Arkansas Blue Cross and Blue Shield

Providers' News

March 2007

Inside the March Issue:

Please Note:

Providers' News contains information pertaining to Arkansas Blue Cross and Blue Shield, a mutual insurance company, its wholly owned subsidiaries, and affiliates. The 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.

We're on the Web!
www.ArkansasBlueCross.com
www.HealthAdvantage-hmo.com
www.BlueAdvantageArkansas.com
and www.fepblue.org

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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Arkansas BlueCross BlueShield
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Countdown to NPI!

Arkansas Blue Cross and Blue Shield needs your National Provider Identifier (NPI) to ensure our payment system is updated before the NPI deadline (May 23, 2007).

Please send a copy of the verification from the National Plan and Provider Enumeration System (NPPES) that indicates the provider and/or organization name and newly assigned NPI to the Provider Network Operations division of Arkansas Blue Cross and Blue Shield.

Simply submitting your NPI on a claim is not sufficient. Providers must register their NPI with Arkansas Blue Cross and Blue Shield by mailing, faxing, or emailing their NPI verification to:

Arkansas Blue Cross and Blue Shield
Provider Network Operations
P.O. Box 2181
Little Rock, Arkansas 72203-2181

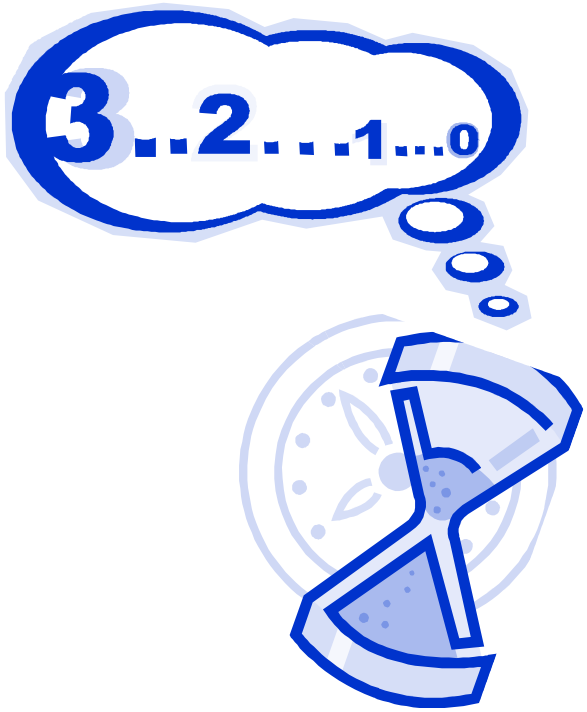
Fax: 501-378-2465
E-mail: providernetwork@arkbluecross.com

Please attach the "Provider Change of Data" form (located under "Forms for Providers" on the "Provider" page of the Arkansas Blue Cross web site at www.arkbluecross.com) with the NPPES confirmation form. If the provider's demographics or payment information data has not changed, they should only complete the Provider #, Name, Email Address, NPI, Medical Records, Fax Number, and Practice Location Address information on the "Provider Change of Data" form.

For those providers with access to AHIN, the Advanced Health Information Network, a program has been created to notify Arkansas Blue Cross and Blue Shield about a provider's NPI assignment submitted through AHIN. All AHIN users can now select the "NPI Administration" button to submit their new NPI. Please check the AHIN bulletin board for instructions and additional information.

Providers who have not already applied for their NPI, please do so ASAP. **HIPAA requires that all covered entities completing electronic claims transactions** (such as providers, healthcare clearinghouses, and large health plans) **must use only the NPI to identify covered healthcare providers in all standard transactions by May 23, 2007.**

For additional information on NPI, visit the CMS website at ***http://new.cms.hhs.gov/***. On the CMS home page, select the "Regulations & Guidance" link located under "CMS Programs & Information" and then the "National Provider Identifier Standard" link located under the "HIPAA Administrative Simplification" section. Providers can also click on the NPPES link or go directly to their web site and apply online at ***http://nppes.cms.hhs.gov***.



Arkansas Blue Cross and Blue Shield Implements NPI Functionality

Arkansas Blue Cross and Blue Shield and our affiliated companies began utilizing the National Provider Identifier (NPI) on October 2, 2006 for those providers who have registered their NPI with our organization. (Due to a nationally-coordinated implementation schedule, the Federal Employees Program (FEP) began NPI implementation in January, 2007.)

During October, providers began submitting their NPI on standard HIPAA transactions such as electronic claim transactions (ANSI 837). Providers may use their new NPI when communicating with Arkansas Blue Cross, including use of the Interactive Voice Response (IVR) unit, and will also begin receiving their NPI on correspondences. **Please note that the 5-digit Arkansas Blue Cross provider number will still be required in the ANSI 837 REF segment through May 23, 2007.**

Providers or Clearinghouses who process Electronic Remittance Advice (ANSI 835) transactions will begin receiving their NPI as the primary provider identifier beginning January, 2007. Please discuss this change with vendors to help ensure HIPAA-compliant transactions containing an NPI can be processed accurately.

The current CMS 1500 and UB-92 paper claim forms were not designed to accommodate the new NPI. New paper claim forms have been designed by NUCC and NUBC, respectively, which do accommodate the NPI.

Providers may bill using their NPI on paper claim forms when the implementation period begins for each form. The current implementation start date for the new CMS 1500 Professional paper claim form was January 2, 2007 and the implementation start date for the UB-04 Institutional paper claim form was March 1, 2007.

This NPI implementation plan, which closely parallels the CMS Medicare implementation plan, should allow for a smooth transition towards HIPAA compliance by the deadline of May 23, 2007.

For additional information on NPI, visit the CMS website at ***http://new.cms.hhs.gov/***. On the CMS home page, select the "Regulations & Guidance" link located under "CMS Programs & Information" and then the "National Provider Identifier Standard" link located under the "HIPAA Administrative Simplification" section. Providers can also click on the NPPES link or go directly to their web site and apply online at ***http://nppes.cms.hhs.gov***.

Upon receipt of an NPI, please register the identifier with Arkansas Blue Cross through AHIN (the Advanced Health Information Network) by selecting the "NPI Administration" button or by faxing the NPPES verification form and the "Provider Change of Data" form to Provider Network Operations at 501-378-2465.

AHIN: Extended Hours of Operation

AHIN (Advanced Health Information Network) has extended hours of operation. Please note the updated hours of operation below:

Monday thru Saturday 6 am until midnight.

Summary of Arkansas Blue Cross and Blue Shield's NPI Guidelines

- **NPI must be used for providers of service and any other provider identification on May 23, 2007 per the HIPAA mandate or electronic claims and applicable electronic transactions will be rejected.**

- **NPI must be used for organizations (facilities, clinics, etc.) on May 23, 2007 per HIPAA mandate or electronic claims and applicable electronic transactions will be rejected.**

- **NPI for all providers of service and any other provider identification must be used on both CMS 1500 and UB-04 paper claim forms on May 23, 2007 or the claims will be rejected.**

- **All providers who file claims directly to Arkansas Blue Cross and Blue Shield must register their NPI with Arkansas Blue Cross and Blue Shield. Simply submitting the NPI on a claim is NOT enough. See *Providers' News* articles on how to register your NPI with Arkansas Blue Cross.**

Hospital Subparts and NPI

Arkansas Blue Cross and Blue Shield and its affiliate companies, USAble Corporation and Health Advantage, have never recognized a hospital's distinct part units. That is, all psychiatric, swing bed, and rehabilitation unit services have been filed under the hospital's acute care information and provider number. This policy and process will NOT change with NPIs.

A hospital may be obtaining separate NPIs for psychiatric, rehabilitation, and swing bed subparts for Medicare but those subparts' NPIs should not be billed to Arkansas Blue Cross, USAble Corporation, and Health Advantage. **The hospital's acute care NPI should be submitted on the claims.**

Arkansas Blue Cross and its affiliates will be able to accommodate claims with subpart NPIs that crossover from Medicare where Arkansas Blue Cross is in a secondary position as well as on Medipak supplement claims.

Organ or Disease - Oriented Panel Pricing

CPT codes require all of the individual codes in an organ or disease panel to be performed for providers to bill the organ or disease panel procedure code. Some providers bill seven of the eight components individually, despite the fact that tests are done on multi-channel analyzers that commonly provide all eight results.

Beginning November 1, 2007, Arkansas Blue Cross will begin limiting the total allowance of multiple laboratory procedures included in an organ and disease panel to the allowance of the organ/disease panel procedure code. If less than the number of required tests for a panel is reported, the maximum allowance for the reported individual tests will be equivalent to the allowance for the panel. See the coding example provided at the end of this article.

