providers' news

A publication for participating providers and their office staffs

inside

Reporting fraud, waste and abuse

If you suspect any potentially fraudulent activity by a provider, beneficiary or another entity, never confront the person suspected; instead call the FRAUD HOTLINE at 1-800-FRAUD-21 (1-800-372-8321). The Fraud Hotline is available 24 hours a day, 7 days a week. All reports are kept strictly confidential, and callers can remain anonymous.

This applies to Arkansas Blue Cross and Blue Shield and its subsidiaries and affiliate companies, including Medi-Pak® Advantage.

ICD-10 countdown

12 months

until the October 1, 2014, ICD-10 compliance deadline.
Will you be ready?

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

Flu vaccine billing for 2013-2014

For the 2013-2014 flu season, the trivalent vaccine will be replaced by the quadrivalent vaccine commercially available for persons three years of age and older. The appropriate codes to bill for this flu season are:

Flu Shot Administration Billing:

- **Adults (Over 18):** HCPCS code G0008 for the administration with diagnosis code V04.81
- **Children (18 and under):** Use the appropriate CPT code (90460—90474) for administration with diagnosis code V20.2

Flu Shot Vaccine Billing:

- **90655**: Influenza virus vaccine, trivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
- **90656**: Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
- **90657**: Influenza virus vaccine, trivalent, split virus, when administered to children 6-35 months of age, for intramuscular use
- **90658**: Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
- **90660**: Influenza virus vaccine, trivalent, live, for intranasal use
- **90672**: Influenza virus vaccine, quadrivalent, live, for intranasal use
- **90686**: Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use

Vaccine administration code billing

When it is necessary to bill multiple occurrences of CPT codes 90460-90474 on the same date of service for the same member, please bill the second and subsequent occurrences with Modifier 59. Using Modifier 59 should allow claims to pay appropriately without triggering a duplicate denial. For FEP, providers must bill all occurrences of one code on one line with multiple units to keep a duplicate denial from triggering. This billing method will also allow claims to pay appropriately without triggering a duplicate denial for all lines of business.

Allergen immunotherapy - provision of antigens

Arkansas Blue Cross and Blue Shield uses the Centers for Medicare & Medicaid Services (CMS) Relative Value Units (RVU) to calculate physician fee schedule amounts. The physician fee schedule allowance for CPT code 95165 is $16.06. CMS regulations indicate that:

> "…a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multi-dose vial would significantly overpay the practice expense component attributable to this service."

Arkansas Blue Cross is adopting this CMS rule. Providers should limit billing of CPT code 95165 to 10 units per multi-dose vial, even if providers actually obtain 30 units from the vial.

CPT code 95165 will be subject to medical review. In the event CPT code 95165 is used, medical records will be ordered. Providers' office records should document the number of doses per vial and the number of vials prepared for each member.

Billing for services to family members prohibited

Arkansas Blue Cross and Blue Shield wishes to remind all providers of a long-standing policy of billing for services to family members. Arkansas Blue Cross, Health Advantage and USAble Corporation have published claims filing policies and procedures which prohibit a participating provider from billing for ***services**** provided to any immediate family member. The immediate family, for this purpose, includes a spouse, parent, child, brother, sister, grandparent or grandchild, whether the relationship is by blood or exists in law (e.g. legal guardianship).

In addition, all underwritten health plans or policies issued by Arkansas Blue Cross and Health Advantage expressly exclude coverage of services to immediate relatives. Any claim intentionally or mistakenly filed and that is subsequently paid for such services, requires the offending provider to immediately refund all such payments upon request.

Violation of these policies and procedures, and/or failure to make prompt refunds for erroneous payments, will subject the offending provider to termination from the networks sponsored by Arkansas Blue Cross, Health Advantage and USAble Corporation. Moreover, filing claims for services to immediate relatives, and receiving payment on such claims, is an abusive claims filing practice that may also constitute fraud, leading to permanent exclusion from the networks.

**Services to immediate family members include not only those personally performed by the provider, but also any services, equipment, drugs or supplies ordered by the provider and performed by another, including any pharmacy charges resulting from prescriptions written by the provider.*

Previous article regarding billing for services rendered to family members are located in the June 2002, September 2003 and March 2011 issues of *Providers' News.*

Payment for physical therapist, occupational therapist and speech pathologist claims

Effective with dates of services on or after September 1, 2013, Arkansas Blue Cross and Blue Shield and Health Advantage will be implementing changes as a result of Arkansas Act 342 (requiring insurance companies to pay comparable reimbursement to physical therapists, occupational therapists and speech-language pathologists). Arkansas Blue Cross and Health Advantage will process claims for eligible services applicable to a group's benefit plan rendered by licensed physical therapists, occupational therapists and speech pathologists with the same member cost obligation (deductible, coinsurance, copayment) as claims for services provided by a primary care physician. These therapists will not be considered primary care providers. Act 342 does not apply to health insurance issued in the individual market.

Medical record fax number updates

Providers should notify Arkansas Blue Cross and Blue Shield if there are changes to their medical records request (MRR) fax number. Providers can submit their updated MRR fax number by either completing the "Change of Data" form located on the Arkansas Blue Cross website or by emailing the corrected fax number to Providernetwork@arkbluecross.com.

High-tech radiology billing requirements

On September 1, 2006, Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble Corporation (Arkansas' FirstSource® PPO and True Blue PPO) changed the billing requirements for high-tech radiology, defined as CT scans, magnetic resonance, PET scans or nuclear cardiology. This change does not affect hospitals billing for these services.

Imaging centers should use their NPI as the rendering provider when billing services for high-tech radiology on the standard electronic claims transactions. In most cases, these imaging center NPI's are the clinic's NPI.

Imaging centers will likewise use their NPI in the appropriate block of the CMS 1500 claim form as the rendering provider for high-tech radiology (Block 24J). Imaging centers will also use their NPI as the clinic billing number on electronic claims and CMS 1500 claim form (Block 33B).

Imaging centers may bill "Total Component" on one line for the high-tech radiology services provided that the imaging center-based physician performing the supervision and interpretation meets the requirements described within the imaging center provider agreement.

All applicable modifiers should be used (e.g. Modifier 26 for Professional Component, TC for Technical Component). Professional component reimbursement for high-tech radiology will only be made to physicians; therefore, payment will be made for the Professional Component only when submitted under a physician's provider number. Physicians billing with Modifier TC will receive a denial. Professional services billed with the imaging centers NPI and /or Modifier 26 will be denied. Imaging center claims should be submitted with place of service "11".

