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providers' news

A publication for participating providers and their office staffs

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Home Sleep Studies

Home sleep studies must be billed with the appropriate HCPCS code to distinguish the level of study provided. The appropriate HCPCS codes are:

Code	Description
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

HCPCS Code G0398 is the only level of sleep study covered in the home setting. Home sleep studies billed using CPT code 95806 will be denied as incorrect coding.

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

5010 Version of Electronic Transactions Mandated by January 1, 2012

The Health Insurance Portability and Accountability Act (HIPAA) requires the adoption of specific standards for electronic health care transactions. The HIPAA transactions that providers and payers exchange are: claims, remittance advice, eligibility inquiries and response, claims status requests and responses, enrollment, premium payment and health care services request for review and response.

The current version for these transactions is 4010A1, but federal regulations published in January 2009 mandate that it be replaced with the newer 5010 version by January 1, 2012. At that time, all electronic transactions that providers, or their vendors, exchange with Arkansas Blue Cross and Blue Shield and its affiliated companies, as well as all other payers, must be in the HIPAA 5010 format.

In the publication of the final rule to require the 5010 formats, the U.S. Department of Health and Humans Services (HHS) asserts that all covered entities should be prepared to demonstrably create and receive 5010 compliant transactions, resulting from the completion of all design/build activities as well as internal testing by December 31, 2010. HHS goes on to state that all covered entities must be fully compliant with the 5010 requirement by December 31, 2011, and that no 4010/4010A1 transactions can be accepted on or after January 1, 2012.

This deadline may appear to be distant but significant work must be accomplished to prepare for this mandatory conversion. Arkansas Blue Cross is making preparations for this federal mandate now. As part of our due diligence, Arkansas Blue Cross would like to partner with providers to test our capabilities of accepting and returning 5010 electronic health care transactions. Although the compliance deadline is not until January 1, 2012, Arkansas Blue Cross recognizes the importance of planning and testing early to ensure there is adequate time to remediate any concerns.

Arkansas Blue Cross is ready to begin testing 5010 claims transactions now. Providers and vendors who are ready to begin testing may contact EDI Services at (501) 378-2419 or (866) 582-3247.

Correct Billing of Discograms (CPT Codes 72285 and 72295)

There has been some confusion regarding the billing of Discograms. From the CPT Assistant, April 2003, page 27,

"Question: Which CPT codes should be reported for a lumbar discography at L2-3, L3-4, L4-5 and L5-S1 levels? Would the appropriate code be reported more than once since the procedure is performed at four different levels? Is the radiological interpretation an inclusive component to the primary procedure, or is it separately reported?"

AMA Comment:

"The discography procedure performed at the L2-3, L3-4, L4-5 and L5-S1 levels may be reported with CPT code 62290, Injection procedure for discography, each level; lumbar. This code should be reported four times since four levels were imaged. Also, CPT code 72295, discography, lumbar, radiological supervision and interpretation, may be reported four times for the radiological supervision and interpretation as this code can be reported for each lumbar level. If the physician performed only the professional component of the discography, then Modifier 26, Professional component, should be appended to CPT code 72295 to indicate this circumstance. There must be documentation of suspected disease at levels in order to receive payment for numerous provocations."

If CPT code 72285, discography, cervical or thoracic, radiological supervision and interpretation, is performed on more than one level, it should be billed in the same manner described above.

The provider who is completing the injection should be billing for CPT code 62290 (Injection procedure for discography, each level; lumbar). If a radiologist is then sent an X-ray of the position of the needle to provide a written report for the record, the radiologist should bill code 72295 with Modifier 26 present, not the provider completing the injection. The provider completing the injection should not bill code 72295.

Proper Billing of Immunoassay for Analytes

There has been some confusion regarding how providers should be billing CPT code 83516. Therefore, this is a review of the proper billing of immunoassays for analytes. CPT code 83516 is an immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method. CPT code 83516 is a nonspecific code for immunoassay procedures which use highly specific antigen to antibody binding to identify specific chemical substances (analytes) by immunoassay techniques for immunoassay procedures that are not specifically identified in CPT. More specific methods reported with these codes include enzyme immunoassay (EIA), and fluoroimmunoassay (FIA). CPT code 83516 is limited to one unit-of-service unless performed for a separate analyte.

CPT code 83516 is a nonspecific code and may be reported for anti-mullerian antibody determination. This test measures a chemical produced in the body called anti-mullerian hormone, or AMH, which has been shown to provide an accurate snapshot of a woman's egg count. Cost for this procedure will accrue to the total benefit allowance for in vitro fertilization, which is a specific member benefit allowance. Arkansas Blue Cross and Blue Shield's Coverage Policy #1998041 excludes coverage of blood/serum testing (cytotoxic food allergy testing). CPT code 83516 is mutually exclusive with CPT Code 83518. If CPT code 83516 is reported with CPT code 83518, CPT code 83516 is denied as a fragmentation.

If the codes listed below are billed with CPT code 83516, 83516 will be denied as a fragmentation. If CPT code 83516 is performed for an analyte separate from the codes listed below, CPT code 83516 should be reported with Modifier 59.