The following panel codes with the individual CPT codes included in the panel code will be impacted:

80048 Basic metabolic panel:

- Calcium (82310)
- Carbon dioxide (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Potassium (84132)
- Sodium (84295)
- Urea Nitrogen (BUN) (84520)

80050 General health panel:

- Comprehensive metabolic panel (80053)
- Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004)

OR

- Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
- Thyroid stimulating hormone (TSH) (84443)

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80051 Electrolyte panel:
- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

80053 Comprehensive metabolic panel:
- Albumin (82040)
- Bilirubin, total (82247)
- Calcium (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphatase, alkaline (84075)
- Potassium (84132)
- Protein, total (84155)
- Sodium (84295)
- Transferase, alanine amino (ALT) (SGPT) (84460)
- Transferase, aspartate amino (AST) (SGOT) (84450)
- Urea Nitrogen (BUN) (84520)

80055 Obstetric panel:
- Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004)

OR

- Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
- Hepatitis B surface antigen (HBsAg) (87340)
- Antibody, rubella (86762)
- Syphilis test, qualitative (eg, VDRL, RPR, ART) (86592)
- Antibody screen, RBC, each serum technique (86850)
- Blood typing, ABO (86900)
- Blood typing, Rh (D) (86901)

80061 Lipid panel:
- Cholesterol, serum, total (82465)
- Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718)
- Triglycerides (84478)

80069 Renal function panel:
- Albumin (82040)
- Calcium (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphorus inorganic (phosphate) (84100)
- Potassium (84132)
- Sodium (84295)
- Urea nitrogen (BUN) (84520)

80074 Acute hepatitis panel:
- Hepatitis A antibody (HAAb), IgM antibody (86709)
- Hepatitis B core antibody (HbcAb), IgM antibody (86705)
- Hepatitis B surface antigen (HbsAg) (87340)
- Hepatitis C antibody (86803)

80076 Hepatic function panel:
- Albumin (82040)
- Bilirubin, total (82247)
- Bilirubin, direct (82248)
- Phosphatase, alkaline (84075)
- Protein, total (84155)
- Transferase, alanine amino (ALT) (SGPT) (84460)
- Transferase, aspartate amino (AST) (SGOT) (84450)

Example: The Arkansas Blue Cross and Blue Shield allowance for CPT Code 80048 is $17.75. The codes included in CPT 80048 and the corresponding Arkansas Blue Cross allowances are:

• Calcium (82310)	$10.80
• Carbon Dioxide (82374)	$10.25
• Chloride (82435)	$ 9.63
• Creatinine (82565)	$10.74
• Glucose (82947)	$ 8.22
• Potassium (84132)	$ 9.63
• Sodium (84295)	$10.08
• BUN (84520)	$ 8.27

If providers bill any combination of the above codes, the most providers will be paid for all of the codes listed will be $17.75. The only combination in this example that would not result in a reduction is 84520 and 82947.

Coverage Policy Manual Updates

The following policies were revised and/or added to the Arkansas Blue Cross and Blue Shield Coverage Policy Manual since September 2006. Notations have been made when coverage has changed. Please access the policy at www.arkbluecross.com to see details regarding coverage.

- Alpha-Fetoprotein for Prediction of risk of Hepatocellular Cancer, Cholangiocarcinoma, Down's Syndrome - 82107 is non-covered.
- Angioplasty/Stenting, Abdominal Aortic & Lower Extremity Artery Stenosis, Percutaneous - Limited coverage for primary stenting.
- Antioxidant Measurement, Non-invasive - Non-covered.
- Atherectomy, Peripheral Artery - Limited coverage added.
- Autologous Serum Tears - Policy of non-coverage.
- Blepharoplasty/Blepharoptosis - Limited coverage for lower lid procedures.
- Brachytherapy of the Prostate - Reference of HDR removed.
- Brachytherapy, Prostate, High-Dose Rate Temporary - Non-covered.
- Brachytherapy, Uterine Cancer - Coverage added for stage 1B, G1 with risk factors.
- Corneal Topography - Limited coverage.
- Dry Hydrotherapy (Hydromassage) - Policy of non-coverage.
- Immune Globulin, Intravenous (coverage added):
  - Treatment of autoimmune hemolytic anemia, warm type, that has not responded to alternative therapy;
  - Treatment of children with human immunodeficiency virus infection, to decrease the risk of serious bacterial infection. This is covered only in children who are not receiving co-trimoxazole as prophylaxis and for children with a CD4 count greater than 200-400;
  - Treatment of IgG subclass deficiency only when there is also a demonstrated deficiency in the ability to form antibodies against a variety of polysaccharide **AND** protein antigens.
- Food and Chemical Sensitivity Testing - Non-covered.
- Interspinous Distraction Devices (Spacers) - Policy of non-coverage.
- Intracranial Atherosclerois, Stenosis, Angioplasty/Stenting, Percutaneous - Limited coverage added.
- Transplant, Liver - Additional indication for cadaver transplant:
  - Hepatic metastasis of neuroendocrine tumor (carcinoid) with progressive disease despite drug therapy and ablation when there is no evidence of extrahepatic metastases
- Iron Therapy, Parenteral - Some changes in covered indications.
- Magnetic Resonance Imaging (MRI), Functional - Very limited coverage for pre-neurosurgical evaluation.
- Magnetic Resonance Imaging (MRI), Very Low Field (<03 T(Tesla)) - Policy of non-coverage.
- Radiofrequency Thermal Therapy for Treatment of Joint Laxity - Non-covered for all joint laxity, not just shoulder.
- Stem Cell Growth Factor, Epoetin & Stem Cell Growth Factor, Darbepoetin - Coverage removed for the treatment of anemia of malignancy when chemotherapy not being given.
- Ultrasound in Maternity Care.

Arkansas Blue Cross Gives Providers Two Easy Options For Patient Information

1. AHIN access for patient eligibility and benefits available to your front office staff and your admissions office staff.

AHIN is **not** just for submitting claims! AHIN allows your front office staff and admission office the ability to retrieve patient eligibility and benefit information.

To access AHIN, go to the Arkansas Blue Cross and Blue Shield web site at www.arkbluecross.com, click on the Provider Page and Select the AHIN link. If your office, facility or hospital already uses AHIN, (ask your Office Manager), you can have immediate access to eligibility, claims and claim-status information.

AHIN is available for more than a million Arkansas Blue Cross, Health Advantage, BlueAdvantage Administrators of Arkansas and USAble Administrators members and former members. AHIN is updated nightly and available for Arkansas Blue Cross and out-of-state Blue Cross and Blue Shield plans, Health Advantage, BlueAdvantage Administrators, USAble Administrators and Medicaid (Texas and Arkansas).

The best news of all is that AHIN access is free of charge and is EASY to use. If you would like more information on setting up your front office staff or admissions staff to have this easy access to AHIN, please call **501-378-2336.** AHIN can limit access to only eligibility and benefit information.

2. My BlueLine, Arkansas Blue Cross and Blue Shield's Provider Service line is available 24/7 (1-800-827-4814). Use your natural, conversational voice to ask for patient specific information.

My BlueLine provides several choices of callers:

- Eligibility and Benefits
- Claim Status
- Addresses

Just pick up the phone, dial 1-800-827-4814 and talk. With My BlueLine it really is that simple and during business hours, frees up our Customer Service Staff to answer your more complicated inquiries.

Please note that all eligibility or benefits information is conditional upon verification *when the claim is received and processed*, and should not be relied upon as assurance of payment of the claim. While Arkansas Blue Cross strives to provide the most current information via AHIN, My BlueLine and otherwise, Arkansas Blue Cross cannot guarantee that all information has been timely furnished to us, or that computer entries have been updated to the time of the inquiry.

All eligibility or benefits information given, via AHIN, My BlueLine or otherwise, is subject to the terms, conditions, exclusions, and limitations of the applicable member's health plan or insurance contract, and the participating provider agreement, which take precedence over any inconsistent or contrary oral or written representations

Note: AHIN and the My BlueLine inquiry capabilities are not available for the Federal Employee Program (FEP) at this time.

IVR Option Available for Providers to Check NIA Authorization Status

National Imaging Associates, Inc. (NIA), the company that provides outpatient imaging management services for Arkansas Blue Cross and Blue Shield and its affiliate companies, has implemented an interactive voice response system (IVR) that allows providers to access information regarding the status of their authorization requests using telephone voice response. Providers may access the IVR system by contacting the NIA Call Center.