This listing of specific claims filing requirements for imaging centers is not exclusive or comprehensive of all Arkansas Blue Cross claims filing or coding policies and procedures. These specific requirements are in addition to and not a substitute for other Arkansas Blue Cross claims filing and coding policies.

Anesthesia conversion factor

Effective for dates of service on October 1, 2013 or after, Arkansas Blue Cross and Blue Shield will increase the anesthesia conversion factor used in the Arkansas Blue Cross fee schedule to $51.00. All applicable discounts applied to the Arkansas Blue Cross fee schedule described in a provider's network agreement (e.g. True Blue PPO, Health Advantage HMO, etc..) will apply. The increase will not apply to previous dates of service.

New alpha prefixes for non-group members

All Arkansas Blue Cross and Blue Shield, Health Advantage and BlueAdvantage Administrators of Arkansas non-group members with an October 1, 2013 effective date have been mailed new member ID Cards with a change to the alpha prefix in the member identification number.

The new prefixes were created to separate group versus non-group coverage and is an internal business need for reporting purposes only. This will not change the patient's deductible, co-pays, and/or benefits in any way.

Three new prefixes have been defined and created for the following:

1) XCP: PPO Group
   XCK: PPO Non-Group

2) XCA: Non PPO Group
   XCL: Non PPO Non-Group

3) XCJ: PPO Group (in Arkansas)
   XCN: PPO Non-Group (in Arkansas)

Payment reduction for multiple therapy services performed on the same day

The Centers for Medicare & Medicaid Services (CMS) completed an in-depth analysis of the practice expense of providing physical therapy, occupational therapy, and speech therapy services. Their analysis found that the practice expense of providing two or more modalities on the same day is less than the practice expense cost as reflected by the practice expense RVUs. Arkansas Blue Cross and Blue Shield uses Medicare/CMS RVUs in calculating payment for physical therapy, occupational therapy, and speech therapy services.

On October 13, 2013, Arkansas Blue Cross, BlueAdvantage Administrators of Arkansas, and Health Advantage will begin following the Medicare policy of reducing payment for the second and subsequent therapy services when multiple therapy procedures are performed on the same day. Medicare decreased multiple therapy services provided in a facility setting by 25% of the practice expense payment and those in a non-facility setting by 20% of the practice expense payment through March 31, 2013. On April 1, 2013, Medicare reduced the payment by 50% of the practice expense payment for the second and subsequent modalities.

Arkansas Blue Cross, BlueAdvantage, and Health Advantage will reduce the second and subsequent therapy procedures by 20% of the practice expense portion of the procedure, whether provided in a facility setting or a non-facility setting. When these services are provided on multiple days, each line item on the claim for the modality must be for one day only. Date spans for these procedures will not be accepted.

The therapy services included in this reduction are as follows:

CPT Code	Description
92506	Speech/hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device evaluation
92607	Ex for speech device RX, 1 hour
92609	Use of speech device service
96125	Cognitive test by HC pro
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97003	Occupational therapy, evaluation
97004	Occupational therapy, re-evaluation
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy e.g., microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy

CPT Code	Description
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97533	Sensory integration
97535	Self care management training
97537	Community/work reintegration
97542	Wheelchair management training
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic management and training
97761	Prosthetic training
97762	C/O for orthotic/prosth use
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagnetic TX for ulcers

Updated radiology authorization program for Tyson members

This correspondence serves as notice of change to the utilization review programs under the True Blue PPO provider agreements for the Tyson members.

Effective January 1, 2014, physicians who order high-tech outpatient radiology services, including CT, MRI/MRA (Magnetic Resonance Angiography), Echo Cardiography, Nuclear Cardiology or PET, on an outpatient basis for any Tyson member or dependent must obtain prior authorization (approval) before services can be considered for reimbursement under the member's health plan. Prior authorization requirements apply to all Tyson members that receive services from an Arkansas provider.

Prior approval is not required for emergency, observation department of a hospital, or inpatient services. Prior authorization does not guarantee payment and is not a guarantee of coverage. Radiology services must be covered under the patient's coverage policy and are subject to the member's eligibility and benefit plan provisions.

AIM Specialty Health uses the following criteria to approve or deny a prior authorization request from a physician:

1. American College of Radiology "Appropriateness Guidelines";
2. Specialty society guidelines and diagnostic algorithms;
3. Literature reviews specific to a given test for a given condition or symptom; and
4. BlueAdvantage National Account coverage policies

The AIM Guidelines for *Clinical Use of Diagnostic Imaging Examinations* were developed from practice experiences, literature reviews, specialty criteria sets and empirical data. AIM guidelines are located on their website at: www.aimspecialtyhealth.com. The guidelines are available in a PDF format that may be printed for future reference.

For additional information, please refer to the updated "Radiology Management Reference Guide".

The following outpatient services require prior authorization*:

- CT Scan
- Nuclear Cardiology
- MRI/MRA
- PET Scan
- Echo Cardiography

**A separate authorization number is required for each procedure ordered.*

How to receive prior authorization:

Providers may obtain prior authorization by calling AIM Specialty Health at 1-866-688-7443 or via the website at www.aimspecialtyhealth.com. Call center hours of operation are Monday through Friday, 8 a.m. to 5 p.m. CST

Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact AIM within two business days of the date of service and before the claim is submitted to obtain proper authorization for the studies, which will still be subject to review.

The prior authorization implementation recommendations for ordering physicians and participating facilities:

As a participating provider of diagnostic imaging services that require prior authorization, it is essential that providers develop a process to ensure the appropriate authorization number(s) is obtained. The following recommendations are offered for review and consideration in developing a procedure that will be effective for each facility. These recommendations are for informational purposes only.

Ordering physician:

It is the responsibility of the physician ordering the imaging examination to call AIM for prior authorization. A separate authorization number is required for each procedure ordered.

Patient symptoms, past clinical history and prior treatment information including physicians with RadExpress privileges will be requested and should be available at the time of the call.