- **80101 -** (Drug screen, single drug class method [e.g., immunoassay, enzyme assay], each drug class) as each code represents qualitative immunoassay for an analyte other than infectious agent antibody or infectious agent antigen.
- **86200 -** (Cyclic citrullinated peptide [CCP], antibody), a semi-quantitative/qualitative enzyme-linked immunosorbent assay.
- **86602 -** CPT 86793, as all of the latter procedures represent qualitative immunoassays for detection of antibodies for specific infectious agents.
- **86021 -** (Antibody identification; leukocyte antibodies), a semi-quantitative/qualitative antibody test.
- **86022 -** (Antibody identification; platelet antibodies), a semi-quantitative/qualitative antibody test.
- **86023 -** (Antibody identification; platelet associated immunoglobulin assay), a semi-quantitative/qualitative antibody test.
- **86255 -** (Fluorescent noninfectious agent antibody; screen, each antibody), a semi-quantitative/qualitative antibody test.
- **86294 -** (Immunoassay for tumor antigen, qualitative or semi-quantitative), a semi-quantitative/qualitative antibody test.
- **86318 -** (Immunoassay for infectious agent antibody, qualitative or semi-quantitative, single step method [e.g., reagent strip]), a semi-quantitative/qualitative antibody test.
- **86376 -** (Microsomal antibodies [e.g., thyroid or liver-kidney], each), a semi-quantitative/qualitative antibody test.
- **86430 -** (Rheumatoid factor; qualitative), a qualitative antibody test.
- **86800 -** (Thyroglobulin antibody), a qualitative antibody test.
- **86850 -** (Antibody screen, RBC, each serum technique), a semi-quantitative/qualitative antibody test.
- **86870 -** (Antibody identification, RBC antibodies, each panel for each serum technique), a semi-quantitative/qualitative antibody test.

Hepatitis A Vaccine

CPT code 90634 is for Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use. There is not a three dose vaccine FDA approved available in the United States at this time. Due to billing errors identified, Arkansas Blue Cross and Blue Shield will begin denying CPT code 90634 as incorrect coding. CPT code 90633 is the appropriate code for the two dose schedule.

EDI Services - FTP Changes

EDI Services currently receives electronic transactions via dial-up or file transfer protocol (FTP). Our customers have provided suggestions for the submission and receiving of transactions via FTP. Therefore, to better serve our customers, EDI Services has developed the means for electronic submitters to transmit and receive electronic transactions via FTP using the third-party program of your choice. EDI Services will provide support for connectivity. However, EDI Services will not provide support for any third-party programs. Electronic submitters will be solely responsible for the setup and maintenance of their third-party programs.

Electronic submitters are not required to use a third-party program. Providers can continue to transmit and receive electronic transactions via FTP using a command line. However, by July 6, 2010, all electronic submitters who have chosen to use a command line or a script will be required to make changes. All electronic submitters, once transitioned, will have an inbound directory, outbound directory, archive directory and changes in the put and get commands. If you are using a command line and running from a script, you will need to contact your vendor so that the necessary changes can be made. Please contact your vendor as soon as possible and allow ample time for them to make the necessary changes. Failure to do so may cause interruption in your transmissions and may cause cash flow issues.

Directory Structure Changes

- Inbound Directory – All upload data should be placed in the submitter number inbound folder for FTP users. Any electronic inbound transaction to EDI Services that has not been placed in the inbound directory will not be processed.
- Outbound Directory – The outbound directory is where all EDI reports, electronic remittance advices and claim status responses will be placed for FTP users.
- Archive Directory – The archive directory is where all EDI reports, electronic remittances advices, and claim status responses will be copied to for users to retrieve when needed. Every outbound transaction from EDI Services that has been placed in your outbound directory will automatically be copied to the archive directory.
- Put Command – For command line users only, electronic submitters will no longer be required to enter the produp!837P or produp!837I statements. The new command will simply be put filename.ext or the “mput” command.
- Get Command – For command line users only, electronic submitters will be able to use the “mget” command. The “mget” command can be used for all extensions. The extensions are 835, rpt, txt, h99 and rej.

Timeline

- **May 1, 2010:** Beginning May 1, 2010, EDI Services will begin accepting beta testers who wish to submit and receive electronic transactions via FTP using third-party programs. If you would like to be a beta tester, contact EDI Services at 1-866-582-3247 or 501-378-2419 to make arrangements. Beta testers will need to have their third-party programs installed and ready for use. Beta testers will be submitting and receiving transactions in production mode on the day of transition. EDI Services will provide support for the telecommunication setup. However, EDI Services will not provide setup and support for third-party programs. Setup and maintenance of third-party programs will be the sole responsibility of the electronic submitter. EDI Services will assist and monitor inbound submissions of electronic transactions during the first transmission as well as the outbound transactions to the user.

- **Before July 6, 2010:** FTP users who will continue to use the command line function will need to notify EDI Services at 1-866-582-3247 or 501-378-2419 when you are ready to begin using the new FTP process. EDI Services will change your profile so you can begin using the new command line functions. The change made to your profile will become effective the next day. Script users will need to ensure that their scripts have been changed accordingly prior to contacting EDI Services. EDI Services highly recommends that you provide this document to your vendor, have your vendor contact us for the document, or download the document from one of the following Web sites.

  arkbluecross.com
  arkmedicare.com
  lamedicare.com

  FTP electronic submitters who have not notified EDI Services by July 6, 2010, will be contacted by our office and will be informed of the new changes. New electronic submitters who have opted to send and receive via FTP will automatically be setup with the new profile changes.