The new IVR system is available 24 hours a day, including weekends and holidays, providing an additional, convenient option for providers to retrieve important authorization information. The IVR uses voice recognition, which allows providers to speak their request into the system, resulting in an easy and user-friendly experience; providers also can request data through touch-tone recognition if preferred.

To access the IVR system, providers can call their applicable toll-free customer service number (Arkansas providers: 1-877-642-0722 or Texas providers: 1-866-214-1624) and select the option for checking authorization status via IVR from the voice menu. Providers then can input their authorization tracking number to begin searching for an authorization status.

Upon confirming the correct authorization, the IVR system provides the status, such as “approved” or “under review.” Providers have the option of requesting a fax summary of the authorization status.

If they prefer, providers can access the authorization status information on the secure web site, www.RadMD.com. Like the web site, the IVR system requires the provider to enter the authorization tracking number in order to retrieve authorization status information.

The IVR system is specifically for provider authorization status inquiries. To request an ***initial*** authorization, or for any additional information, providers need to speak to an NIA Call Center representative. Or, where it currently is available, providers may access the NIA Web site at www.RadMD.com/signup for processing new requests.

As Arkansas Blue Cross and Blue Shield continues to work to improve our customer services, additional options are being reviewed that may be added to the IVR system to address both provider and patient needs. Arkansas Blue Cross will keep providers informed of any new IVR system features as they become available.

Helpful IVR Tips

- Have the necessary information available prior to calling the IVR.
- Call from a quiet place.
- Listen closely to each prompt before responding.
- Speak with normal speech patterns or choose the touch-tone option.
- Users may interrupt the system with an answer at any time.
- Allow 48 hours before verifying information entered through IVR or online.

Therapeutic Services & Equipment Billing Procedures

Providers should ensure that billing for therapeutic services and equipment is specific to the service being rendered or equipment used. As additional medical techniques become available, it becomes important for providers to ensure proper billing and coding of claims for such services. **Providers should contact the manufacturer for proper coding of new equipment.** Arkansas Blue Cross and Blue Shield relies on the proper coding to process provider claims and to adjudicate the member's benefits.

The codes providers enter on claims are representations to Arkansas Blue Cross that the member's treatment (and your claim) was for the coded diagnosis, and the procedures performed by the provider are as described in the American Medical Association Current Procedural Terminology (CPT) Manual or the Health Care Procedural Coding System Manual (HCPCS).

Providers can use AHIN's Clear Claim Connection for a resource to provide coding information as well as AHIN's Code Specific Coverage to determine benefit coverage per code. Providers may be asked to submit the equipment manufacturer's name for the equipment they have or plan to purchase. Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation, or other remedial action.

If additional information is needed regarding billing of these services, providers may contact their Provider Network Representative.

Incorrect Billing Practices for Computed Tomography Angiography

Arkansas Blue Cross and Blue Shield has identified inappropriate billings of computed tomography angiography. Some providers are billing separately for CTA pelvis (CPT Code 72191), CTA abdomen (CPT Code 74175), and CTA lower extremity (CPT Code 73706), rather than appropriately billing using CPT Code 75635 (Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, radiological supervision and interpretation, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing). Future claims billed incorrectly will be reduced to the allowance for 75635.

60 Day Follow-Up Phone Calls for Medical Record Request Letters

Effective January 12, 2007, Arkansas Blue Cross and Blue Shield discontinued the 60 day follow-up phone calls for the Medical Record Request (MRR) letters. The 20 and 40 day follow-up letters will continue to be sent and Arkansas Blue Cross is pursuing other options to make providers aware of the outstanding requests.

Arkansas Blue Cross is providing a monthly list of outstanding requests which age to 60 days to the Network Development Representatives in each Region. Arkansas Blue Cross also made the MRR letters available on AHIN for providers to view.

One additional item, which is still under investigation, is to add an MRR Alert on AHIN advising providers when MRR letters awaiting their response have aged to a specific age.

Medical Records Request Letter on AHIN

Effective February 12, 2007, the Bar-coded MRR letters became available to providers on AHIN. Arkansas Blue Cross and Blue Shield will continue to fax and/or mail the letters as we have in the past and we ask that providers continue to respond to them through fax or mail as you do today. Arkansas Blue Cross and Blue Shield making the letter available to providers on AHIN as an additional resource to assist in claims research.

All MRR letters created January 1, 2006 and after will be available on AHIN and will remain accessible for 12-months. Once the MMR letter is 12-months old, it will no longer be available to view. Arkansas Blue Cross and Blue Shield will update the system each evening with new letter requests, status updates on existing letters, and remove those that reach the 1-year time limit.

Providers can access the MRR Letters through the Claim Status Search function in AHIN. Therefore, the security to the MMR letters is limited to only those claims which providers have access to on AHIN. Providers will have access to all letters Arkansas Blue Cross sends on claims; providers will see letters sent to them, letters sent to the member, and letters sent to a different provider (i.e. referring provider).

Process to view letters:

1. Follow the existing process to open the Claim Status Search page for a specific claim.
2. The MRR Letter data is available at the end of the Claim Status Data. If MRR data exists for a claim, a new link called 'Medical Record Request' will be enabled on the top right side of the window.
3. Click the Medical Record Request link to go directly to the MRR Data.
4. Field descriptions:
   a) View – Click this button to view the actual letter sent. In addition to viewing the letter, you can save it to your PC or print it. Once you have completed your review, close the letter and you will return to the claim status window.
   b) ICN – The number assigned to the claim at the time of submission.
   c) Status – The status of the MRR Letter.
      - **Submitted**: the MMR letter has been sent and is outstanding
      - **Received**: Arkansas Blue Cross received a response to the letter
      - **Closed-no response**: Arkansas Blue Cross closed the letter as a response was not received.
      - **Closed-manual**: Arkansas Blue Cross determined the information was not needed and closed the letter.
   d) Sent To Provider – The provider's name that Arkansas Blue Cross requested the information from.
   e) ABCBS Number – The Arkansas Blue Cross number assigned for the provider.
   f) NPI – The NPI for the provider Arkansas Blue Cross sent the letter to.
   g) Dated – The date Arkansas Blue Cross created the letter.
   h) Status Date – The date of the last activity of the letter (i.e. when it was created, when information was received, etc.).
   i) Follow Up Date – The date Arkansas Blue Cross sent a follow-up letter or identified it for a phone call.
   j) Inquiry ID – An internal number Arkansas Blue Cross assigns to letters. Providers can reference this number when speaking with Customer/Provider Service.

Once providers have completed their review, return to the Claim Search window to begin a new search.

New Online Tool Designed To Help Patients Estimate Medical Costs

The Physician Connection is a new online tool available exclusively to Arkansas Blue Cross and Blue Shield, Health Advantage, Blue Advantage Administrators of Arkansas and USAble Administrators members, and it offers a "Medical Cost Estimator" to help members estimate costs for specific medical treatment options available through their health-care providers. Additionally, the Physician Connection online tool also allows members to search for a physician by specialty, medical condition, surgery, or procedure. It will help members find a physician to meet their specific need.

The Medical Cost Estimator allows members to learn more about health-care costs. This tool provides members with the ability to compare the costs of different medical treatment options* and allows members to understand their health-care options based on their insurance plan. The Physician Connection Information provides members with the typical health plan allowance for an entire course of treatment relating to a medical condition or surgery or the average allowance for a medical procedure.

Member out-of-pocket expense will vary depending on whether members stay in net-work and the type of insurance or health plan. Members can use the results from the Medical Cost Estimator to help plan for health-care costs and make more informed health-care decisions. With the Medical Cost Estimator, members can search for estimated costs by:

- Surgery or medical procedure
- Medical condition or disease
- Medications
- Comparison of surgery treatment costs by place of service, if the operation is typically performed in different healthcare settings

The Physician Connection also allows members to complete a personal health survey, offers suggestions on medical condition, procedure or surgery-specific questions to ask their physician during office visits, and allows members to complete a short physician satisfaction survey. There also is a glossary of medical terms, a drug cost calculator and other health tools to assist members.

All of these online health tools are available on the secure self-service member portal, *My Blueprint*, on the Arkansas Blue Cross, Health Advantage and BlueAdvantage web sites, and these tools also are available behind the *My Tracker* self-service member portal on the USAble Administrators Web site.

*The estimated costs are estimates only, based on a limited review of claims filed with Arkansas Blue Cross and Blue Shield and its affiliates by physicians and hospitals. Accordingly, members should use Medical Cost Estimator as **a rough guide only**, not an accurate forecast of the costs of any procedure or course of treatment. To determine the actual charge that may be made by a specific health-care provider, members should contact the health-care provider directly.

