 32.00	$ 32.00
Y9125	RN, per visit	$ 87.00	$ 87.00
Y9126	LPN, per visit	$ 50.00	$ 50.00
Y9130	PT, per visit	$ 73.00 (no change)	$ 73.00 (no change)

FirstSource Group Additions

The following Arkansas FirstSource Group(s) will be effective January 1, 2002.

- **Bridgestone / Firestone – Russellville**
- **Landers – United Auto Dealership**

HCPCS Codes for Ambulance:

The 2001 HCPCS update included deletion of 7 ambulance codes. These codes were replaced by 5 new codes. A list of deleted codes and replacement codes are listed below. Please use the new HCPCS codes for billing these services to ABCBS, USAble, Health Advantage and AR FirstSource.

DELETED CODE	USE CODE
A0030	A0430
A0040	A0431
A0050	A0429
A0300	A0428
A0302	A0429
A0304	A0428
A0306	A0426
A0308	A0429
A0310	A0427
A0320	A0428
A0322	A0429
A0324	A0428
A0326	A0426
A0328	A0429
A0330	A0427
A0340	A0428
A0342	A0429
A0344	A0428
A0346	A0426
A0348	A0429
A0350	A0427
A0360	A0428
A0362	A0429
A0364	A0428
A0366	A0426
A0370	A0427
A0380	A0425
A0390	A0425

Home Health Allowance Update:

Home health allowances for RN, LPN, and Nursing Aide visits were updated effective September 1, 2001 for ABCBS, USAble Administrators, and Health Advantage. The details of these changes were described in letters sent to all participating home health agencies.

As a reminder, routine supply costs are included in the continuous and intermittent care reimbursement per the Home Health Agency provider contract. Examples of routine supplies include all dressing supplies, syringes, alcohol wipes, tape, gloves, disinfectants, sterile water or saline.

For supplies considered non-routine, claims should be submitted with itemized descriptions of the supplies. These supplies should also be submitted using the appropriate HCPCS codes.

Effective March 1, 2002, home health supply services submitted without the appropriate HCPCS code describing the supply, will be denied. This includes a "dump" code or revenue code 270 without the appropriate HCPCS code.

Influenza Vaccine - Correct Coding:

CPT Code 90659 describes a whole virus vaccine, a vaccine not being manufactured for the 2001-2002-influenza season. This code will be denied as not medically necessary.

Correct coding of split virus flu vaccine is 90657 for children 6-35 months of age or 90658 for patients 3 years and older. Our allowance for the vaccine includes the administration charge. However, our policy on administration fee reimbursement is changing effective April 1, 2002.

Injections - Allowance Changes:

Effective April 1, 2002, ABCBS, USAble, Health Advantage, and AR FirstSource Access-only will no longer include an administration fee in the allowance for injection and immunization codes. The allowance for injection and immunization codes will cover only the drug. Providers must bill separately using the applicable administration code to receive reimbursement for administration of the injection or immunization.

Mail Alert:

Be Aware! Because of the September 11th attack and the Anthrax problem, ABCBS has increased the scrutiny of mail received. It is very important that any envelopes or packages mailed to Arkansas Blue Cross Blue Shield must be properly addressed, labeled, and include a return address.

Mail that is received without proper information will be treated as suspicious mail. Examples of suspicious mail include but not limited to:

- Poorly typed addresses
- Handwritten addresses
- Misspelled names
- No return address
- Address not consistent with place of mailing
- Large or lopsided packages

We are instructed not to open the mail, isolate the suspicious mail, and contact the authorities.

Medicare Supplement Claim Submission:

Arkansas Blue Cross and Blue Shield entered into an agreement, effective April 1, 2001, with Health Data Management Corporation (HDM) to electronically submit our Member's Medicare Part A and B supplemental claims from Medicare Fiscal Intermediaries / Carriers throughout the United States directly to Arkansas Blue Cross Blue Shield. (HDM is a national clearinghouse for Medicare Part A and B claims).

This agreement will allow HDM to electronically submit Medicare Part A and B supplemental claims from Medicare Intermediaries / Carriers nationwide. This means that Providers from states other than Arkansas, or Arkansas providers that submit their patient's Medicare claims through an out of state Medicare Intermediary / carrier, no longer have to submit paper claims to Arkansas Blue Cross.