- **July 6, 2010:** All electronic submitters will be required to start using the new FTP command line functions or a third-party FTP program of their choice. Failure to do so by July 6, 2010, may cause interruption in your transmissions and may affect your cash flow.

Billing of Pathology Consultation Codes (CPT Codes 88331 and 88332)

Due to some confusion as to the appropriate manner which CPT code 88331 should be billed, the following is a guideline for the appropriate billing of this code.

CPT code 88331 is the pathology consultation during surgery; first tissue block, with frozen section(s), single specimen. The CPT Assistant July 2000, Page 4 states, "During the course of a surgical procedure, a pathology consultation may be required. Pathology consultations during surgery that involve frozen sections are reported with CPT codes 88331 and 88332." The phrase "... with frozen section(s), single specimen," has caused some confusion over the intent of the code, prompting some to believe that CPT code 88331 can only be used once per surgery, rather than once per specimen. In fact, multiple separately submitted specimens may be received during surgery for frozen section examination for diagnosis or immediate evaluation, resulting in the use of multiple units of 88331.

In order to properly use these codes, the terms "block" and "section" must be defined. A block is a portion of tissue from a specimen that is frozen or encased in a support medium such as paraffin or plastic, from which sections are prepared. A section is a thin slice of tissue from a block prepared for examination. The examination is usually by light microscopy.

When a section from the first block of tissue from a specimen is examined, CPT code 88331 would be used. When sections from subsequent blocks of the same specimen are examined, the appropriate coding is one unit of service of CPT code 88332 for each section examined. If more than one specimen is submitted for consultation, the services for each specimen would be coded as explained above.

Any routine stains (e.g., rapid H&E, Wright) applied to the frozen section are included in CPT codes 88331 and 88332. If other techniques (e.g., fine needle aspiration, touch preparation, examination of a cell sample) are used in the course of a pathology consultation during surgery, they should be reported using appropriate cytology codes. When the definitive permanent section examination is performed, subsequent to the frozen section during surgery, the appropriate surgical pathology code should be reported.

CPT CHANGES INFORMATION

CPT Changes 2001 Rationale CPT code 88331 was revised to allay confusion regarding the intent of the code. The descriptor of CPT code 88331, "with frozen section(s), single specimen," has caused confusion over the intent of the code prompting some to believe that CPT code 88331 can only be used once per surgery rather than once per specimen. The addition of "first tissue block" to the code descriptor was necessary to prevent misinterpretation.

Therefore CPT code 88331 is restricted to one unit per specimen. If a frozen section is performed on a second block of tissue, CPT code 88331 should be reported with Modifier 59 or the LT or RT Modifiers.

Focused Review

Focused review is a provider claims evaluation process that, depending on the specific objectives defined for a given focused review project, may seek to identify cost, utilization or quality trends, as reflected in the available claims data, at both the macro and micro levels.

The goal of focused review is to construct for each claims evaluation project and affected provider a systematic and sustained review of claims over time, hopefully thereby leading to identification, clarification and potential resolution of problem areas in which the provider under review is deficient in terms of either cost, utilization or quality standards, or the published coverage policies, coding and claim filing policies and procedures, network terms and conditions, provider manual or other written policies and procedures applicable to claims submission and processing or to network participation. (See special note, below, on focused review scope and meaning).

Focused review may include examination of provider practice patterns, as well as trends in health care delivery provided to our members in relation to local, regional, state and/or national benchmarks, utilization or quality standards or trends in health care delivery. When practice patterns in general are the defined objective for focused review, provider practice patterns will be monitored to try to identify those providers whose delivery of care differs considerably from a defined peer group norm. When indicated, in-depth review, including on-site audit, may be performed to determine the underlying reason(s) for this variation and to initiate appropriate corrective actions.

Providers may be selected for focused review application through a wide variety of methods or sources, including but not limited to complaints or inquiries from customers, members, other providers, law enforcement or other government agencies, members of the general public, media reports, a problem claim in one or more separate or related incidents, anomalies appearing in any provider profiles generated by Arkansas Blue Cross or its affiliates, or referrals from a medical director, provider network development representative, Provider Network Operations, or any employee or other individual with relevant knowledge about a given provider or their practice. This may include referrals from the Special Investigations Unit at Arkansas Blue Cross as well as the interpretation of profiling information from the Health Care Information Systems Department.