FEP: Federal Employee Program Dental - Guidelines on How to File FEP Dental Claims & 2007 FEP Dental Fee Schedule

Effective January 1, 2007, the American Dental Association has deleted procedure codes D1201, D1205 and D6971. Claims billed with D1201 and D1205 for dates of service January 1, 2007 and forward will be denied requesting the correct procedure code for these services.

When dental claims for the Federal Employee Program (FEP) members are rendered in the state of Arkansas, use the FEP identification number beginning with an R followed by 8 digits (Example R12345678) and submit claims to Arkansas Blue Cross and Blue Shield at the following address:

Arkansas Blue Cross and Blue Shield
Attention FEP
P O Box 2181
Little Rock AR 72203.

Note: FEP does cover Prophylaxis and Topical application of fluoride billed separately. For a complete list of services covered, please refer to the FEP 2007 dental fee schedule.

Standard Option enrollment code 104 & 105:
The FEP Dental fee schedule is not intended to be payment in full, but a benefit to offset the provider's charge. When the member uses a Preferred network dentist, the member pays the difference between the FEP fee schedule amount and the (MAC) Maximum Allowable Charge.

Basic Option enrollment code 111 & 112:
For Basic Option, a preferred provider must perform the service. **Members covered under Basic Option must use Preferred providers to receive benefits.** If the provider is participating with Arkansas Blue Cross and Blue Shield, the provider is considered Preferred provider. The members pay a $20 copayment for each evaluation charge. FEP pays 100% of

the Maximum Allowable Charge (MAC) for all other covered dental services when rendered by a preferred provider.

Special Note Regarding Oral Surgery:
Under Standard and Basic Option:
Oral Surgery and removal of impacted teeth are not included in the dental fee schedule. These services are covered under Surgical Benefits. The provider reimbursement rate will be based on the type of provider contract providers have with Arkansas Blue Cross and Blue Shield.

National Provider Identifier (NPI):
All providers must file claims using their National Provider Identifier (NPI) beginning May 23, 2007. Providers can submit claims using their 5 digit Arkansas Blue Cross provider number AND/OR their NPI number until the May 23, 2007 deadline. Beginning May 23rd, claims received without an NPI will be returned.

For more information on how to submit claims on the 2006 ADA claim form or how to obtain an NPI, refer to the December 2006 issue of the ***Providers' News*** available on the Arkansas Blue Cross web site at www.arkbluecross.com.

2007 FEP Dental Fee Schedule:

Below is a list of dental services covered under Standard Option effective January 1, 2007.

Dental Code	Service	Up to Age 13	Age 13+	MAC
Clinical oral evaluations				
D0120	Periodic oral evaluation*	$12.00	$8.00	$26.00
D0140	Limited oral evaluation	$14.00	$9.00	$35.00
D0150	Comprehensive oral evaluation	$14.00	$9.00	$36.00
D0160	Detailed and extensive oral evaluation	$14.00	$9.00	$50.00
Radiographs				
D0210	Intraoral complete	$36.00	$22.00	$85.00
D0220	Intraoral periapical-single first film	$7.00	$5.00	$18.00
D0230	Intraoral periapical-each additional film	$4.00	$3.00	$15.00
D0240	Intraoral -occlusal film	$12.00	$7.00	$25.00
D0250	Extraoral-single film	$16.00	$10.00	$30.00
D0260	Extraoral-each additional film	$6.00	$4.00	$20.00
D0270	Bitewing-first film	$9.00	$6.00	$18.00
D0272	Bitewing-two film	$14.00	$9.00	$26.00
D0274	Bitewing-four film	$19.00	$12.00	$35.00
D0277	Bitewings-vertical-seven or eight films	$12.00	$7.00	$50.00
D0290	Posterior-anterior or lateral skull and facial bone survey film	$45.00	$28.00	$60.00
D0330	Panoramic film	$36.00	$23.00	$65.00
Tests and laboratory exams				
D0460	Pulp vitality tests	$11.00	$7.00	$25.00
Palliative treatment				
D9110	Palliative (emergency) treatment of dental pain minor proc	$24.00	$15.00	$45.00
D2940	Fillings (sedatives)	$24.00	$15.00	$37.00
Preventive				
D1120	Prophylaxis-Child *	$22.00	$14.00	$32.00
D1110	Prophylaxis-Adult*		$16.00	$47.00
D1203	Topical application of fluoride child (excluding prophylaxis)	$13.00	$8.00	$18.00
D1204	Topical application of fluoride adult (excluding prophylaxis)		$8.00	$12.00
Space maintenance (passive appliances)				
D1510	Space maintainer-fixed-unilateral	$94.00	$59.00	$160.00
D1515	Space maintainer-fixed-bilateral	$139.000	$87.00	$200.00
D1520	Space maintainer-removable-unilateral	$94.00	$59.00	$160.00
D1525	Space maintainer-removable-bilateral	$139.00	$87.00	$200.00
D1550	Space maintainer-re-cementation of space maintainer	$22.00	$14.00	$40.00

*** Limited to two per person per calendar year**

Dental Code	Service	Up to Age 13	Age 13+	MAC
Amalgam restorations (including polishing)				
D2140	Amalgam-one surface, primary or permanent	$25.00	$16.00	$65.00
D2150	Amalgam-two surfaces, primary or permanent	$37.00	$23.00	$80.00
D2160	Amalgam-three surfaces, primary or permanent	$50.00	$31.00	$94.00
D2161	Amalgam-four surfaces, primary or permanent	$56.00	$35.00	$115.00
Filled or unfilled resin restorations				
D2330	Resin--one surface, anterior	$25.00	$16.00	$75.00
D2331	Resin--two surfaces, anterior	$37.00	$23.00	$95.00
D2332	Resin-three surfaces, anterior	$50.00	$31.00	$112.00
D2335	Resin--four or more surfaces or involving the incisal angle	$56.00	$35.00	$160.00
D2391	Resin Based Composite - one surface posterior	$25.00	$16.00	$90.00
D2392	Resin Based Composite - two surfaces posterior	$37.00	$23.00	$120.00
D2393	Resin Based Composite - Three surfaces posterior	$50.00	$31.00	$150.00
D2394	Resin Based Composite - Four or more surfaces posterior	$50.00	$31.00	$165.00
Inlay restorations				
D2510	Inlay--metallic--one surface, permanent	$25.00	$16.00	$380.00
D2520	Inlay--metallic--two surfaces, permanent	$37.00	$23.00	$480.00
D2530	Inlay--metallic--three surfaces, permanent	$50.00	$31.00	$520.00
D2610	Inlay--porcelain/ceramic--one surface	$25.00	$16.00	$450.00
D2620	Inlay--porcelain/ceramic--two surfaces	$37.00	$23.00	$500.00
D2630	Inlay--porcelain/ceramic--three surfaces	$50.00	$31.00	$600.00
D2650	Inlay--composite/resin--one surface	$25.00	$16.00	$425.00
D2651	Inlay--composite/resin--two surfaces	$37.00	$23.00	$445.00
D2652	Inlay--composite/resin--three surfaces	$50.00	$31.00	$500.00
Other restorative services				
D2951	Pin Retention--per tooth, in addition to restoration	$13.00	$8.00	$45.00
Extractions- includes local anesthesia and routine post-operative care				
D7140	Extraction Erupted Tooth or Exposed Root	$30.00	$19.00	$75.00
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	$43.00	$27.00	$168.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$71.00	$45.00	$189.00
D9220	General Anesthesia in connection w/covered extractions	$43.00	$27.00	$250.00

FEP Fee Schedule Amount is the amount Standard Option Pays toward a covered dental service. MAC (Maximum Allowable Charge) is the maximum amount Preferred network dentists will charge the FEP member for a covered dental service. The MAC may be updated periodically and is subject to change. For providers who sign a participating agreement with Arkansas Blue Cross and Blue Shield agree to accept the Arkansas Blue Cross Dental Fee schedule. (**Note:** This is the FEP Maximum Allowable charge.) When members use a Preferred network dentist, the member pays the difference between the FEP fee schedule and the MAC charge.

New UB-04 Claim Form

HEADS UP! Changes are coming to the UB form used to submit facility claims. Below is a summary of the changes as well as the effective dates for the changes.

Form locaters have been added and some are being relocated on the form. Please notify whoever files your claims that these changes are coming and be prepared.