Providers only need to complete the "other insurance" information on their patient's claims submitted to Medicare, which includes the Arkansas Blue Cross and Blue Shield member's Identification Number, and the claims will be electronically submitted to Arkansas Blue Cross Blue Shield. This does not apply to FEP.

If a provider has a claim inquiry question, they may call the Arkansas Blue Cross Blue Shield Customer Service Division at 1-800- 238-8379 or 501- 378-2010.

We remain committed to finding more efficient ways to serve our customers and this is just one of them.

Medi-Pak HMO Non-Renewal:

Attention: Medi-Pak HMO Participating Providers:
Effective January 1, 2002 Health Advantage is not renewing the Medi-Pak HMO contract with the Centers for Medicare and Medicaid Services (CMS) (formerly

HCFA) for Medicare+Choice. Therefore, Medi-Pak HMO will no longer offer Medicare health benefits to our Medicare members in Garland, Hot Spring, Lonoke, Montgomery, Prairie, Pulaski, Saline, White, and Woodruff counties.

It is vitally important that your office is aware of this non-renewal due to claims filing. Any claims for dates of service January 1, 2002 or after need to be filed directly with Medicare.

There is a 180 day timely filing provision for Medi-Pak HMO claims submission, therefore all 2001 dates of service must be submitted by June 30, 2002. If a claim or bill for services is **not** submitted and actually received by Health Advantage within 180 days following the 2001 date of service, the claim will be denied.

Please note this does not affect Health Advantage's other benefit programs or other policyholders, only the Medi-Pak HMO members. This also has no impact on the Medi-Pak Supplemental policies through Arkansas Blue Cross Blue Shield, and in fact, we expect many of the Medi-Pak HMO members to switch to Medi-Pak at the termination of their Medi-Pak HMO benefits.

If you have any questions, please call our office at 954-5200 or 1-800-354-9904, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Public School Employees (PSE) Benefit Changes:

Effective October 1, 2001 the following benefit changes apply to Public School Active and Retired Employees.

Health Advantage HMO & POS In-Network Benefits:

- Primary Care Physician (PCP) Office Visits: $25 Copayment
- Specialist Office Visits: $35 Copayment
- In-Network Out-of-Pocket Limit: $1,500 (individual) $3,000 (family)
- In-Network Hospital Inpatient Services: $500 Copayment and 20% Coinsurance
- In-Network Outpatient Facility Surgical Services: $100 Copayment and 20% Coinsurance
- Home Health/Nurse Visits: 120 Visits per year and 20% Coinsurance
- Infusible Drugs/Solutions/Supplies: 20% Coinsurance
- Durable Medical Equipment: 20% Coinsurance
- Out Patient Physical, Occupational, Speech Therapy, Cardiac Rehabilitation and Chiropractic Services: 60 Visits per year (combined) and 20% Coinsurance
- OB Physician Services: 20% Coinsurance
- OB Inpatient Services: $500 Copayment and 20% Coinsurance
- POS Out-of-Network Annual Deductible: $500 (individual) $1,000 (family)
- POS Out-of-Network Coinsurance: 40%
- POS Out-of-Network Out-of-Pocket Limit: $5,000 (individual) $10,000 (family)
- POS Out-of-Network Inpatient Services: Deductible and 40% Coinsurance
- POS Out-of-Network Outpatient Services: Deductible and 40% Coinsurance
- Mental Health/Substance Abuse Benefits: Not Covered by Health Advantage
- Routine Eye Exams: Not a Covered Benefit
- Preventive Dental Services: Not a Covered Benefit

Arkansas Blue Cross and Blue Shield Benefits:

- In-Network Deductible: $500 (individual) $1,000 (family)
- In-Network Coinsurance: 20%
- In-Network Annual Out-of-Pocket Limit: $3,000 (individual) $6000 (family)
- In-Network Lifetime Maximum: None
- Physical, Occupational, Speech Therapy, Cardiac Rehabilitation and Chiropractic Services: 60 Visits per year (combined) and 20% Coinsurance
- Home Health/Nurse Visits: 120 Visits per year and 20% Coinsurance
- Home IV Drugs/Solutions/Supplies: 20% Coinsurance
- Out-of-Network Deductible: $1,500 (individual) $3,000 (family)
- Out-of-Network Coinsurance: 40%
- Out-of-Network Annual Out-of-Pocket Limit: $8,000 (individual) $16,000 (family)
- Out-of-Network Lifetime Maximum: $1,000,000
- Mental Health/Substance Abuse Benefits: Not Covered by Blue Cross
- $500 Supplemental Accident Endorsement (SAE): Not a Covered Benefit

Wellness Benefits: FirstSource PPO Group:

The FirstSource PPO Group Wellness Benefit as currently defined and administered requires extensive manual handling in claims and leads to numerous customer service / adjustment issues when providers file claims for wellness services with a diagnosis code.