General Outline of Standard Process Steps (which may be varied when appropriate to a given case):

- Identify aberrant practice patterns or other potential problems or violations of applicable standards.
- Send written request to the affected provider for an explanation of such behaviors.
- Upon receipt of written response from affected provider, attempt to determine whether behavior is justified.
- If behavior is not justified, furnish the affected provider with a written statement outlining clear expectations for change as well as education on the issue(s) under review. This written notice should include a specific calendar deadline by which positive change in the aberrant practice patterns, potential problem areas or violations of applicable standards must be demonstrated by the affected provider, based on ongoing review of claims and other available data. The focused review, with respect to an affected provider, shall be deemed to begin upon her/his receipt of this written notice.
- Once underway, the focused review process will include furnishing each affected provider with interim feedback in written form concerning progress or lack of progress at a frequency appropriate to the circumstances. For any focused review lasting longer than 90 days, an affected provider should ordinarily receive one interim feedback report for each 180-day period of the focused review; for any focused review continuing for fewer than 90 days, written interim feedback may or may not be furnished, depending on the circumstances.
- At the focused review deadline, as specified in the initial written notice to the affected provider, determine whether the behavior has changed.
- If no change in behavior, a disciplinary process may begin according to the terms of applicable provider contracts, including network terms and conditions.
- If behavior changed significantly but not in all material respects, the affected provider may be placed on written probation including notice that he/she will be subject to re-examination one year later, at which time any evidence of ongoing aberrancy or violations of standards will be grounds for disciplinary actions.

While it is impossible to account for all variations in providers and provider practices, the goal of focused review processes will be to achieve consistency of review and process, to the extent feasible and practical, leading to treatment of like providers and like circumstances in the same or substantially similar manner. It is understood that neither focused review nor any other process can identify all violators of like kind, but once identified, it is the goal of focused review that all identified providers of the same or substantially similar practice and specialty who demonstrate the same behaviors will be treated substantially the same.

As a condition of network partici-

Focused Review (Continued from page 6)

pation, providers are required to fully cooperate with the focused review process, including responding to all inquiries, and providing, without charge, copies of medical records or other data needed to conduct an evaluation. Providers may also be required to submit to on-site audits as deemed appropriate under the circumstances. Failure to fully cooperate in the focused review process will constitute grounds for network disciplinary measures, which may include termination from the networks.

Special Note on Scope and meaning of Focused Review:

Providers subject to focused review should understand that the process is most often narrowly-focused on specific issues or circumstances, and may even be focused on just one or two procedures or associated CPT codes, i.e., focused review is not typically a comprehensive or even broad-ranging review of all services or activities of an affected provider. Instead, the focused review process is designed to look at a specific, limited issue or question that may have been brought to the network sponsors' attention by a variety of methods, depending on the issue or question. Focused review is not ordinarily intended as a general review of all possible issues or questions relating to a provider's practice, billings or claims, and the termination of any focused review process, in itself, should not, therefore, be interpreted as a finding or conclusion regarding the validity or appropriateness of any particular practice. The mere fact that a given focused review process has been completed does not mean that the questioned claims or practices, or other claims filings or billing practices, are not thereafter subject to questions or further review; in fact, the network sponsors constantly attempt to monitor claims and billing practices on an ongoing basis and reserve the right to take further action and conduct additional reviews as indicated by the circumstances.

Billing Information for Nerve Block

If a nerve block is used in the pre or post operative period as pain management following the procedure, the appropriate block code should be billed with Modifier - 59 to indicate the pain block was not part of the anesthesia for the procedure, and Modifier - 51 as multiple procedure rules.

If the nerve block is used as the anesthesia for the procedure, and given along with conscious sedation, the nerve block would be considered the anesthesia and would be allowed. If the nerve block is given prior to or during the procedure, along with deep sedation (for which a general anesthesia code is billed), the nerve block would not be allowed as it would be considered part of the anesthesia for the procedure.

If the nerve block is given in the preoperative setting and only conscious sedation is given during the procedure (i.e., no general anesthesia code is reported), the nerve block is covered as the anesthesia for the procedure.

NIA Authorization Reminder

Reminder: some self-funded accounts (such as Wehco Media and Southern Bancorp) require NIA authorization for coverage of high-tech imaging services. Please check the members coverage policy for high-tech imaging services requirements.

BlueCard

Coordination of Benefits Questionnaire

Providers can obtain and submit Coordination of Benefits (COB) questionnaires to Arkansas Blue Cross and Blue Shield before filing a claim. Questionnaire responses should not be sent as an attachment to a claim. The two-page COB questionnaire should be printed as a one-sided document to prevent imaging problems. Do not print the COB questionnaire on the front and back of the page. If the member belongs to another Blue Plan, Arkansas Blue Cross will forward the COB questionnaire responses to the member's Blue Cross and Blue Shield Plan on the provider's behalf. The COB questionnaire is available on the Arkansas Blue Cross Web site and through the Advanced Health Information Network (AHIN). Completed forms can be faxed to 501-378-2433 or mailed to:

Arkansas Blue Cross and Blue Shield
Attn: Blue Card Support
P.O. Box 2181
Little Rock, AR 72203

FEP

FEP Edit in AHIN on Subscriber Loop

The Federal Employee Program (FEP) implemented an edit in the AHIN systems on April 15, 2010, that affects the subscriber loop. If the patient loop is not present, the subscriber loop (2010BA) must be present. If the patient loop is present and the address (2010CA) is not equal to "AR" (Arkansas), then the subscriber loop (2010BA) is required.