To expedite the authorization process, please have the following information ready before calling the AIM Utilization Management staff:

- Name and office telephone number of ordering physician*;
- Member name and ID number*;
- Requested examination*;
- Name of provider office or facility where the service will be performed*;

(Continued on page 7)

Updated radiology authorization program for Tyson members (continued from page 6)

- Anticipated date of service (if known); and
- Details justifying examination:*
  - -- Symptoms and their duration;
  - -- Physical exam findings;
  - -- Conservative treatment patient already has completed (for example: physical therapy, chiropractic or osteopathic manipulation, hot pads, massage, ice packs, medications);
  - -- Preliminary procedures already completed (for example: X-rays, CTs, lab work, ultrasound, scoped procedures, referrals to specialist, specialist evaluation); and
  - -- Reason the study is being requested (for example: further evaluation, rule out a disorder)

**Required information*

Please be prepared to fax the following information when requested:

- Clinical notes
- X-ray reports
- Previous CT/MRI reports
- Specialist reports/evaluation ultrasound reports

Participating imaging facilities:

It is the responsibility of the ordering physician to ensure that prior authorization is obtained. The rendering facility should not schedule procedures without prior authorization.

For urgent tests, the rendering facility can begin the process, and AIM will follow up with the ordering physician to complete the process. Procedures performed that have not been properly authorized will not be reimbursed, and the member cannot be balance billed. A separate authorization number is required for each procedure ordered.

Emergency room, observation department of a hospital and inpatient imaging procedures do not require prior authorization. If an emergency clinical situation exists outside of a hospital emergency room, providers should proceed with the examination and call AIM the next business day at 1-866-688-1449 to proceed with the normal review process.

To ensure that authorization numbers have been obtained, the following recommendations should be considered:

- Communicate to all personnel involved in outpatient scheduling that prior authorization is required for the listed procedures.
- If a physician office calls to schedule a patient for a procedure requiring prior authorization, request the authorization number.
- If the provider has not obtained prior authorization, inform the provider of the requirement and advise them to call AIM at the toll-free number, 1-866-688-1449.
- Facilities may elect to institute a time period in which to obtain the authorization number (for example, one business day).
- If a patient calls to schedule a procedure that requires prior authorization and the patient does not have the authorization number, the patient should be directed back to the referring physician who ordered the examination.

PPACA: Correction to preventive services chart under the health care law regarding HPV

On page 41 of the March 2013 issue of *Providers' News,* an error was made in the preventive services chart regarding CPT code 90649 - Human Papilloma Virus (HPV). The chart incorrectly listed the age for male adolescents. The male adolescents and adults ages 9-21 is INCORRECT and should be 11-21.

Correct age range:

90649 – Human papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use. Note: coverage for 90649 is limited to female adolescents & adults ages 11 – 26. Male adolescents & adults ages **11-21**. (Males effective July 2010.) (Approp ICD-9 code is V04.89)

ASE/PSE

Inpatient pre-certification required October 1, 2013

Effective October 1, 2013, the ARBenefits health plan, sponsored by the State and Public School Life and Health Insurance Board and administered by the Employee Benefits Division, will require pre-certification for all inpatient hospital admissions for Arkansas State Employees and Public School Employees groups. Determinations for these admissions will be made for medical necessity, appropriate length of stay and level of care based on nationally accepted industry standards, and ARBenefits Coverage Policy. **Failure to obtain appropriate pre-certification will result in the facility writing off the charges for covered services and holding the member harmless.**

Medi-Pak® Advantage

In-home personal health check-ups for members

Beginning this fall, selected Medi-Pak® Advantage (PFFS & PPO) members will be given the opportunity to participate in a FREE in-home personal health checkup. The goals of the checkups are to help members detect unknown health issues and to coordinate needed preventive and chronic care with their physicians.

Arkansas Blue Cross and Blue Shield has contracted with ExamOne, a Quest Diagnostics company, to provide this service. The check-ups will begin with in-home lab draws followed by consultations performed by local, specially trained licensed nurse practitioners.

The personal health checkups will include a biometric screening, member home safety check and medication reconciliation. Each member who participates in the health checkup will receive a personal lab report. The nurse practitioner will also send the member's primary care physician a summary report of the findings from the in-home visit (fall risks, medication reconciliation, etc.). In addition, the ExamOne nurse practitioners will help facilitate scheduling follow-up visits with physicians should the need for urgent or emergent care be identified.

Over the next couple of weeks, Arkansas Blue Cross will provide more details of the program and a listing of the members who are eligible to participate.

Health Insurance Marketplace

What is the Health Insurance Marketplace?

This fall, millions of Americans under age 65 will purchase a health plan through the Health Insurance Marketplace (exchange).

The Health Insurance Marketplace is a website designed to determine if a person is eligible for financial help to cover their health insurance costs. Some Americans will be eligible for a $0 premium plan or a new kind of tax credit that lowers their monthly premiums. It also helps people shop for and purchase health insurance. People also may contact the Health Insurance Marketplace by telephone.

A Health Insurance Marketplace is being set up in each state, either by the state itself, by the federal government, or in Arkansas' case, in partnership with the federal government. Each marketplace will be responsible for:

- Creating and maintaining a consumer shopping website.
- Providing access to all information necessary to determine if those applying are eligible for help paying for their premium or if they qualify for free coverage.
- Helping consumers shop for and purchase health plans.
- Making sure all health plans offered on the marketplace meet all the new regulations.

The Health Insurance Marketplace will be open October 1, 2013 through December 15, 2013 for people to purchase coverage with an effective date of January 1, 2014. The final date to purchase health care coverage without risking a penalty is March 31, 2014 for effective dates up to June 1, 2014.

Many people will be eligible to receive advance premium tax credits (subsidies) if they purchase a health plan through the marketplace. An advance premium tax credit is a new tax credit that can lower monthly premium costs beginning January 1, 2014.

The amount of the advance premium tax credit that each household will receive is calculated by using their income, the size of their family and other factors. This new tax credit helps lower- and middle-income families. Some households, based on their income, will receive additional financial assistance when they receive medical care, known as cost-sharing reductions.

Qualifying for a tax credit

Federal Poverty Level – *2013*

PEOPLE in family	100%	133%	200%	300%	400%
1	$11,490	$15,282	$22,980	$34,470	$45,960
2	$15,510	$20,628	$31,020	$46,530	$62,040
3	$19,530	$25,975	$39,060	$58,590	$78,120
4	$23,550	$31,322	$47,100	$70,650	$94,200
5	$27,570	$36,668	$55,140	$82,710	$110,280
6	$31,590	$42,015	$63,180	$94,770	$126,360
7	$35,610	$47,361	$71,220	$106,830	$142,440
8	$39,630	$52,708	$79,260	$118,890	$158,520

NOTE: Federal minimum wage employee working 50 weeks per year, 40 hours per week would earn $14,500.

Health Insurance Marketplace

How does the Arkansas Medicaid Expansion affect health care providers?