In an effort to alleviate these problems, ABCBS redesigned the Wellness Benefit. These changes do not apply to USAble Administrators groups or FEP.

The current wellness benefit has first dollar coverage for routine adult physicals, mammograms and PAP smears. Routine adult physicals are covered, subject to an age schedule, up to $150 annually. PAP smears are covered up to $200 annually; this amount also includes a mammogram subject to an age schedule.

Historically, wellness services have not been covered by traditional indemnity plans. As a result, much of the physician community, in order to provide a "covered" service for patients, filed claims with diagnosis codes that more appropriately should have been filed as preventive, screening, or wellness.

The continuation of these practices has resulted in claims for members with wellness benefits to pay incorrectly (i.e. applied to the deductible and paid at contract benefits). The fallout for ABCBS has been:

- Increased number of customer service calls.
- Increased member frustration.
- Increased number of claim adjustments.
- Increased number of claims filed.
- Increased administrative costs.

Additionally, because of the configuration of the current benefit structure on the ABCBS claims processing system, much of the administration of this benefit is performed manually by claims processors. Obviously, this creates longer claims turnaround times, increases the likelihood of error, and requires more staff.

All of this has led to the need to develop a wellness benefit more palatable for our customers with greater administrative efficiency for ABCBS. The new wellness benefit to meet this need can be found in the attachments (page 17).

Upon review, you'll notice the following positive changes:

- All age schedule limitations for adults have been removed.
- The overall coverage limit for wellness services has been increased to $500.
- Preventive child care and immunizations coverage will NOT change (E/M codes and immunization codes pay at 100%), i.e. first dollar coverage will remain.
- These services will now help satisfy member's deductible.
- PSA tests are covered.
- Services may be obtained in or out of network.

In addition to the above, it is important to emphasize with groups and members one of the major hassles under the old benefit has been removed. Regardless of how the claim is filed, either with or without a diagnosis code, the claim will be automatically adjudicated through the system without the necessity of an adjustment for an incorrect code.

Also note:

- Claims incurred prior to January 1, 2002 will be paid under the "old" wellness benefit
- If a FirstSource group has a PCP co-pay, wellness services performed and billed by the PCP will be paid at 100% after the co-pay and subject to the $500 annual maximum

Please feel free to use the attachment (page 17) as a supplement to your benefit summaries. A new wellness brochure will not be printed.

The Providers' News
The Providers' News is a quarterly publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments about the Providers' News to:

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FEP Summary of benefits: 2002 Standard Option and 2002 Basic Option

- **Do not rely on this chart alone.** This chart is a summary of the features of the Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read the plan's federal brochure (RI 71-005). All benefits are subject to the definitions, limitations and exclusions set forth in the federal brochure. For a contractual and complete description of the benefits available under the Service Benefit Plan, please refer to the 2002 Blue Cross and Blue Shield Service Benefit Plan brochure.

- An asterisk (*) indicates the item is subject to the calendar year deductible: $250 per person or $500 per family for 2002 Standard Option; no deductible for 2002 Basic Option. Under Standard Option, if you use a Non-Participating physician or other health care professional you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown in the table below. **Basic Option does not provide benefits when you use Non-Preferred providers.**

What You Pay For Benefits:

BENEFIT	2002 STANDARD OPTION **Enrollment code 104 - self only** **Enrollment code 105 - self & family**	2002 BASIC OPTION **Enrollment code 111 - self only** **Enrollment code 112 - self & family**
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	**PPO:** 10%* of our allowance; $15 per office visit **Non-PPO:** 25%* of our allowance	**PPO:** $20 copay per office visit for primary care physicians; $30 copay per office visit for specialists **Non-PPO:** You pay all charges
Surgical services provided by physicians:	**PPO:** 10%* of our allowance **Non-PPO:** 25%* of our allowance	**PPO:** $100 per surgery **Non-PPO:** You pay all charges
****Services provided by a hospital: including maternity** • Inpatient • Outpatient ****Precertification required for all inpatient admissions except for Maternity.**	**PPO**: $100 per admission **Non-PPO**: $300 per admission **PPO**: 10%* of our allowance (no deductible for surgery) **Non-PPO**: 25%* of our allowance (no deductible for surgery)	**PPO**: $100 per day up to $500 per admission **Non-PPO**: You pay all charges **PPO**: $30 per day per facility **Non-PPO**: You pay all charges
Maternity Care provided by physicians:	**PPO**: Nothing for Prenatal Care and delivery **Non-PPO**: 25%* of our allowance	**PPO**: Nothing for Prenatal Care -$100 copay applies to physician charge for delivery. **Non-PPO**: You pay all charges
Preventive Care/ Well Child Care	**PPO**: $15 copay for associated office visit. Nothing for covered Preventive services or test **Non-PPO**: All Charges	**PPO**: Covered physical exams, cancer screenings and immunizations for adults; well child care for children up to age 22 in full after $20 PCP or $30 Specialist visit copay. **Non-PPO**: You pay all charges
Emergency benefits: • Accidental injury • Medical emergency	**PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter** **Non-PPO**: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter **PPO & Non-PPO**: Regular benefits	**PPO**: $50 copayment for emergency room care; $30 copayment for urgent care **Non-PPO**: $50 copayment for emergency room care **PPO & Non-PPO**: Same as accidental benefits.

BENEFIT	2002 STANDARD OPTION Enrollment code 104 - self only Enrollment code 105 - self & family	2002 BASIC OPTION Enrollment code 111 - self only Enrollment code 112 - self & family
Dental:	**Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery. All services due to a dental accident must be completed within 1 year**	**PPO**: $20 copayment for 2 exams, X-rays, cleanings per year, and sealant for children up to age 16; $20 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery **Non-PPO**: You pay all charges
Chiropractic:	No Benefit	**PPO**: $20 copay per chiropractic spinal manipulation, up to 20 annual (includes benefits for initial office visits and initial set of x-rays) **Non-PPO**: You pay all charges
Ambulance: • Medical • Accident • Medical • Accident	**Non-Participating:** Medical 25% of allowance subject to CYD. Member owes difference between total and allowed charges. **Non-Participating:** Accident within 72 hours paid in full up to our allowance. Member owes the difference between total and allowed charges. **Preferred Facility:** Medical 10% of allowance subject to CYD. Accident within 72 hours paid in full up to our allowance. **Preferred Facility:** Accident 10% of allowance subject to CYD. Accident within 72 hours paid in full up to our allowance.	**Ambulance & Hospital Billing:** **PPO/Par/Non-Par:** $50.00 copayment. We pay remaining charges. (Not subject to our allowance.)
Physical Therapy, Occupational Therapy and Speech Therapy.	**PPO Facility**: 10% of allowance subject to CYD. Limited to 50 visits for PT, combined limitation of 25 visits between Occupational and Speech Therapy **Participating Facility**: 25% of allowance subject to CYD. Limited to 50 visits for PT combined limitation of 25 visits between Occupational and Speech Therapy. **PT, OT, ST Non-Participating**: 25% of allowance subject to CYD. Limited to 50 visits for PT, combined limitation of 25 visits between Occupational and Speech Therapy. Member owes difference between total and allowed charges.	**PPO** Facility $30 copayment per visit per facility. 50 visit combination between Physical, speech and occupational therapy. **Non-PPO:** You pay all charges for Non-PPO facility, physician, and therapist billing.
***Home Health Benefits	**No Benefits available**	**No Benefits available**

BENEFIT	2002 STANDARD OPTION **Enrollment code 104 - self only** **Enrollment code 105 - self & family**	2002 BASIC OPTION **Enrollment code 111 - self only** **Enrollment code 112 - self & family**
Prescription drugs		
• **Retail Pharmacy Program**	**PPO**: 25% of our allowance up to a 90-day supply **Non-PPO**: 45% Average Wholesale Price (AWP) allowance up to a 90-day supply.	**PPO**: $10 for generic/$25 for formulary brand-name drugs/50% coinsurance ($35 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments. **Non PPO**: You pay all charges
• **Home delivery**	**Home delivery:** Available through Internet Retail Pharmacies, or:	**Home delivery:** Available through Internet Retail Pharmacies
• **Mail Service Prescription Drug Program**	**Mail Service Prescription Drug Program:** • $10 generic/$35 brand-name per prescription up to a 90-day supply.	**Mail Service Prescription Drug Program:** • No benefit
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $4,000 (PPO) or $6,000 (combined PPO/Non-PPO) per contract per year; some costs do not count towards this protection.	Nothing after $5,000 (PPO) per contract per year; some costs do not count towards this protection.