Access Only PPO Customers of USAble Corporation as of June 1, 2010

Access Only Group	PPO Network
AALF's Manufacturing Inc / Midland's Choice	Arkansas' FirstSource®
Ark Sheet Metal Workers -Local #36-L	True Blue
Arkansas State University Athletes	True Blue
ArVest Bank	True Blue
Ashley County Medical Center	Arkansas' FirstSource®
BEKAERT - Rogers, AR Location	True Blue
BEKAERT - Van Buren, AR Location	True Blue

Access Only PPO Customers of USAble Corporation - (Continued from page 7)

Access Only Group	PPO Network
Brentwood Industries, Inc	Arkansas' FirstSource®
Bryce Corporation	True Blue
Christus St Michael - Cobra Employees	Arkansas' FirstSource®
Diocese Of Little Rock / Christian Brothers	True Blue (Effective 9/1/09)
Franklin Electric	Arkansas' FirstSource®
Harps Food Stores	True Blue
Iron Workers Local 321 *	True Blue
KLA Benefits/Klipsch LLC	Arkansas' FirstSource®
La Darling	True Blue
Levi Hospital	True Blue
Magnolia Hospital	Arkansas' FirstSource®
Motor Appliance Corporation	Arkansas' FirstSource®
Odom's Tennessee Pride Sausage	True Blue
Razorback Concrete Company	True Blue
Rea Magnet Wire	True Blue
Siplast Inc	Arkansas' FirstSource®
Stevens Media Group	True Blue
UFCW (Kroger & Consumer Market)	True Blue
Wabash National / Cloud Corp	Arkansas' FirstSource®

Terminating Access Only PPO Groups

Terminating Access Only Groups	Term Date
St Michael - C H Wilkerson, Texarkana	6/30/2010
St. Michael Healthcare - Hospital	6/30/2010
St. Michael Healthcare - Rehabilitation	6/30/2010
Iron Workers Local 321	7/31/2010

Coverage Policy Manual Updates

The following policies were added or updated in the Arkansas Blue Cross and Blue Shield Coverage Policy Manual since March 2010. To view the entire policies, access the coverage policies located on the Arkansas Blue Cross Web site at arkansasbluecross.com.

New Policies:

Policy ID	Policy Name
1997014	Autologous Chondrocyte Implantation and Other Cell-based Treatments of Focal Articular Cartilage Lesions
1997088	Hyperbaric Oxygen Pressurization (HBO)
1998008	Orthoptic Training for the Treatment of Vision and Learning Disabilities
1998161	Infliximab (Remicade)
1999017	Molecular Diagnostic Tests for Infectious Diseases
2006016	Rituximab (Rituxan), Off-label Use
2009023	Pain Management, Radiofrequency Facet Joint Denervation
2009034	Intensity Modulated Radiation Therapy (IMRT)_Prostate
2009035	Intensity Modulated Radiation Therapy (IMRT)_Lung
2009047	Hormone Pellet Implantation for Hormone Replacement Therapy in Women
2010009	Bevacizumab (Avastin)_Ocular Indications
2010010	Electrical Stimulation, Vagus Nerve Stimulation for Treatment of Headaches
2010011	Myoelectric Prosthesis for the Upper Limb
2010012	Positional Magnetic Resonance Imaging
2010013	Injection, Clostridial Collagenase for Fibroproliferative Disorders
2010014	Genetic Test: Array Comparative Genomic Hybridization (aCGH) for the Genetic Evaluation of Patients with Developmental Delay/Mental Retardation or Autism Spectrum Disorder
2010015	Genetic Test: Colon Cancer; Prediction of Disease Recurrence (Oncotype DX)

Coverage Policy Manual Updates (Continued from page 10)

Policy ID	Policy Name
2010016	Occipital Nerve Stimulation
2010017	Aqueous Shunts and Devices for Glaucoma
2010019	Epiretinal Radiation Therapy for Age-Related Macular Degeneration
2010020	Plugs for Anal Fistula Repair
2010021	Spinal Stenosis, Image-Guided Minimally Invasive Lumbar Decompression
2010022	Prostate Cancer Predicting Risk of Recurrence Systems Pathology
2010023	Orthopedic Applications of Stem Cell Therapy
2010025	Irreversible Electroporation, Nanoknife

Fee Schedule

Fee Schedule Updates

The following CPT and HCPCS codes were updated on 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
37765	$762.93	$0.00	$0.00	$762.93	$0.00	$0.00
54440	BR	$0.00	$0.00	BR	$0.00	$0.00
78451	$365.16	$109.67	$255.50	$0.00	$109.67	$0.00
78452	$623.63	$129.82	$493.80	$0.00	$129.82	$0.00
78453	$317.74	$79.44	$238.31	$0.00	$79.44	$0.00
78454	$305.88	$105.52	$200.37	$0.00	$105.52	$0.00

Fee Schedule Updates (continued from page 11)