UB-92 to UB-04 Core Changes

Additions to Form Locators:

Additions were made to better align the paper form with the electronic version:

1) Pay-to-name and address
2) Patient name – ID
3) Accident State
4) Page _ of _ Creation date
5) Identifiers
   - National Provider Identifier (NPI)
6) Diagnosis indicator field
   - To report if the diagnosis was present on admission
7) Patient Reason for Visit code
8) PPS code field

Form Locators Removed:

Deletions were made based on industry needs and input from users:

1) Patient marital status
2) Patient prior payments
3) Due from patient
4) Employment status code
5) Employer location
6) Provider representative signature
7) Date bill submitted
8) Various unlabeled fields

Modifications to Current Form Locators:

Modification of existing form locators were required to align the paper claim form to the electronic format and to prepare for future reporting.

1) Increase Type of Bill from 3 characters to 4
2) Increase field size for HCPCS/Rates/HIPPS Rate codes
   - Allows 2 additional modifiers
3) Added 3 Condition Code fields
4) Increased diagnosis code fields from 9 to 18
5) Expanded diagnosis code field to prepare for ICD-10-CM
6) Added additional Occurrence Span Code field
7) Usage matrix created for Type of Bill
8) Back of form modified to align language with current regulations and industry standards

Substitutions to Current Form Locators:

Various fields substituted or moved:

1) Covered Days – reported as Value Codes
2) Non-covered Days – reported as Value Codes
3) Coinsurance Days – reported as Value Codes
4) Lifetime Reserve Days – reported as Value Codes
5) Medical record number – moved
6) ICN/DCN – moved

Paper claims are designed to use the 10-pitch Pica type, 6 lines per inch. The new UB form is very unforgiving on space. Please make sure the correct type is used.

New UB-04 Claim Form Implementation Schedule

Schedule/Date	Specification/Task	Responsible Industry User
June 2005	UB-04 form approved	NUBC
June 2005 — August 2006	Draft UB-04 Data Specifications Manual (Beta 1) and updates (available at www.nubc.org)	NUBC
September 2006 — May 2007	Final UB-04 Data Specifications Manual	NUBC
May 2006	OMB # Assigned	CMS
June 2005 — May 2007	Full color paper proofs of the UB-04 form available for mechanical, scanning, and other testing purposes	Health Plans, Providers, Information support vendors, and Government
March 1, 2007	Receivers of the UB-04 manual must be able to receive the revised form	Health Plans, Providers, Information Support Vendors, and Government
March 1, 2007 — May 22, 2007	UB-04 or UB-92 forms/data set specifications can be used	Providers
May 23, 2007	UB-92 form/data set is discontinued (based on claims submission date, not date of service)	Health Plans, Providers, Information support vendors, and Government

Arkansas Blue Cross Updates Time-Frame to Follow CMS Changes

The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional contractors (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. The CMS-1500 form is also used for billing of some Medicaid State Agencies.

The National Uniform Claim Committee (NUCC) is responsible for the maintenance of the CMS-1500 form. CMS does not provide the CMS-1500 form to providers for claim submission.

It has come to the attention of CMS that there are incorrectly formatted versions of the revised form. Given, the circumstances, CMS has decided to extend the acceptance period of the CMS-1500 Form (12/90) version beyond the original April 1, 2007 deadline to a new target deadline of June 1, 2007 while this situation is resolved. Contractors will be directed to continue to accept the CMS-1500 Form (12/90) until notified by CMS to cease.

The following link will help providers to properly identify which form is which. To read more about the implementation of the CMS-1500 go to the CMS web site:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

PDF download:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/1500%20problems.pdf

Arkansas Blue Cross and Blue Shield and its affiliates intend to follow the CMS schedule for the new CMS 1500 (08/05) claim form.

CMS-1500: Revised Timeline

Arkansas Blue Cross and Blue Shield will follow the revised Medicare timeline below for the CMS-1500 claim form:

- **January 1, 2007:** Health plans, clearing-houses, & other information support vendors should be ready to handle and accept the revised (08/05) CMS-1500 claim form.
- **January 1 – March 31, 2007:** Providers can use either the current (12/90) version or the revised (08/05) version of the CMS-1500 claim form. **Submitters must continue to include the five-digit Arkansas Blue Cross number on all paper claims submissions during this time.**
- **April 1, 2007 deadline extended until June 1, 2007:** CMS has extended the deadline to accept the current (12/90) version of the CMS-1500 claim form due to the problem with the use of non approved forms (see the related article above).

Please be advised that if CMS does not extend the ability to submit legacy provider numbers, the form extension does no good after May 23, 2007 since there is not a place on the old form for the NPI. Arkansas Blue Cross will notify providers as information is received from CMS.

Diagnosis Codes: Use of 4th & 5th Digits

In order to be HIPAA compliant, beginning July 1, 2007 Arkansas Blue Cross and Blue Shield and its affiliates will require the use of 4th and 5th digit diagnosis codes from providers when the ICD-9-CM coding manual indicates a fourth or fifth digit is required.

Providers who file claims through AHIN will be prompted to supply a 4th or 5th digit if they file an ICD-9 code using a 3rd or 4th digit when the code is designated as requiring a 4th or 5th digit. Claims with dates of service July 1, 2007 and after, using a three or four digit diagnosis code when a more specific diagnosis code is available will be rejected.

Low Osmolar Contrast Media (LOCM)

Effective April 1, 2007, Arkansas Blue Cross and Blue Shield will begin paying separately for medically necessary low osmolar contract media (LOCM). The HCPCS Codes for LOCM are Q9945 - Q9951.

ASE/PSE: Changes for Arkansas State and Public School Employees

State and Public School Members Changing Claims Administrators: Effective with dates of service May 1, 2007, Arkansas State and Public School members currently with QualChoice can transfer to Health Advantage. New ID Cards will be provided by the Employee Benefits Division of the Department of Finance and Administration to members that decide to move to Health Advantage.

QualChoice HMO members transferring to Health Advantage HMO would be following the Health Advantage 'script' referral process. Members on the POS Plan have 'open access' to in-network specialists. For all HMO and POS members, referrals to out-of-network specialists must be prior approved by Health Advantage.

Members currently receiving treatment from a Health Advantage out-of-network provider will be granted **90 days continuity of care** for services related to treatment of a current condition. However, Health Advantage must be notified of the services and the providers rendering the services for authorizations to be issued.

Arkansas Blue Cross and Blue Shield suggests provider offices check available information on the members' coverage for services rendered after **April 30** and transmit claims to the appropriate insurer. Member eligibility information can be obtained on AHIN or by calling Customer Service at 1-800-482-8416. Checking for available eligibility information and claims transmission to the appropriate insurer helps avoid claims adjudication delays.

Please note that all responses to eligibility are subject to the terms of the member's health benefit plan or policy and the provider's participation agreement.

Updated Wellness Chart: On the following pages is an updated list of Wellness Benefits for the State and School Employees. Please note the mammogram codes have been changed to reflect the 2007 CPT codes and two adult immunizations, herpes zoster and meningitis vaccines, have been included in the wellness benefit.

ASE /PSE Preventative Benefits

New Patient - Well Baby Visits:

CPT Codes	Ages	Diagnosis Code Required
99381	Under 1 year	Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99382	Age 1-4	Early Childhood -- Must be billed with diagnosis code V20.2
99383	Age 5-11	Late Childhood -- Must be billed with diagnosis code V20.2
99384	Age 12-17	Adolescent -- Must be billed with diagnosis code V20.2

New Patient - Annual Preventive (Over 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99385	Age 18-39	Must be billed with diagnosis codes: V72.3, V70, V70.0, V7231, V7232, or V7612.
99386	Age 40-64	
99387	Age 65+	

Established Patient - Well Baby Visits (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99391	Under 1 Year	Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99392	Age 1-4	Early Childhood -- Must be billed with diagnosis code V20.2
99393	Age 5-11	Late Childhood -- Must be billed with diagnosis code V20.2
99394	Age 12-17	Adolescent -- Must be billed with diagnosis code V20.2

Established Patient - Annual Preventive Care (Over 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99395	Age 18-39	Must be billed with diagnosis codes: V72.3, V70, V70.0, V7612, V7231, or V7232.
99396	Age 40-64	
99397	Age 65+	

Newborn Care -Well Baby Visits (Under 18 years of age):

CPT Codes	Ages	Diagnosis Code Required
99432	Under 1 Year	Must be billed with diagnosis code V20.2

Preventive Care—Adult (members age 18 and over):

Description	CPT Codes	Ages	Diagnosis Code Required
Annual Physical		Age 18+	Must be billed with Diagnosis codes: V72.3, V70, V70.0, V7612, V7231, or V7232.
Office Visit	99385 & 99395	Age 18-39	
Office Visit	99386 & 99396	Age 40-64	
Office Visit	99387 & 99397	Age 65 +	
Laboratory Services	81000-81005, 80051, 80053, 80061, 85018, 85014, 85025, or 85027	Age 18+	

- **Screening Mammogram (including breast exam)**

Description	CPT Codes	Ages	Diagnosis Code Required
Mammogram - with computer-aided detection	77055, 77056 billed with 77051 77057 billed w/ 77052	Age 40 +	Allowable with any diagnosis code.
Digital Mammogram - Computer-aided detection add-on codes are ineligible when billed with a digital mammogram.	G0202, G0204, G0206 or Revenue code 403	Age 40 +	

- Pap Smear

CPT Codes	Ages	Diagnosis Code Required
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174-88175, G0101, Q0091	Age 18+	Allowable with any diagnosis code.