*** **Benefits are still available for Home Nursing Care, Physical Therapy, Speech Therapy, Occupational Therapy and Home Hospice.**

†MHSA Prior approval or Precertification is required for 2002 Standard and Basic Option -**Physician** Treatment plans are required prior to the ninth visit for Standard Option. Under Basic Option, prior approval required before first visit. **Outpatient Hospital** IOP or PH requires Prior approval. **Inpatient Hospital** requires Precertification. Call 1-800-367-0406 MHSA number for prior approval or Precertification.

Please Note: Certain deductibles, copayments, and coinsurance amounts do not apply if Medicare is your primary coverage for medical services (Medicare pays first).

On limited occasions, such as for certain drugs requiring prior approval, you will need to file a claim for services received from network providers.

Federal Employee Program (FEP): Basic Option Drug Copayment Level.

To find out if a pharmacy is preferred for Basic Option, you may call the Retail Pharmacy Program at 1-800-625-4060. (The Mail Order Program is not available for Basic Option members.)

Copayment Level:

1) Generic up to $10.00
2) Formulary up to $25.00
3) Non-formulary minimum $35.00. When drug costs is more than $70, member owes 50% of drug costs.

Drug Name	Copayment Level
Accolate	2
Accu-Check Strips	2
Accupril	2
Accuretic	3
Aceon	3
Aciphex	3
Actonel	2
Actos	2
acyclovir oral	1
Adalat CC	1,2
Aerobid/Aerobic M	3
Ak-Tracin	1,3
albuterol, levalbuterol	1
Alesse	1,2
Allegra	2
Allegra D	2
Alora	3
Alphagan	2
Altace	2
Amaryl	2
Ambien	2
Amerge	3
amitriptyline	1
amoxicillin	1
Amoxil	1,3
Amoxil fil coated tablets	3
ampicilin	1
Anafranil	1,3
Anaprox	1,3
Armour Thyroid	1,3
Astelin	2
Atacand/Atacand HCT	3
atenolol	1
Augmentin	2
Avalide	2
Avadia	2
Avapro	2
Avelox	3
Axid	3

Drug Name	Copayment Level
Azmacort	2
Azopt	2
bacitracin	1
bacitracin & polymyxin B	1
Beclovent	3
Beconase	3
Beconase AQ	3
Betagan	1,3
Betimol	2
Biaxin/Biaxin XL	2
Bleph-10	1.3
Brethaire	3
Brevicon	1,3
bupropion	1
Buspar	1,3
Cafergot	2
Calan SR	1,3
Capoten	1,3
captopril	1
Cardene SR	3
Cardizem CD	1,3
Cardura	1,3
Ceclor	1,3
Ceclor CD	3
Cedax	3
cefaclor	1
Ceftin	3
Cefzil	3
Celebrex	3
Celexa	2
Cenestin	3
cephalexin	1
Chemstrip bG strip	2
cholestyramine	1
Ciloxan	3
cimetidine	1
Cipro	2
Claritin	2
Claritin D	2

Drug Name	Copayment Level
Climara	1,3
clomipramine	1
Combipatch	3
Coreg	2
Cosopt	3
Coumadin	1,3
Covera HS	3
Cozaar	2
Daypro	1,3
Demulen	1,3
despramine	1
Desogen	1,3
Desyrel	1,3
Detrol/Detrol LA	2
DHE 45	3
Diabeta	1,3
Diflucan, except 150 mg	3
Diflucan 150 mg	2
Dilacor XR	1,3
diltiazem	1
diltiazem extended release	1
Diovan/Diovan HCT	3
dipivefrin	1
Ditropan	1,3
Ditropan XL	3
doxazosin	1
doxepin	1
doxycycline	1
Dynabac	3
Dynacirc	3
Dynacirc CR	3
E.E.S	1,3
Effexor	2
Effexor XR	2
E-Mycin	1,3
Elavil	1,3
enalapril	1
ERYC	1,3
Erythrocin	1,3
erythromycin	1
erythromycin base	1
erythromycin ethylsuccinate	1
erythromycin stearate	1
esterified estrogens	1
estropipate	1
Estrace	1,3
Estraderm	2
Estratab	1,3