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
88187	$101.38	$101.38	$0.00	$101.38	$101.38	$0.00
88188	$125.73	$125.73	$0.00	$125.73	$125.73	$0.00
88189	$160.52	$160.52	$0.00	$160.52	$160.52	$0.00
88321	$145.83	$145.83	$0.00	$132.19	$132.19	$0.00
90662	$17.25	$0.00	$0.00	$0.00	$0.00	$0.00
90670	$108.75	$0.00	$0.00	$0.00	$0.00	$0.00
93010	$14.82	$14.82	$0.00	$14.82	$14.82	$0.00
93018	$26.08	$26.08	$0.00	$26.08	$26.08	$0.00
93042	$13.04	$13.04	$0.00	$13.04	$13.04	$0.00
99500	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99501	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99502	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99503	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99504	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99505	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99506	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99507	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99509	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99510	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99511	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99512	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
99600	$139.00	$0.00	$0.00	$139.00	$0.00	$0.00
A6530	$68.59	$0.00	$0.00	$0.00	$0.00	$0.00
A6533	$76.80	$0.00	$0.00	$0.00	$0.00	$0.00
A6535	$54.91	$0.00	$0.00	$0.00	$0.00	$0.00
A6536	$102.88	$0.00	$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
A6537	$120.14	$0.00	$0.00	$0.00	$0.00	$0.00
A6538	$50.06	$0.00	$0.00	$0.00	$0.00	$0.00
A6539	$116.02	$0.00	$0.00	$0.00	$0.00	$0.00
A6540	$109.64	$0.00	$0.00	$0.00	$0.00	$0.00
A6541	$207.81	$0.00	$0.00	$0.00	$0.00	$0.00
A6543	$122.56	$0.00	$0.00	$0.00	$0.00	$0.00
A6544	$20.95	$0.00	$0.00	$0.00	$0.00	$0.00
A6549	$73.92	$0.00	$0.00	$0.00	$0.00	$0.00
A9576	$2.39	$2.39	$0.00	$0.00	$0.00	$0.00
A9577	$2.68	$2.68	$0.00	$0.00	$0.00	$0.00
A9578	$2.61	$2.61	$0.00	$0.00	$0.00	$0.00
A9579	$2.34	$2.34	$0.00	$0.00	$0.00	$0.00
G0398	$264.98	$131.60	$133.38	$0.00	$131.60	$0.00
G0399	$211.98	$105.28	$106.70	$0.00	$105.28	$0.00
G0400	$158.99	$78.96	$80.03	$0.00	$78.96	$0.00
J1190	$234.88	$0.00	$0.00	$0.00	$0.00	$0.00
J1885	$0.29	$0.00	$0.00	$0.00	$0.00	$0.00
J7302	$703.05	$0.00	$0.00	$0.00	$0.00	$0.00
L3915	$440.38	$0.00	$0.00	$0.00	$0.00	$0.00
S2083	$76.50	$0.00	$0.00	$55.80	$0.00	$0.00
S9123	$40.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9124	$32.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9128	$75.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9129	$75.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9131	$135.00	$0.00	$0.00	$0.00	$0.00	$0.00
S9342	$48.44	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule

Home Health Agency Fee Schedule

The following Home Health Agency codes were updated on the Arkansas Blue Cross fee schedule on June 1, 2010.

Revenue Code	CPT/HCPCS Code	Description	Allowance	Comments
571 (Home Health Aide Visit)	99600	Unlisted home health service or procedure	Per Case Manager	This code and service only paid when pre-approved by case management. Detailed description of service will likely be requested.
552	S9123	Nursing care, in the home; by RN, per hour	$40.00 Per hour	This code and service only paid when pre-approved by case management. Detailed description of service will likely be requested.
572	S9122	Home health aide or certified nurse assistant, per hour.	$17.00 Per Hour	One unit equals one hour. This service will require case management approval. Four hours/units equals one Home Health Aide visit
552	S9124	Nursing care, in the home; by LPN, per hour	$32.00 Per hour	This code and service only paid when pre-approved by case management. Detailed description of service will likely be requested.
551	99500 - 99512, 99600	RN Visit See CPT code book for code descriptions Modifier TD Required	$139 Per visit	One unit equals one visit (Up to approximately 2 hours)
551	99500 - 99512, 99600	LPN Visit See CPT code book for code descriptions Modifier TE Required	$100 Per visit	One unit equals one visit (Up to approximately 2 hours)
561	S9127	Social Work visit, in the home, per diem	$70.00	One unit equals one day's services
441	S9128	Speech Therapy, in the home, per diem	$75.00	One unit equals one day's services
431	S9129	Occupational Therapy, in the home per diem	$75.00	One unit equals one day's services
421	S9131	Physical Therapy, in the home, per diem	$135.00	One unit equals one day's services

Fee Schedule

Injection Code Updates

The following injection codes were updated on the Arkansas Blue Cross and Blue Shield fee schedule on April 1, 2010.