- Prostate Specific Antigen (PSA)

CPT Codes	Ages	Diagnosis Code Required
84152, 84153, 84154, G0102, G0103	Age 40 +	Allowable w/any diag code.

- Colorectal Cancer Screening (Choice of the following beginning at age 50)

Description	CPT Codes	Age /Frequency	Diagnosis Code Required
Fecal occult blood test and one of the following:	82270, 82274, G0107, G0328	Annually	Allowable with any diagnosis code.
- Flexible sigmoidoscopy	45330—45339, G0104	Every 5 years	
- Colonoscopy	45378—45385, G0105 or G0121	Once every 10 yrs	
- Double contrast barium enema	74280, G0106	Once every 5 yrs	

- Cholesterol and HDL Screening

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Males Age 35+	82465, 83718-83721	Once every 5 yrs	Allowable with any diagnosis code.
Females Age 45+	82465, 83718-83721	Once every 5 yrs	

Immunizations – Adult (members age 18 and over):

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
Diphtheria	90719	Every 10 years	Allowable with any diagnosis code.
Diphtheria and Tetanus toxoid (Td) ages over 7	90718	Every 10 years	
Hepatitis B (Hep B)	90740, 90747, 90746	Once Per Lifetime	
Human papilloma virus (HPV) 3-dose seriew	Gardasil 90649	Age 19 - 26	
Influenza	90658	Annually	
Pneumococcal Conjugate	90732	Adults over 55 or Immunosuppressed	
Herpes Zoster	90736	Adults 60 and over	
Meningitis	90733, 90734	Age 18+	

Preventative Care—Child:

Description	CPT Codes	Age / Frequency	Diagnosis Code Required
All childhood immunizations	Mandated services	Under age 18	Allowable with any diagnosis code.
Human papilloma virus (HPV) 3-dose seriew	Gardasil 90649	Age 9 - 18	
Rotavirus	Rota Teq 90680	2 m - 2 yrs 8m	

Electronic Remittance Advice (ANSI 835)

Effective April 1, 2007, Arkansas Blue Cross Blue Shield, Health Advantage, BlueAdvantage Administrators of Arkansas, Medi-Pak® and the Federal Employee Program will be making changes to the Electronic Remittance Advice (ANSI 835). HIPAA regulations allow for the regular revision of the code sets used to communicate specific information in the standard electronic transactions.

Recent revision to the Claim Adjustment Reason Codes will require that each time an Adjustment Reason Code of 16, 17, 96 or 125 is used, it must be accompanied by at least one Remittance Advice Remarks Code. The transaction format has always allowed for this coding. The change is only to make the Remittance Advice Remarks Code a requirement for these four Claim Adjustment Reason Codes.

If you have any questions relating to this change please contact Arkansas Blue Cross and Blue Shield EDI Services Division at (501) 378-2419.

Reimbursement to Critical Access Hospitals for Medi-Pak® Advantage

Critical Access hospitals will be paid based upon current Medicare Allowable costs or cost based reimbursement. Hospitals are requested to submit a current copy of their interim inpatient per-diem rate letter from CMS which will become the basis for claim payment.

Settlements to CAH's will be made based upon submission of the final settlement notice from CMS. Interim settlements will be made upon request by the hospital and submission of interim settlement per-diems notice furnished to the hospital by CMS.

Tips to Avoid Delays in Claims Payment

The following tips can help avoid delays in claims payment. By following these easy tips, providers can help avoid unnecessary delays in their claims payment.

- When specialty services are being billed, an authorization number is required by **Health Advantage** in order for claims to process correctly. Please populate the PCP's referral number in the required filed. Without the authorization number, the claim will deny or the payment will drop to out of network benefits if on a POS plan.
  - For CMS-1500, this field is Block 23.
  - For ANSI, this would be found in Loop 2300 using REF segment with a G1 qualifier.
- For all lines of business, when billing an office visit and surgical code, Modifier 25 should be used appropriately. Definition of Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service.) **Note:** This modifier is not used to report an E&M service that resulted in a decision to perform surgery.
- Please be sure to bill claims with the member's information exactly as it appears on the ID card.

Fee Schedule Updates

The following CPT4 and/or HCPCS Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule effective January 1, 2007.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
17311	$957.37	$0.00	$0.00	$679.35	$0.00	$0.00
17312	$406.20	$0.00	$0.00	$255.06	$0.00	$0.00
17313	$957.37	$0.00	$0.00	$679.35	$0.00	$0.00
17314	$406.20	$0.00	$0.00	$255.06	$0.00	$0.00
17315	$154.13	$0.00	$0.00	$70.95	$0.00	$0.00
33677	$0.00	$0.00	$0.00	$3,364.08	$0.00	$0.00
37210	$2,505.14	$0.00	$0.00	$789.14	$0.00	$0.00
77371	$1,217.71	$0.00	$1,217.71	$0.00	$0.00	$0.00
77432	$666.31	$666.31	$0.00	$666.31	$666.31	$0.00
77435	$995.56	$995.56	$0.00	$995.56	$995.56	$0.00
80502	$113.22	$113.22	$0.00	$113.22	$113.22	$0.00
82107	$89.99	$6.30	$83.69	$0.00	$6.30	$0.00
83698	$47.43	$3.32	$44.11	$0.00	$3.32	$0.00
83913	$18.66	$1.31	$17.35	$0.00	$1.31	$0.00
86788	$23.54	$1.65	$21.89	$0.00	$1.65	$0.00
86789	$20.11	$1.41	$18.70	$0.00	$1.41	$0.00
87305	$12.59	$0.88	$11.71	$0.00	$0.88	$0.00
87498	$49.04	$3.43	$45.61	$0.00	$3.43	$0.00
87640	$49.04	$3.43	$45.61	$0.00	$3.43	$0.00
87641	$49.04	$3.43	$45.61	$0.00	$3.43	$0.00
87653	$49.04	$3.43	$45.61	$0.00	$3.43	$0.00
87808	$12.59	$0.88	$11.71	$0.00	$0.88	$0.00
92025	$32.40	$19.20	$13.20	$0.00	$19.20	$0.00
94005	$109.67	$66.39	$0.00	$66.39	$66.39	$0.00
A4600	BR			$0.00	$0.00	$0.00
A4601	BR			$0.00	$0.00	$0.00
A8000	$153.35	$15.33	$115.03	$0.00	$0.00	$0.00
A8001	$153.35	$15.33	$115.03	$0.00	$0.00	$0.00
A8002	BR			$0.00	$0.00	$0.00
A8003	BR			$0.00	$0.00	$0.00
A8004	BR			$0.00	$0.00	$0.00
A9279	BR			$0.00	$0.00	$0.00
A9527	BR			$0.00	$0.00	$0.00
A9568	$1,025.00	$1,025.00	$0.00	$0.00	$0.00	$0.00