Drug Name	Copayment Level
Estratest	3
Estrostep FE	2
Evista	2
famotidine	1
Famvir	3
FemHRT	2
Flagyl	1,3
Flonase	2
Flovent/Florven Rotadisk	2
Floxin	3
fluoxetine	1
Fosamax	2
fragmin	3
Garamycin	1,3
gemfibrozil	1
gentamicin	1
Geocillin	3
glopizide	1
Glucophage	2
Glucotrol	1,3
Glucotrol XL	2
Glucovance	3
glyburide	1
Glynase	1,3
Glyset	3
Helidac	3
Humalog	2
Humulin	2
Hytrin	1,3
Hyzaar	3
ibuprofen	1
Ilotycin	1,3
imipramine	1
Imitrex	3
Inderal	1,3
Inderal LA	1,3
Indocin	1,3
indomethacin	1
Iopidine	3
Isopto Carpine	1,3
Keflex	1,3
Kerlone	1,3
ketoconazole oral	1
Lamisil oral	2
Lescol/Lescol XL	2
Levaquin	2
Levatol	3

Drug Name	Copayment Level
levobunolol	1
levothyroxine	1
Lipitor	2
Lo/Ovral	1,2
Lodine/LodineXL	1,3
Loestrin(FE)	2
Lopid	1,3
Lopressor	1,3
Lorabid	3
Lotensin	3
Lovenox	2
Luvox	1,3
Mavik	3
Maxair	3
Maxair Autohaler	2
Maxalt/Maxalt MLT	2
Maxaquin	3
metoprolol	1
metronidazole	1
Mevacor	3
Micardis	3
Micronase	1,3
Micronor	2
Midrin	1,3
Migranal	3
Mircette	2
Modicon	1,2
Monopril	3
Monopril HCT	3
morphine oral	1
Motrin	1,3
MS Contin	1,3
Mycelex	3
nabumetone	1
Naprosyn	1,3
naproxen	1
Nasacort	2
Nasacort AQ	2
Nasarel	3
Nasonex	2
Nexium	2
Nimotop	3

Drug Name	Copayment Level
Nizoral oral	1,3
Nordette	1,2
Norinyl 1 + 50	1,3
Norinyl 1 + 35	1,3
Noroxin	3
Norpramin	1,3
nortriptyline	1
Norvasc	2
Ocuflox	2
Ocupress	1,3
Ogen	1,3
Omnicef	2
One Touch strips	3
Optipranolol	1,3
Ortho Tri Cyclen	2
Ortho-Cept	1,2
Ortho-Cyclen	2
Ortho-Novum1/35	1,2
Ortho-Novum1/50	1,2
Ortho-Novum 7/7/7	2
Ortho-Novum 10/11	1,2
Ovcon	3
Ovral	1,2
oxybutynin	1
OxyContin	2
Pamelor	1,3
Paxil	2
PCE	3
penicillin VK	1
Penlac	3
Pepcid	1,3
Phospholine Iodide	3
pilocarpine opth.	1
Pilopine HS gel	3
Plendil	2
Polysporin	1,3
Polytrim	1,3
Prandin	3
Pravachol	3
Precose	3
Premarin	2
Premphase	2
Prempro	2
Prevacid	3
Prevpac	3
Prilosec	2
Principen	1,3
Prinivil	3

Drug Name	Copayment Level
Procardia XL	1,3
Propine	1,3
Proscar	3
propranolol	1
Protonix	2
Proventil	1,3
Proventil HFA	3
Prozac	1,3
Pulmicort Turbuhaler	3
Questran	1,3
Questran Light	1,3
ranitidine tabs	1
Relafen	1,2
Remeron/Remeron Soltabs	2
Rhinocort	2
Serevent/Serevent Diskus	2
Serzone	2
Sinequan	1,3
Singulair	2
Sonata	3
Sporanox	3
Sular	2
sufacetamide	1
Suprax	2
SureStep strips	3
Synthroid	1,2
Tagament	1,3
Tenormin	1,3
Tequin	3
terazosin	1
Teveten	3
thryoid hormone	1
Tiazac	3
timolol	1
Timoptic-XE	1,3
tobramycin	1
Tobrex	1,3
Tofranil	1,3
Toprol XL	2