On April 23, 2013, Arkansas Governor Mike Beebe signed historic legislation approving the Medicaid expansion program in Arkansas. This unique legislation will give about 250,000 Arkansans access to private health care coverage and allow them to shop for their coverage.

People who choose the Arkansas Blue Cross and Blue Shield health plans approved for Medicaid will have access to any of the doctors or hospitals within the True Blue PPO network, and will either pay nothing or very little when they receive medical care. They will receive member ID cards similar to those issued to Arkansas Blue Cross members.

The majority of providers will continue to receive the same rate of reimbursement for their new patients with individual metallic health plans. Some providers will see reimbursement changes for all metallic plans, not just the Medicaid plans. As these patients previously did not receive any health care coverage and were less likely to pay for services out of pocket, providers seeing these patients likely will see an increase in reimbursement overall.

NOTE: Because of the anticipated enrollment of many new members effective on the same date, Arkansas Blue Cross strongly encourages physician and other health care professional offices including facilities to use AHIN for verifying eligibility, benefits, and claims status.

Providing care under the health care law

Arkansas health care providers have long struggled under the burden of providing uncompensated care. The new health care law (the Affordable Care Act), and the new Arkansas law which dramatically expands Medicaid coverage eligibility to hundreds of thousands of low-income Arkansans, will have a very positive financial impact on health care practitioners, which is certainly good news.

Under the new Arkansas law, Arkansans with household incomes below 138 percent of the federal poverty level will shop for and purchase commercial health insurance policies offered by private carriers like Arkansas Blue Cross and Blue Shield on Arkansas' new Health Insurance Marketplace. This new marketplace also will provide financial assistance to those whose household incomes fall below 400 percent of the federal poverty level. Taken together, these new laws mean that many low- and middle-income Arkansans will find private health insurance coverage either at no cost to the them or otherwise within reach.

These new privately insured Arkansans will buy "qualified health plans" from private carriers on and off the marketplace. Arkansas Blue Cross will offer qualified health plans on and off the marketplace, accessing our True Blue network. To best serve these new private customers and to meet the evolving requirements of the Medicaid "private option" program, we will reduce the fee schedule allowances used by some providers in the True Blue network for those metallic plans sold on the health insurance marketplace. This new fee schedule will apply only to individual metallic health plans sold on and off the health insurance marketplace and will not include any of the other product lines that currently access the True Blue network. Reimbursement for our existing products will not change.

Arkansas Blue Cross looks forward to working with you as you meet the health care needs of this new group of patients.

Should you have any questions about the new health insurance marketplaces, please contact your regional Network Development Representative.

Health Insurance Marketplace

Essential health benefits at the core of new health plans on the Health Insurance Marketplace

Standardizing Health Plans

Consumers have long complained that choosing a health insurance plan is complicated. They have difficulty comparing what medical services are covered by each health plan under consideration. In addition, it is difficult for consumers to compare which plan offers the best financial value.

It is easy to compare monthly premiums from one plan to the next, but more difficult to figure out what total out-of-pocket costs might be when considering deductibles, copayments and coinsurance maximums.

In an effort to make this process easier for employers and consumers, the new health care law specifies the medical services that must be covered by health plans.

Standardizing Covered Medical Services

Non-grandfathered health plans must cover a core set of benefits called "Essential Health Benefits." This core set of benefits includes services in the following ten categories:

1. Outpatient care
2. Emergency services
3. Hospitalization
4. Mental health and substance abuse treatments
5. Prescription drugs
6. Rehabilitative and "habilitative" services and devices
7. Laboratory services
8. Preventive and wellness services
9. Pediatric dental* and vision care
10. Maternity and newborn care

Most of these services already are covered by most health plans, although some, such as mental health services and preventive care, may have been optional for employers. When the new law is effective, these services will be offered in every plan with no annual or lifetime dollar limits.

Preventive care and many women's preventive services will be offered with no member cost sharing as required by law. In other words, services like colonoscopy and contraceptives will be provided at no charge.

Effective January 1, 2014

These new health care rules become effective January 1, 2014, for all new fully insured individual and small group health plans sold, and for non-grandfathered plans at the first renewal date on or after January 1, 2014.

However, grand-fathered and self-insured health plans will be exempt. Large group plans (groups with more than 50 employees) are required to meet the cost-sharing limits and the benefit levels, but are not required to provide the full scope of benefits in the essential benefits package.

While the Affordable Care Act requires coverage for each of these categories, the law does not define the specific services that must be covered or the amount, duration, or scope of services. The Health & Human Services secretary will define the specific benefits within each of these categories and will be able to update the definition over time to address gaps or respond to changing medical practices in the future.

In defining the essential benefits package, the Health & Human Services secretary must decide not only which health services to include, but also how much discretion to leave to insurers in coverage decisions. For example, if the secretary determines that physical therapy to treat lower back pain is a covered benefit, she could determine the minimum number of physical therapy sessions that must be covered to treat the condition, or she could leave that to the discretion of the insurers.

**Pediatric Dental is not included in our Metallic Plan since there are stand-alone pediatric dental plan available.*

Health Insurance Marketplace

Affordable Care Act redefines out-of-pocket cost for health plan members

Health plan members – whether belonging to a PPO, HMO or traditional comprehensive major medical plan – are familiar with cost sharing requirements in the form of copayments, coinsurance and deductibles. Once a policyholder meets his/her deductible, a coinsurance amount is paid until an annual out-of-pocket maximum is reached.

Although no more financial obligation is required by the policyholder for major services, traditionally, cost sharing in the way of copayments still was expected for services rendered at a clinic or other health care facility, and pharmacy copayments for medications were required each time a prescription was filled.

Beginning in 2014, all new non-grandfathered individual and group health plans will be required to have a single out-of-pocket maximum that applies to all in-network, covered medical services, including prescription drugs. This amount excludes premium cost. This is being called the True Out-Of-Pocket (TrOOP) maximum.

The intent of this rule is that once the out-of-pocket maximum has been met, the member is not responsible for additional out-of-pocket cost sharing for in-network covered medical services for the remainder of the plan year.

The U.S. Department of Health and Human Services recognized the complexity in which group health plans using multiple service providers (such as a third-party administrator for major medical benefits and a separate pharmacy benefit manager (PBM) for prescription drugs) will experience coordinating the necessary exchange of out-of-pocket information and provided transitional relief (also known as the "enforcement safe harbor") for 2014.

Under the transitional rule, self-funded, non-grandfathered health plans that use multiple service providers can qualify for relief from having to combine all out-of-pocket cost shares from separate service providers into one accumulator until the plan's 2015 plan year start date.