Code	Allowance
90371	$120.01
90375	$145.33
90376	$158.47
90385	$26.15
90585	$113.84
90586	$118.94
90632	$47.13
90633	$24.89
90645	$24.27
90647	$24.27
90648	$24.34
90675	$188.52
90691	$57.87
90700	$16.80
90702	$33.56
90703	$23.68
90707	$48.95
90713	$29.26
90714	$21.49
90715	$35.16
90716	$84.93
90717	$67.43
90718	$16.51
90721	$48.20
90732	$44.98
90733	$107.55
J0129	$20.76

Code	Allowance
J0130	$481.34
J0132	$2.54
J0135	$389.46
J0150	$10.18
J0152	$86.03
J0170	$0.70
J0180	$141.69
J0205	$43.66
J0207	$341.08
J0210	$37.79
J0215	$31.86
J0220	$132.16
J0256	$3.92
J0270	$0.66
J0275	$25.32
J0278	$0.58
J0280	$0.42
J0282	$0.27
J0285	$13.17
J0287	$10.23
J0290	$2.31
J0295	$2.53
J0330	$0.19
J0348	$0.52
J0360	$5.02
J0364	$4.41
J0456	$6.31

Code	Allowance
J0461	$0.02
J0470	$28.78
J0475	$212.04
J0476	$76.44
J0480	$1,825.95
J0500	$20.90
J0515	$43.84
J0560	$26.90
J0570	$46.59
J0580	$48.15
J0583	$2.50
J0585	$5.71
J0586	$8.01
J0592	$0.79
J0595	$1.14
J0598	$44.46
J0600	$126.66
J0610	$0.33
J0630	$51.23
J0637	$12.05
J0640	$1.06
J0641	$0.81
J0670	$1.81
J0690	$0.66
J0692	$3.49
J0694	$6.41
J0697	$3.06

Injection Code Changes (continued from page 15)

Code	Allowance
J0698	$4.33
J0702	$6.81
J0713	$2.30
J0718	$3.93
J0720	$12.47
J0725	$8.47
J0735	$102.59
J0740	$791.55
J0743	$12.23
J0744	$1.30
J0745	$1.61
J0770	$20.66
J0780	$1.87
J0795	$4.67
J0833	$76.12
J0834	$94.58
J0881	$3.00
J0882	$3.00
J0885	$9.82
J0886	$9.82
J0894	$30.83
J0895	$11.11
J0970	$24.33
J1020	$1.63
J1030	$3.54
J1040	$6.91
J1051	$8.00
J1070	$3.85
J1080	$5.21
J1110	$25.23
J1120	$31.62
J1160	$1.21

Code	Allowance
J1162	$507.30
J1165	$0.81
J1170	$2.00
J1200	$0.83
J1205	$366.46
J1212	$72.78
J1230	$5.88
J1240	$3.54
J1245	$0.86
J1250	$6.11
J1265	$0.55
J1270	$3.13
J1300	$189.91
J1325	$14.30
J1327	$19.76
J1335	$28.68
J1364	$7.75
J1380	$9.82
J1390	$19.63
J1410	$92.23
J1438	$199.22
J1440	$231.97
J1441	$362.63
J1450	$6.27
J1451	$7.96
J1453	$1.68
J1455	$10.79
J1457	$2.11
J1458	$353.35
J1459	$36.51
J1460	$16.67
J1470	$33.35

Code	Allowance
J1480	$50.02
J1490	$66.70
J1500	$83.37
J1510	$100.08
J1520	$116.66
J1530	$133.40
J1540	$166.75
J1550	$166.75
J1560	$166.75
J1562	$7.48
J1566	$32.10
J1568	$39.20
J1570	$47.93
J1571	$52.65
J1572	$38.49
J1573	$52.65
J1580	$0.92
J1600	$13.03
J1610	$84.67
J1626	$0.56
J1630	$1.62
J1631	$2.93
J1640	$8.51
J1642	$0.17
J1644	$0.34
J1645	$11.78
J1650	$6.65
J1652	$6.38
J1655	$2.82
J1670	$142.29
J1720	$3.27
J1740	$147.04

Code	Allowance
J1742	$433.27
J1745	$61.09
J1750	$13.13
J1756	$0.38
J1790	$1.99
J1800	$3.49
J1815	$0.43
J1817	$2.14
J1930	$30.48
J1940	$0.23
J1945	$243.75
J1950	$536.73
J1953	$0.50
J1955	$6.25
J1956	$5.63
J1980	$11.19
J2010	$5.36
J2020	$33.88
J2060	$0.72
J2150	$0.96
J2175	$1.87
J2185	$4.10
J2248	$1.14
J2250	$0.11
J2260	$3.58
J2270	$2.22
J2275	$2.54
J2278	$6.67
J2280	$3.02
J2300	$0.97
J2310	$6.30
J2315	$2.53
J2323	$8.65

Code	Allowance
J2325	$39.91
J2353	$113.37
J2354	$1.10
J2355	$254.89
J2357	$20.57
J2360	$7.47
J2370	$0.79
J2400	$12.74
J2405	$0.14
J2410	$2.30
J2425	$11.80
J2430	$16.89
J2440	$0.79
J2469	$18.33
J2501	$3.68
J2503	$1,071.55
J2505	$2,529.80
J2510	$11.32
J2515	$12.88
J2540	$1.09
J2543	$6.14
J2545	$49.46
J2560	$3.40
J2562	$279.32
J2590	$0.61
J2597	$1.97
J2675	$1.53
J2680	$6.57
J2690	$5.90
J2700	$2.16
J2710	$0.10
J2720	$0.50
J2760	$56.98