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
E0676	BR			$0.00	$0.00	$0.00
E0936	BR			$0.00	$0.00	$0.00
E2373	BR			$0.00	$0.00	$0.00
E2374	BR			$0.00	$0.00	$0.00
E2375	BR			$0.00	$0.00	$0.00
E2376	BR			$0.00	$0.00	$0.00
E2377	BR			$0.00	$0.00	$0.00
E2381	$76.18	$7.63	$57.14	$0.00	$0.00	$0.00
E2382	$20.77	$2.07	$15.57	$0.00	$0.00	$0.00
E2383	$151.88	$15.19	$113.91	$0.00	$0.00	$0.00
E2384	$80.91	$8.11	$60.68	$0.00	$0.00	$0.00
E2385	$49.50	$4.96	$37.11	$0.00	$0.00	$0.00
E2386	$150.51	$15.05	$112.87	$0.00	$0.00	$0.00
E2387	$67.49	$6.75	$50.65	$0.00	$0.00	$0.00
E2388	BR			$0.00	$0.00	$0.00
E2389	BR			$0.00	$0.00	$0.00
E2390	BR			$0.00	$0.00	$0.00
E2391	BR			$0.00	$0.00	$0.00
E2392	BR			$0.00	$0.00	$0.00
E2393	BR			$0.00	$0.00	$0.00
E2394	BR			$0.00	$0.00	$0.00
E2395	BR			$0.00	$0.00	$0.00
E2396	$66.51	$6.65	$49.89	$0.00	$0.00	$0.00
G0122	$222.30	$84.18	$138.12	$0.00	$84.18	$0.00
G0228	$1,972.71	$122.71	$1,850.00	$0.00	$122.71	$0.00
J0129	$19.45			$0.00	$0.00	$0.00
J0348	$1.99			$0.00	$0.00	$0.00
J0364	$3.22			$0.00	$0.00	$0.00
J0594	$9.25			$0.00	$0.00	$0.00
J0696	$4.00	$0.00	$0.00	$0.00	$0.00	$0.00
J0894	$27.55			$0.00	$0.00	$0.00
J1324	$1,921.78			$0.00	$0.00	$0.00
J1458	$314.91			$0.00	$0.00	$0.00
J1740	$144.40			$0.00	$0.00	$0.00
J2170	$112.50			$0.00	$0.00	$0.00
J2248	$1.85			$0.00	$0.00	$0.00
J2315	$1.98			$0.00	$0.00	$0.00
J3243	$0.94			$0.00	$0.00	$0.00
J3473	$0.42			$0.00	$0.00	$0.00

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
J7187	$0.93			$0.00	$0.00	$0.00
J7311	BR			$0.00	$0.00	$0.00
J7319	$118.90	$0.00	$0.00	$0.00	$0.00	$0.00
J7345	$38.98			$0.00	$0.00	$0.00
J7346	$741.81			$0.00	$0.00	$0.00
J7607	BR			$0.00	$0.00	$0.00
J7609	BR			$0.00	$0.00	$0.00
J7610	BR			$0.00	$0.00	$0.00
J7615	BR			$0.00	$0.00	$0.00
J7634	BR			$0.00	$0.00	$0.00
J7645	$0.22	$0.00	$0.00	$0.00	$0.00	$0.00
J7647	BR			$0.00	$0.00	$0.00
J7650	BR			$0.00	$0.00	$0.00
J7657	BR			$0.00	$0.00	$0.00
J7660	BR			$0.00	$0.00	$0.00
J7667	BR			$0.00	$0.00	$0.00
J7670	BR			$0.00	$0.00	$0.00
J7685	BR			$0.00	$0.00	$0.00
J8650	$16.00			$0.00	$0.00	$0.00
J9261	$86.26			$0.00	$0.00	$0.00
K0733	$30.21	$3.04	$22.67	$0.00	$0.00	$0.00
K0734	$331.47	$33.15	$248.60	$0.00	$0.00	$0.00
K0735	$421.78	$42.19	$316.33	$0.00	$0.00	$0.00
K0736	$334.19	$33.42	$250.66	$0.00	$0.00	$0.00
K0737	$423.06	$42.30	$317.39	$0.00	$0.00	$0.00
K0855		$910.51		$0.00	$0.00	$0.00
L6703	$276.63			$0.00	$0.00	$0.00
L6704	$648.73			$0.00	$0.00	$0.00
L6706	$336.56			$0.00	$0.00	$0.00
L6707	$1,197.57			$0.00	$0.00	$0.00
L6708	$804.87			$0.00	$0.00	$0.00
L6709	$1,180.90			$0.00	$0.00	$0.00
L7007	$3,837.72			$0.00	$0.00	$0.00
L7008	$6,040.17			$0.00	$0.00	$0.00
L7009	$3,915.69			$0.00	$0.00	$0.00
L8690	$6,000.00			$0.00	$0.00	$0.00
L8691	$3,000.00			$0.00	$0.00	$0.00
L8695	$14.10			$0.00	$0.00	$0.00
Q4083	$118.90	$0.00	$0.00	$0.00	$0.00	$0.00
Q4084	$201.24	$0.00	$0.00	$0.00	$0.00	$0.00
Q4085	$119.56	$0.00	$0.00	$0.00	$0.00	$0.00
Q4086	$214.32	$0.00	$0.00	$0.00	$0.00	$0.00

The following HCPCS Codes were updated effective January 1, 2007 in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
E0445	$0.00	$130.42	$0.00	$0.00	$0.00	$0.00
E0781	$0.00	$8.83	$0.00	$0.00	$0.00	$0.00
E0935	$0.00	$21.32	$0.00	$0.00	$0.00	$0.00
E2402	$0.00	$57.22	$0.00	$0.00	$0.00	$0.00
L7520	$30.86	$0.00	$0.00	$0.00	$0.00	$0.00

Effective January 1, 2007, the following CPT4 Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule.

CPT/HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS/ Used
83890	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83891	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83892	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83893	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83894	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83896	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83897	$8.40	$0.00	$8.40	$0.00	$0.00	$0.00
83898	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83900	$46.84	$0.00	$46.84	$0.00	$0.00	$0.00
83901	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83902	$29.75	$0.00	$29.75	$0.00	$0.00	$0.00
83903	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83904	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83905	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83906	$35.13	$0.00	$35.13	$0.00	$0.00	$0.00
83907	$18.66	$0.00	$18.66	$0.00	$0.00	$0.00
83908	$23.42	$0.00	$23.42	$0.00	$0.00	$0.00
83909	$23.42	$0.00	$23.42	$0.00	$0.00	$0.00
83912	$8.40	$8.40	$0.00	$8.40	$8.40	$0.00

Fee Schedule Updates

Effective January 1, 2007, the following Injection Codes were updated in the Arkansas Blue Cross and Blue Shield Fee Schedule.

HCPCS Code	Fee
90371	$131.96
90375	$67.97
90376	$72.36
90385	$9.17
90585	$120.27
90586	$118.72
90632	$45.33
90633	$25.25
90634	$25.25
90645	$23.34
90647	$23.34
90648	$22.65
90655	$15.99
90656	$17.24
90657	$6.56
90658	$13.13
90660	$22.02
90691	$54.36
90702	$19.03
90703	$20.17
90704	$21.18
90705	$16.14
90706	$17.86
90707	$43.39

HCPCS Code	Fee
90713	$26.82
90714	$19.62
90716	$75.66
90717	$56.62
90718	$19.71
90721	$43.39
90732	$28.11
90733	$87.84
90735	$100.07
90740	$119.10
90743	$25.33
90744	$31.28
90746	$59.55
90747	$119.10
J0130	$430.65
J0170	$0.83
J0210	$10.48
J0256	$3.55
J0275	$23.55
J0278	$1.15
J0280	$0.41
J0282	$0.28
J0285	$9.33
J0287	$11.22

HCPCS Code	Fee
J0288	$12.48
J0289	$17.33
J0290	$2.45
J0295	$6.33
J0300	$2.71
J0330	$0.18
J0470	$26.53
J0475	$206.20
J0476	$72.32
J0500	$15.89
J0530	$13.68
J0540	$29.50
J0550	$31.71
J0560	$22.19
J0570	$37.90
J0580	$44.83
J0583	$1.83
J0585	$5.30
J0587	$8.60
J0592	$0.79
J0595	$0.74
J0600	$41.79
J0630	$42.42
J0636	$0.58

HCPCS Code	Fee
J0637	$32.45
J0640	$1.00
J0690	$1.52
J0692	$7.24
J0694	$7.37
J0696	$1.83
J0698	$4.61
J0706	$3.62
J0713	$4.17
J0715	$3.10
J0720	$11.68
J0735	$68.47
J0743	$14.21
J0744	$5.27
J0760	$4.75
J0770	$25.42
J0780	$2.12
J0795	$4.66
J0800	$119.11
J0850	$901.25
J0878	$0.35
J0881	$3.22
J0882	$3.22
J0885	$9.71
J0886	$9.96
J0895	$15.33
J0970	$35.60
J1020	$2.27
J1030	$5.31