Deductible maximums

The Affordable Care Act establishes that the maximum deductible for a group in a non-grandfathered benefit plan be no greater than $2,000 for an individual and $4,000 for a family. This requirement goes into effect with a group's first effective date on or after January 1, 2014.

Additional guidance related to group deductible maximums is anticipated as it remains unclear whether this flexibility is available only as necessary to achieve bronze-level plans (60%) or if it may also be used to meet other metal tiers. Additionally, while the law allows for the use of Health Reimbursement Arrangements (HRA) and Health Savings Accounts (HSA) to be used, it remains unclear as to whether deductible maximums may be exceeded when balanced by these funding arrangements.

Out-of-pocket maximums

The Affordable Care Act establishes a maximum annual out-of-pocket amount of $6,300 for an individual and $12,600 for a family, which may be paid for in-network essential benefits covered under a plan with anticipated increases for inflation. Once a maximum is reached in a given plan year, any additional costs incurred for in-network essential benefits covered by the plan will be covered at 100% for the balance of the plan year. Remember that AHIN does maintain the current status of member's out of pocket expenses.

Health Insurance Marketplace

Health care providers can take advantage of Arkansas Blue Cross and Blue Shield program to help Arkansans find free or low-cost health insurance

Arkansas Blue Cross and Blue Shield has launched a statewide educational outreach with trusted institutions in an effort to educate thousands of uninsured, low-income Arkansans about the importance of health insurance and how to get help paying for it.

In May 2013, the state legislature expanded the Medicaid program, enabling an estimated 250,000 more residents to qualify for Medicaid. Thousands more will qualify for a federal tax credit that offsets the cost of purchasing health insurance through the Health Insurance Marketplace. The program will inform them about both forms of assistance.

Arkansas Blue Cross' educational outreach is being supported by two very important groups already serving these constituents in Arkansas:

1. Nonprofit organizations and
2. Health care providers

Nonprofit organizations

Through 70 nonprofit organizations around the state, Arkansas Blue Cross is providing "Be Covered Arkansas" material and a website to help uninsured, low-income Arkansans understand why insurance is important, what's covered and how it all works, and how to find free or low-cost health insurance.

Community and civic organizations will be distributing "Be Covered Arkansas" educational material to people who may be looking for health insurance. Each nonprofit organization already focuses on educating their community and helping the people they serve understand how to obtain other free or low-cost services.

A call center is available now through December 2013 to field additional health insurance questions and help individuals determine if they're eligible for free or low-cost coverage. The Call Center toll-free number is 1-866-283-4817. Information also is available at www.BeCoveredArkansas.org.

Health care providers

To support the requests of many physicians, clinics, hospitals and other health care providers to make information available to their patients who have health care needs as well as the need for assistance to pay for their care, Arkansas Blue Cross is providing a branded version of the "Be Covered Arkansas" brochure.

The messaging is the same inside this version of the brochure:

- The new health care law will allow many people to qualify for low- or no-cost health insurance.
- People can get health insurance even if they have health problems.
- With this new program, people can get free checkups and cancer screenings.
- This health insurance will cover things like doctor visits, medical tests and prescription drugs.

The idea is to keep the messaging simple and help the reader know the next steps to getting more information and coverage.

This brochure has a different telephone number available for Medicaid-eligible and low-income Arkansans to call – 1-855-625-0451 – but the same assistance is available from a knowledgeable, friendly staff. Those who are interested also can go online to www.ArkansasBlueCross.com and select "Free or low-cost health insurance" to find out more information.

Get your materials today

Arkansans without insurance face barriers in accessing quality health care and necessary medications. Having insurance will help overcome many of those barriers.

Arkansas Blue Cross recognizes that as health care providers, having more patients insured will help your practice as well.

To get copies of the health care provider version of the brochure, posters and brochure holders for your clinic or facility, please contact your Arkansas Blue Cross Network Development Representative.

Health Insurance Marketplace

Frequently asked questions about the health care law

What is the health insurance marketplace?

The new health care law, the Affordable Care Act, created these health insurance marketplaces (exchange) as a means for consumers to buy "qualified health plans" from private carriers. People who have not had access to health insurance in the past will now have access to several options. The health insurance marketplace (exchange) is a state run, web-based service where Arkansas Blue Cross will offer qualified health plans that will access our True Blue PPO network. This new health insurance marketplace will also provide financial assistance to eligible insurance purchasers whose household incomes fall below 400 percent of the federal poverty level.

What is a qualified health plan?

A qualified health plan is an insurance plan that is certified by the federal government, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. They may be sold on and off the marketplace.

What are essential health benefits?

Qualified health plans are required to cover 10 essential health benefits at 100 percent; meaning the member pays nothing out of pocket for the medical service. These health benefits include:

- Ambulatory patient services, such as doctor's visits and outpatient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral* and vision care

What does "on" and "off" the marketplace or exchange mean?

All health plans sold on the health insurance marketplace must be qualified health plans. People who purchase health plans on the marketplace may receive tax credits and in some cases additional financial assistants paying their medical costs. Insurance companies also may sell the qualified health plans off the marketplace to people who do not qualify for a tax credit. They also may sell HIPAA-Excepted Benefit (HEB) products, which include short-term policies, new self-insurance products and defined contribution products.

What are Metallic Plans?

Qualified health plans must fall within two percent of four value levels, which have been given metallic names to represent their financial worth. Each level indicates a set percentage of medical costs a health plan would pay for the average person. For example, a bronze plan will cover 60 percent of the health care costs an average person might use in a year, while a platinum plan will cover 90 percent. The more the health plan pays, the higher the premium will be and the less out-of-pocket cost there will be when a policyholder receives medical care. (See the metallic coverage levels chart on the following page.)

What are Multi-State Plans?

Multi-state plans (MSP) offer coverage from the same insurer to families or small employer groups that may reside or operate in more than one state. The law recommends at least two MSPs in each marketplace, one of which must be offered by a non-profit organization. The Office of Personnel Management (OPM) directs the MSP program. These MSPs will be among the health insurance options from which individuals and small employer groups will be able to choose during the open enrollment beginning this October.