Code	Allowance
J2765	$0.36
J2770	$152.95
J2778	$420.88
J2780	$1.19
J2783	$179.42
J2785	$52.76
J2788	$26.15
J2790	$80.57
J2791	$5.41
J2792	$19.29
J2794	$5.26
J2796	$45.95
J2805	$70.33
J2810	$0.02
J2820	$26.25
J2916	$4.75
J2920	$2.37
J2930	$3.18
J2993	$1,618.22
J2997	$38.85
J3000	$8.38
J3010	$0.34
J3030	$48.55
J3070	$10.03
J3101	$48.61
J3105	$2.02
J3120	$3.06
J3130	$6.12
J3230	$8.93
J3240	$1,095.55
J3246	$7.68
J3250	$4.83
J3260	$2.36

Injection Code Changes (continued from page 17)

Code	Allowance
J3300	$3.34
J3301	$1.62
J3303	$1.46
J3315	$170.66
J3355	$62.41
J3360	$1.08
J3370	$3.33
J3396	$9.88
J3410	$1.12
J3411	$2.65
J3415	$5.47
J3465	$6.05
J3470	$14.76
J3471	$0.17
J3472	$143.31
J3486	$6.50
J3487	$229.97
J3488	$231.84
J7030	$0.49
J7070	$2.36
J7100	$20.72
J7120	$1.08
J7185	$1.12
J7187	$0.90
J7189	$1.41
J7192	$1.13
J7193	$0.94
J7194	$0.91
J7197	$2.40
J7308	$139.92
J7321	$95.64
J7323	$118.34

Code	Allowance
J7324	$183.77
J7325	$12.26
J7500	$0.20
J7501	$100.14
J7502	$3.44
J7504	$507.40
J7505	$1,178.84
J7507	$3.42
J7509	$0.09
J7511	$401.95
J7513	$365.15
J7515	$0.87
J7516	$28.34
J7517	$1.96
J7518	$3.10
J7525	$144.99
J7605	$5.44
J7606	$4.91
J7608	$2.05
J7612	$0.15
J7613	$0.06
J7614	$0.27
J7620	$0.22
J7626	$6.68
J7631	$0.47
J7639	$24.84
J7644	$0.25
J7682	$72.03
J8501	$5.89
J8510	$3.80
J8515	$1.56
J8520	$6.53

Code	Allowance
J8521	$21.49
J8530	$0.88
J8540	$0.40
J8560	$29.39
J8600	$5.03
J8610	$0.17
J8700	$9.18
J8705	$77.65
J9000	$3.16
J9001	$490.89
J9010	$601.13
J9015	$878.21
J9017	$38.93
J9020	$63.38
J9025	$5.20
J9027	$121.14
J9031	$118.94
J9033	$19.21
J9035	$59.87
J9040	$27.12
J9041	$39.77
J9045	$5.52
J9050	$183.46
J9060	$2.06
J9062	$10.31
J9065	$29.35
J9070	$4.52
J9080	$9.04
J9090	$22.60
J9091	$45.20
J9092	$90.39
J9098	$508.46

Code	Allowance
J9100	$1.57
J9110	$3.83
J9120	$593.36
J9130	$3.88
J9140	$7.67
J9150	$20.23
J9151	$58.57
J9155	$2.70
J9160	$1,554.62
J9171	$18.57
J9178	$2.58
J9181	$0.51
J9185	$214.04
J9190	$1.53
J9200	$44.71
J9201	$150.90
J9202	$203.04
J9206	$9.52
J9208	$31.99
J9209	$4.43
J9211	$66.11
J9216	$448.17
J9217	$229.22
J9218	$4.44
J9225	$1,575.86
J9230	$160.68
J9245	$1,560.33
J9250	$0.22
J9260	$2.18
J9261	$110.15
J9263	$7.10
J9264	$9.81
J9265	$11.92

Code	Allowance
J9268	$1,296.23
J9280	$21.17
J9290	$84.69
J9291	$169.38
J9293	$47.08
J9300	$2,794.71
J9303	$90.72
J9305	$52.65
J9310	$601.54
J9320	$294.18
J9328	$5.10
J9330	$51.82
J9340	$118.07
J9355	$69.07
J9360	$1.06
J9370	$4.48
J9375	$8.96
J9380	$22.40
J9390	$10.45
J9395	$85.51
J9600	$3,051.65
P9041	$21.34
P9043	$8.57
P9046	$21.93
Q0138	$0.85
Q0139	$0.85
Q0163	$0.03
Q0165	$0.02
Q0166	$7.13
Q0167	$7.46
Q0168	$14.73
Q0169	$0.46
Q0173	$0.73

Code	Allowance
Q0175	$0.53
Q0176	$0.49
Q0177	$0.05
Q0178	$0.06
Q0179	$6.64
Q0180	$65.71
Q2009	$0.46
Q2017	$337.53
Q3025	$201.69
Q4081	$0.98
Q4102	$4.81
Q4103	$4.81
Q4104	$15.44
Q4105	$10.39
Q4106	$41.70
Q4107	$95.72
Q4108	$18.71
Q4109	$80.95
Q4110	$35.73
Q4111	$7.70
Q4112	$356.03
Q4113	$356.03
Q4114	$951.00
Q9953	$64.53
Q9954	$10.86
Q9956	$43.15
Q9957	$64.72
Q9960	$0.14
Q9965	$1.28
Q9966	$0.33
Q9967	$0.18

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providers' news staff

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Please Note

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