HCPCS Code	Fee
J1040	$9.83
J1060	$4.31
J1070	$5.66
J1080	$13.34
J1100	$0.11
J1110	$23.59
J1120	$16.75
J1165	$0.76
J1170	$2.00
J1190	$182.20
J1200	$0.83
J1205	$128.79
J1212	$43.21
J1245	$1.52
J1265	$0.85
J1270	$3.01
J1325	$15.01
J1327	$16.50
J1335	$25.27
J1380	$13.02
J1410	$63.21
J1430	$72.51
J1435	$0.14
J1436	$74.26
J1438	$168.88
J1440	$195.82
J1441	$311.05
J1450	$11.04
J1451	$12.75

HCPCS Code	Fee
J1455	$10.58
J1460	$12.30
J1470	$24.60
J1480	$36.89
J1490	$49.20
J1500	$61.50
J1510	$73.86
J1520	$86.03
J1530	$98.40
J1540	$110.80
J1550	$123.00
J1560	$122.97
J1565	$16.82
J1566	$26.63
J1567	$31.66
J1570	$41.13
J1580	$1.11
J1590	$0.87
J1595	$48.69
J1626	$7.94
J1630	$2.20
J1631	$5.46
J1640	$7.07
J1644	$0.23
J1645	$11.56
J1652	$6.08
J1655	$2.55
J1670	$99.74
J1720	$2.07

HCPCS Code	Fee
J1730	$116.33
J1742	$278.53
J1745	$55.88
J1751	$12.16
J1752	$10.82
J1756	$0.38
J1785	$4.08
J1790	$1.17
J1800	$3.95
J1817	$2.50
J1835	$39.41
J1885	$0.51
J1931	$24.82
J1945	$160.85
J1950	$449.23
J1955	$9.73
J1956	$7.86
J1980	$9.04
J1990	$21.89
J2010	$3.99
J2020	$25.69
J2060	$1.27
J2150	$0.90
J2175	$1.87
J2180	$3.94
J2185	$3.91
J2210	$4.78
J2250	$0.25
J2260	$3.36

HCPCS Code	Fee
J2270	$2.66
J2278	$6.74
J2280	$4.16
J2300	$0.60
J2310	$1.91
J2320	$3.33
J2321	$6.68
J2322	$13.30
J2325	$32.95
J2353	$99.21
J2354	$3.18
J2355	$255.91
J2357	$17.34
J2370	$0.76
J2400	$15.81
J2410	$2.46
J2425	$11.75
J2430	$35.30
J2440	$0.63
J2460	$0.97
J2469	$18.16
J2501	$3.92
J2503	$1,096.89
J2504	$184.95
J2505	$2,238.43
J2510	$9.24
J2515	$5.72
J2540	$1.00
J2543	$5.07

HCPCS Code	Fee
J2545	$46.52
J2550	$1.92
J2560	$3.31
J2590	$2.27
J2597	$2.76
J2675	$1.76
J2680	$1.55
J2690	$2.33
J2700	$1.60
J2710	$0.09
J2720	$0.45
J2730	$69.15
J2760	$24.93
J2765	$0.46
J2770	$120.10
J2780	$0.70
J2783	$137.88
J2788	$27.21
J2790	$84.86
J2792	$17.18
J2794	$4.99
J2800	$12.77
J2805	$54.05
J2810	$0.03
J2820	$25.88
J2850	$21.13
J2916	$4.96
J2920	$2.03
J2930	$2.58

HCPCS Code	Fee
J2941	$48.43
J2950	$0.40
J2993	$937.41
J2997	$34.07
J3000	$7.06
J3010	$0.35
J3030	$60.83
J3070	$6.04
J3100	$2,132.24
J3105	$4.02
J3120	$5.38
J3130	$10.76
J3230	$4.10
J3246	$9.00
J3250	$4.19
J3260	$2.05
J3265	$2.44
J3285	$58.12
J3301	$1.49
J3303	$3.56
J3305	$150.86
J3315	$185.26
J3320	$19.03
J3355	$52.73
J3360	$0.81
J3364	$9.52
J3365	$476.04
J3370	$3.57
J3410	$0.22

HCPCS Code	Fee
J3415	$3.61
J3420	$0.36
J3465	$5.00
J3470	$17.38
J3472	$140.78
J3475	$0.15
J3486	$5.29
J3487	$213.20
J7030	$1.10
J7040	$0.55
J7050	$0.28
J7060	$1.35
J7070	$2.71
J7100	$14.54
J7110	$9.00
J7189	$1.17
J7190	$0.73
J7192	$1.11
J7193	$0.93
J7194	$0.77
J7195	$1.03
J7197	$1.70
J7308	$111.23
J7310	$4,929.40
J7330	$19,016.99
J7340	$29.90
J7341	$1.89
J7342	$14.99
J7343	$19.04

HCPCS Code	Fee
J7500	$0.29
J7501	$51.57
J7502	$3.68
J7504	$329.83
J7505	$911.91
J7506	$0.20
J7509	$0.07
J7510	$0.09
J7511	$344.31
J7513	$327.17
J7515	$0.99
J7516	$21.46
J7517	$2.65
J7518	$2.23
J7520	$7.51
J7525	$146.00
J7608	$2.49
J7613	$0.07
J7614	$1.45
J7626	$4.77
J7631	$0.07
J7639	$20.66
J7669	$0.25
J7674	$0.44
J7682	$59.61
J8501	$5.24
J8510	$2.21
J8515	$17.96
J8520	$4.12

HCPCS Code	Fee
J8521	$13.71
J8530	$1.02
J8540	$0.27
J8560	$31.76
J8610	$0.23
J8700	$7.71
J9000	$6.49
J9001	$401.53
J9010	$562.95
J9015	$769.10
J9017	$34.83
J9020	$56.96
J9025	$4.39
J9027	$121.24
J9031	$118.72
J9035	$59.78
J9040	$34.63
J9041	$33.99
J9045	$9.30
J9050	$145.37
J9055	$51.83
J9060	$2.55
J9062	$12.75
J9065	$39.08
J9080	$3.99
J9090	$16.37
J9091	$19.93
J9092	$39.87
J9093	$2.06

HCPCS Code	Fee
J9094	$4.13
J9095	$10.33
J9096	$17.77
J9097	$41.30
J9098	$409.97
J9100	$1.71
J9110	$8.55
J9120	$513.17
J9130	$4.86
J9140	$9.71
J9150	$23.69
J9151	$58.15
J9160	$1,446.13
J9170	$318.38
J9175	$3.88
J9178	$25.59
J9181	$0.53
J9182	$5.33
J9185	$253.82
J9190	$1.56
J9200	$60.60
J9201	$129.53
J9202	$208.45
J9206	$131.74
J9208	$51.60
J9209	$9.25
J9211	$296.79
J9212	$4.83
J9213	$38.78

HCPCS Code	Fee
J9214	$14.37
J9216	$301.46
J9217	$239.60
J9218	$7.52
J9219	$1,785.72
J9225	$1,661.36
J9230	$147.27
J9245	$1,245.69
J9250	$0.26
J9260	$2.69
J9263	$9.27
J9264	$9.01
J9265	$12.86
J9266	$1,755.36
J9268	$1,549.73
J9280	$17.81
J9290	$71.26
J9291	$142.51
J9293	$168.86
J9300	$2,451.72
J9305	$45.42
J9310	$506.02
J9320	$157.81
J9340	$42.23
J9350	$853.38
J9355	$59.03
J9360	$1.26
J9370	$8.01
J9375	$16.02

HCPCS Code	Fee
J9380	$40.06
J9390	$19.10
J9395	$83.68
J9600	$2,605.61
P9041	$19.76
P9043	$15.13
P9046	$15.13
P9047	$57.30
P9048	$30.26
Q0163	$0.04
Q0164	$0.03
Q0165	$0.05
Q0166	$45.94
Q0167	$4.83
Q0168	$10.45

HCPCS Code	Fee
Q0170	$0.41
Q0173	$0.34
Q0175	$0.20
Q0176	$0.22
Q0179	$38.30
Q0180	$50.66
Q0515	$1.82
Q2009	$5.89
Q2017	$274.65
Q3025	$119.76
Q4079	$8.03
Q4080	$35.61
Q9945	$0.29
Q9946	$1.97
Q9947	$1.39

HCPCS Code	Fee
Q9948	$0.33
Q9949	$0.37
Q9950	$0.23
Q9952	$2.92
Q9953	$31.62
Q9954	$9.29
Q9956	$51.59
Q9957	$64.05
Q9958	$0.08
Q9960	$0.10
Q9961	$0.20
Q9962	$0.13
Q9963	$0.41
Q9964	$0.20

Providers' News

Arkansas Blue Cross and Blue Shield
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