(Continued on page 15)

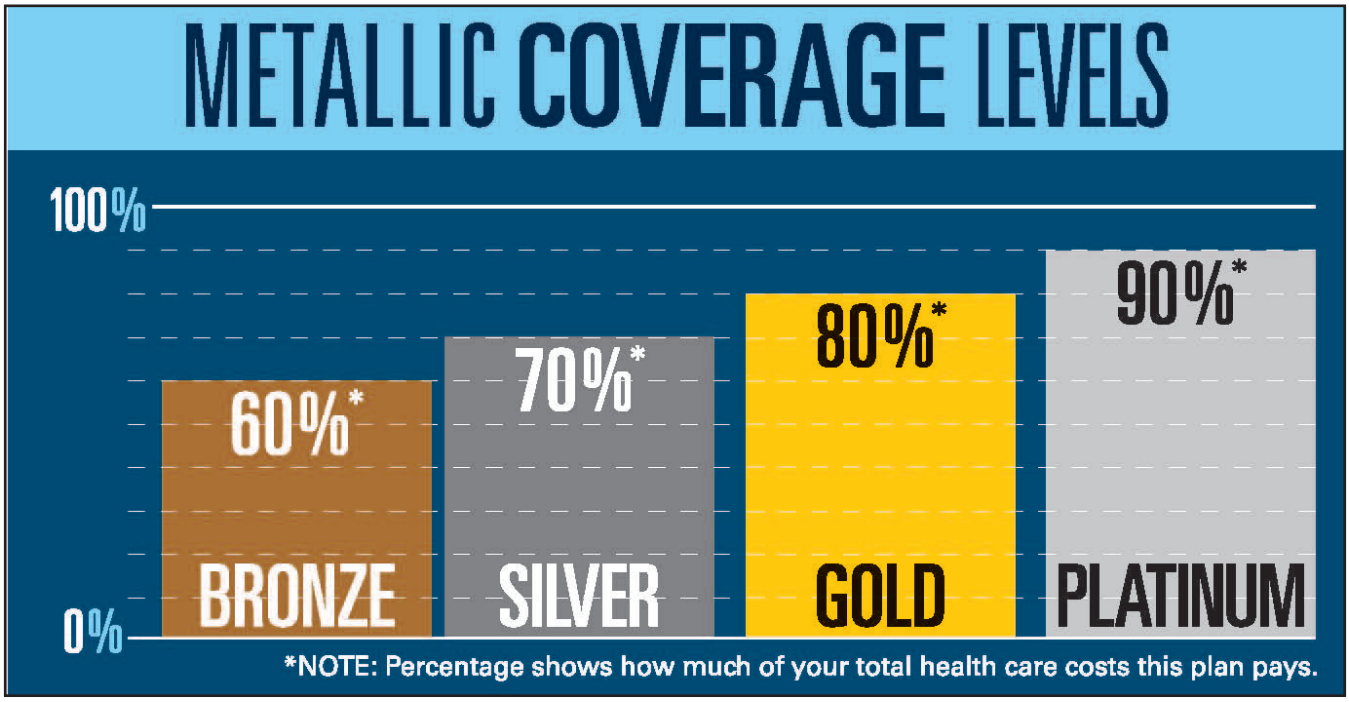
FAQs: the health care law (continued from page 14)

OPM has contracted with the Blue Cross and Blue Shield Association and claims will be filed and processed locally by Arkansas Blue Cross and Blue Shield and paid based on the metallic plan fee schedule.

Are Medicare health plans affected by the health care law?

No. Medicare patients will not have to make changes to their policies as a result of the health care law. They will not have to shop on the marketplace for their coverage and most of them will be able to keep their health plans. People eligible for Medicare, however, are not eligible for tax credits under the health care law.

**Pediatric Dental is not included in our Metallic Plan since there are stand-alone pediatric dental plan available.*



Metallic benefits requiring an authorization

1. Hospital services in connection with dental treatment with prior approval
2. Advanced diagnostic imaging services with prior approval
3. In vitro fertilization with prior approval
4. Autism spectrum disorder benefits with prior approval
5. Durable medical equipment with costs >$5,000.00 with prior approval
6. Implantable osseointegrated hearing aids for patients with single-sided deafness, for chronic external otitis or otitis media with prior approval
7. Prosthetic devices with costs >$20,000 with prior approval
8. Reduction mammoplasty with prior approval
9. Certain drugs with prior approval
10. All transplants other than kidney/cornea with prior approval
11. Neurologic rehabilitation facility services with prior approval
12. Pediatric vision services, vision therapy developmental testing with prior approval
13. Enteral feedings with prior approval
14. Gastric pacemaker with prior approval
15. “Off label” medicine use with prior approval

Health Insurance Marketplace

Arkansas leads the way in addressing the uninsured population

Arkansas is the first and only state in the country to expand coverage to low income residents by way of private coverage on the insurance exchange. As is the case in most states, effective January 1, 2014, residents with income between 138% and 400% of the federal poverty level will qualify for premium subsidy to purchase health insurance on the exchange. What is new and different in Arkansas is that Medicaid expansion is planned to happen through private coverage and not simply an expansion of the existing Medicaid program.

Arkansas Blue Cross and Blue Shield is excited to offer products in all Arkansas counties. This approach represents great promise to significantly reduce the rate of uninsured at payment rates that exceed historical Medicaid and Medicare levels.

Frequently asked questions:

Why is Medicaid involved with the marketplace?

In conjunction with the Affordable Care Act, a new Arkansas law expands Medicaid coverage by offering private health insurance options to Arkansans with household incomes below 138 percent of the federal poverty level. These eligible members will shop for and purchase commercial health insurance policies (funded in full by Arkansas Medicaid) offered by private carriers like Arkansas Blue Cross and Blue Shield on Arkansas' new health insurance marketplace. Our new laws result in many low- and middle-income Arkansans finding private health insurance coverage much more affordable.

What if a provider wants to opt out of this True Blue PPO amendment and not see exchange members?

A participating True Blue PPO provider would need to send a letter to USAble Corporation per the terms of their participating provider agreement that indicates their desire to terminate participation in the True Blue PPO network. Their termination also means that they will be out of network for all other business that uses the True Blue PPO network such as the Federal Employee Program (FEP), BlueCard, most self funded employer groups administered by BlueAdvantage Administrators of Arkansas and the largest PPO commercial enrollment that has purchased Arkansas Blue Cross Blue Shield products.

Can providers terminate from the True Blue PPO but stay in other networks like Health Advantage?

Yes. Terminating from True Blue PPO will not affect participation in the Preferred Payment Plan, Health Advantage HMO or if applicable, Arkansas' FirstSource PPO® or Medi-Pak® Advantage.

What if a provider doesn't want to see members who have purchased coverage through the exchange?