Drug Name	Copayment Level
Tracer bG strips	2
trazodone	1
Tri-Levlen	1,3
Tri-Norinyl	2
Triphasil	1,2
Trusopt	3
Univasc	3
Valtrex	3
Vancenase	3
Vancenase AQ	3
Vanceril	2
Vantin	3
Vasotec	1,3
Veetids	1,3
Ventolin	1,3
verapamil sustained release	1
Verelan	1,3
Vioxx	2
Vivelle/Vivelle Dot	2
Voltaren/Voltaren SR	1,3
warfarin	1
Wellbutrin	1,3
Wellbutrin SR	2
Xalatan	2
Zagam	3
Zantac tabs	1,3
Zebeta	1,3
Zestoretic	3
Zestril	2
Zithromoax	2
Zocor	3
Zoloft	2
Zomig/Zomig ZMT	2
Zovia	1
Zovirax oral	1,3
Zyflo	3
Zyrtec	3
Zyvox	3

Key - All Drugs in **BOLD** have a generic

Level 1	Level 2	Level 3
Generic Drugs (all lower case letters)	Formulary Brand Name Drugs	Non-Formulary Drugs
Lowest Copayment	Mid-level copayment	Highest Copayment*
Up to $10.00	Up to $25.00	Minimum copayment $35.00.When drug is more than 70.00, member pays 50% of drug.

Wellness Benefit - Overview of Arkansas FirstSource Wellness Benefits:

I. The following services will be covered, subject to deductible and in or out of network coinsurance, up to a $500 maximum per calendar year for each covered person.

Adult Routine Physical Exam, Including:

- Initial evaluation
- Examination
- Appropriate lab tests
- PSA tests

Routine Gynecological Examinations, Including:

- Annual routine pelvic exams
- Annual routine PAP smears
- Routine mammography

(For members, whose benefit plans include both an office visit copayment and a wellness benefit, these services will be covered subject to the office visit copayment up to $500 per year.)

II. The following child wellness services will be paid at 100% (E/M codes and immunizations codes) with no annual maximum:

Preventive Child Care:

The Wellness Benefit for preventive childcare is for children from birth through age 18, according to the schedule of visits and covered benefits shown below. Covered preventive childcare includes:

- Medical history
- Physical exams
- Routine tests
- Appropriate immunizations
- Lab tests

Wellness Benefits - Illustrations of Arkansas FirstSource Wellness Benefits:

Scenario #1:
Member has a $500 deductible which she has not met. Claim is filed by an in-network provider for her annual routine PAP smear.

Allowed:	$300
Deductible:	$500
Amount applied to deductible (member responsibility):	$300
Amount paid under wellness benefit:	$0
Remaining deductible to be met:	$200

Remaining annual wellness benefit: $500 annual max - $0 wellness payments = $500

Scenario #2:
Member has a $1000 deductible which HAS been met and an 80% coinsurance plan. An in-network provider files a claim for a physical, related blood work, and PSA test.

Total allowed charges:	$850
Applicable coinsurance:	80%
Balance:	$680
Annual maximum:	$500
ABCBS payment:	$500
Member responsibility	((20% X 850) + (680-500)) = $350

Remaining annual wellness benefit: $500 annual max - $500 ABCBS payment = $0

Scenario #3:
Member has a $10 PCP copay and has a routine mammogram billed by the PCP:

Allowed:	$250
Copay:	$10
ABCBS payment:	$240
Member responsibility:	$10

Remaining annual wellness benefit: $500 annual max - $240 ABCBS payment = $260

Scenario #4:
Member has a $10 PCP copay and has a routine mammogram and PAP smear billed by the PCP.

Allowed:	$800
Copay:	$10
Balance:	$790
Annual maximum:	$500
ABCBS payment:	$500
Member responsibility:	($10 copay + ($790-$500)) = $300

Remaining annual wellness benefit: $500 annual max - $500 ABCBS payment = $0