If a provider's practice is already closed to all new patients then they are certainly not required to open it for people who have purchased coverage via the exchange.

If a provider does not currently participate in Medicaid, can they participate in the marketplace through True Blue and continue not to participate in Medicaid?

This has no effect on a provider's decision to participate or not participate with Medicaid. However, all consumers who purchase Arkansas Blue Cross coverage through the marketplace will be Arkansas Blue Cross members, including those who were previously covered by Medicaid.

Does this affect the current reimbursement providers receive in the True Blue PPO network?

This amendment has nothing to do with current commercial business using the True Blue PPO network. This amendment only applies to the metallic health plans sold to individuals both on and off the exchange.

(Continued on page 17)

Arkansas leads the way in addressing the uninsured population (continued from page 16)

How did Arkansas Blue Cross determine payment rates for individual metallic health plans?

Based on the State's expectation that deflationary pressure on the cost of care should reduce premium pricing, Arkansas Blue Cross is offering rates that will accomplish that goal and at the same time offer providers payment rates above those of public programs. Arkansas Blue Cross expects a large majority of enrollees in these plans to either have been previously uninsured or traditional Medicaid beneficiaries with coverage that historically paid at levels far below the Arkansas Blue Cross metallic schedule.

An additional benefit to providers is that people enrolling in these plans who have relatively low incomes will have very little out of pocket expense, thus collections for providers will be significantly minimized. Payment rates for members covered under commercial plans will not be affected by this new offering. As the exchange becomes available, Arkansas Blue Cross expects very little migration from commercial plans to metallic options.

Will there be member cost sharing in these metallic benefit plans including Medicaid?

Like usual insurance plans, the member out-of-pocket amounts will vary depending on the product the member chooses to purchase. However, it is worth noting that for eligible members of the Medicaid private option who earn less than 100% of Federal Poverty Level (FPL), Arkansas Blue Cross will pay 100% of the fee schedule for Covered Services (no member out of pocket) and for those who earn between 100 – 138% of FPL, there is a very low patient cost share.

In addition, for the most highly subsidized (non-Medicaid) exchange participants, there will be very low member out of pocket amounts as we will pay a higher percentage of the benefit. So for these patients, a provider's accounts receivable will be significantly reduced if not eliminated altogether.

There are two Blue Cross Blue Shield options that are being offered on the exchange. What is the difference?

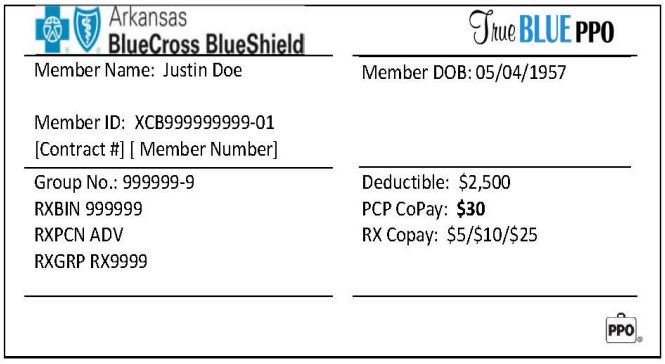
The Office of Personnel Management's Multi-State Plan Program is a new program established under §1334 of the Affordable Care Act, which directs the U.S. Office of Personnel Management to contract with private health insurance issuers to offer at least two Multi-State Plans in each state which are available to eligible individuals and small businesses and offered through the Health Insurance Marketplace.

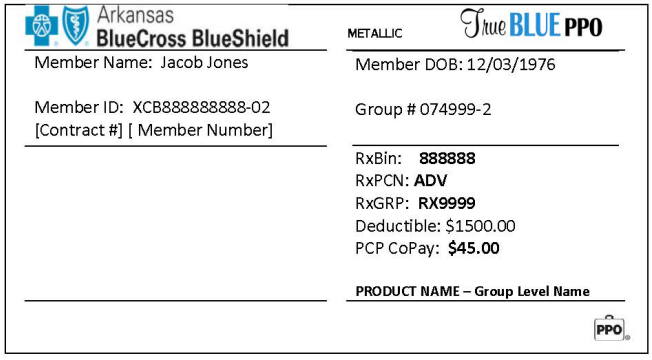
The Multi-State Plan Program will promote competition in the Marketplace and help ensure consumers have more high-quality, affordable health insurance options. These Multi-State Plans will be among the health insurance options from which individuals and small employer groups will be able to choose starting during the open enrollment beginning October 2013.

What will the ID cards look like?

At this time Arkansas Blue Cross is still working on the card design but they will be marked with Arkansas Blue Cross logo that providers are accustomed to seeing. We hope to include as much valuable information as possible on the ID cards so that providers can easily identify patients having individual metallic coverage. (See sample member ID cards located below)

(Continued on page 18)





Arkansas leads the way in addressing the uninsured population (continued from page 17)

Will information about exchange members be available on AHIN?

Yes. The goal of Arkansas Blue Cross is to provide the same type of information providers are used to on AHIN including benefits and eligibility.

Will providers have local customer/provider service?

Yes. Arkansas Blue Cross has trained representatives to handle customer and provider calls.

The True Blue PPO network is currently used by the Blue Card program. Will providers see out-of-state members in this exchange business?

Yes. Out-of-state consumers who have purchased a Blue Cross Blue Shield product on an exchange in another state and seek care from a True Blue PPO provider will use the BlueCard program.

Why focus on primary care?

Arkansas Blue Cross believes that a strong primary care foundation is essential for the delivery system to provide proactive, patient-centered wellness and health management services. Arkansas Blue Cross also believe that in order to achieve the state's long term goal of enhancing the health of the population, more medical students need to see the value in primary care as a career. That is why Arkansas Blue Cross offers continued support of efforts like patient-centered medical home programs that will help primary care practices transform their business models and processes to maximize value to patients and also their financial success. In our continued support of primary care, Arkansas Blue Cross will maintain current payment levels (True Blue PPO) for the metallic plans for primary care physicians.

Helpful telephone numbers for health insurance information

Customer service: 800-800-4298
PPO provider locator: 800-810-2583
BlueCard® eligibility: 800-676-BLUE

Pharmacy customer service: 800-863-5561
Admission outside of Arkansas: 800-451-7302
Pharmacy help line: 800-364-6331

Out-of-state/out-of-network pre-notification: 800-558-3865

Important dates regarding the new Health Insurance Marketplace

- October 1, 2013 - Health insurance plans for 2014 become available
- December 15, 2013 - Final day to enroll in health insurance for a January 1, 2014, start date
- January 1, 2014 - First day that new health insurance plans will become effective
- March 31, 2014 - Last day to sign up for a health insurance plan during the open enrollment period

Health Insurance Marketplace Provider Workshops

Providers interested in attending one of the workshops listed below can register on-line. If you have any additional questions regarding a workshop in your area, contact your Network Development Representative.

Central Region:
Little Rock
Embassy Suites
Wednesday, October 23

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Afternoon session
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Northeast Region:
Jonesboro
St. Bernard's Medical Center
- Auditorium
Wednesday, October 2

Morning session:
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Afternoon session:
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

Northwest Region:
Mountain Home
Baxter Regional Medical Center
- Lagerborg Conference Room
Tuesday, October 29
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Northwest Region:
Springdale
Jones Center for Families
- Rooms 226-228
Wednesday, October 30
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

South Central Region:
Hot Springs
National Park Community College
- Martin Eisele Auditorium
Tuesday, October 29
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 4:00 p.m.

Southeast Region:
Pine Bluff
Pine Bluff Country Club
Wednesday, October 16
Registration 8:30 – 9:00 a.m.
Workshop 9:00 – 11:00 a.m.

Southwest Region:
El Dorado
El Dorado Country Club
Tuesday, October 8
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 4:00 p.m.

Southwest Region:
Texarkana
Christus St. Michael Medical Center
- North conference room
Wednesday, October 9
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 4:00 p.m.

West Central Region:
Fort Smith
Sparks Regional Hospital
- Sheffield Education Center
Tuesday, October 15
Registration 1:00 – 1:30 p.m.
Workshop 1:30 – 3:30 p.m.

To register on-line, please choose from the following locations:

- El Dorado: http://www.surveymonkey.com/s/abcbs2013-ELDORADO
- Fort Smith: http://www.surveymonkey.com/s/abcbs2013-FORTSMITH
- Hot Springs: http://www.surveymonkey.com/s/abcbs2013-HOTSPRINGS
- Jonesboro: http://www.surveymonkey.com/s/abcbs2013-JONESBORO
- Little Rock: http://www.surveymonkey.com/s/abcbs2013-LITTLEROCK
- Mountain Home: http://www.surveymonkey.com/s/abcbs2013-MOUNTAINHOME
- Pine Bluff: http://www.surveymonkey.com/s/G3GQZ58
- Springdale: http://www.surveymonkey.com/s/abcbs2013-SPRINGDALE
- Texarkana: http://www.surveymonkey.com/s/abcbs2013-TEXARKANA

Helpful websites for health care law information

www.arkansasbluecross.com
www.healthadvantage-hmo.com
www.becoveredarkansas.org

Coverage policy manual updates

Since June 2013, the following policies were added or updated in Arkansas Blue Cross and Blue Shield's Coverage Policy manual. To view entire policies, access the coverage policies located our website at arkansasbluecross.com.

New / Updated Policies:

Policy #	Policy Name
1997014	Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions
1997113	Immune Globulin, Intravenous and Subcutaneous
1997153	Iron Therapy, Parenteral
1998024	Home Apnea Monitors
1998033	Gait Analysis
1998068	Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging
1998099	Electrical Stimulation, Deep Brain (e.g. Parkinsonism, Dystonia, Multiple Sclerosis, Post-Traumatic Dyskinesia)
1998104	Transplant, Liver
1998110	Chelation Therapy
1998142	Osteochondral Autograft Transfer (OATS) and/or Mosaicplasty for Osteochondral Defects of the Knee
2000034	Hyperhidrosis Treatment
2002009	Phototherapy for Psoriasis (UVB)
2003024	Kyphoplasty, Percutaneous and Mechanical Vertebral Augmentation
2003061	Brachytherapy, Radioembolization of Primary & Metastatic Tumors of the Liver with Therapeutic Microspheres
2004031	Radiofrequency Ablation and Other Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids
2006006	Osteochondral Allograft and/or Mosaicplasty for Osteochondral Defects of the Knee
2006032	Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)
2008022	Genetic Test: Cancer of Unknown Primary, Pathwork Tissue of Origin Test, Cup Print, MI Review and Cancer Type ID
2009015	Golimumab (Simponi®)
2009033	Femoroacetabular Impingement, Surgical Treatment of
2010009	Bevacizumab (Avastin) for Ocular Indications
2010011	Myoelectric Prosthesis for the Upper Limb
2011013	Preventive Services for Non-grandfathered (PPACA) Plans: Aspirin to Prevent Cardiovascular Disease In Adults
2011017	Preventive Services for Non-grandfathered (PPACA) Plans: Breast Cancer Preventive Medication
2011019	Preventive Services for Non-grandfathered (PPACA) Plans: Breast feeding Counseling
2011030	Preventive Services for Non-grandfathered (PPACA) Plans: Obesity In Children; Screening And Counseling
2011034	Preventive Services for Non-grandfathered (PPACA) Plans: Nutrition (Dietary) Counseling, Adults

Policy #	Policy Name
2011035	Preventive Services for Non-grandfathered (PPACA) Plans: Gonorrhea Prophylaxis, Newborn Ophthalmic
2011036	Preventive Services for Non-grandfathered (PPACA) Plans: Hearing Loss Screening In Newborns
2011040	Preventive Services for Non-grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV) Counseling & Screening
2011043	Preventive Services for Non-grandfathered (PPACA) Plans: Depression Screening, Adults
2011045	Preventive Services for Non-grandfathered (PPACA) Plans: Colorectal Cancer Screening
2012005	Genetic Test: Molecular Testing Of Tumors for Genomic Profiling As A Therapeutic Guide (Target Now®, Foundationone®)
2012009	Skin And Soft Tissue Substitutes, Bio-Engineered Products
2012018	Preventive Services for Non-grandfathered (PPACA) Plans: Skin Cancer, Behavioral Counseling for Prevention
2012021	Preventive Services for Non-grandfathered (PPACA) Plans: Intimate Partner Violence; Screening In Women
2012031	Preventive Services for Non-grandfathered (PPACA) Plans: Well-Woman Visits for Adult Women
2012033	Preventive Services for Non-grandfathered (PPACA) Plans: Human Immunodeficiency Virus (HIV), Counseling And Screening, Annually for Sexually Active Women
2012035	Preventive Services for Non-grandfathered (PPACA) Plans: Contraceptive Use And Counseling
2012037	Preventive Services for Non-grandfathered (PPACA) Plans: High Blood Pressure, Screening In Infants, Children And Adolescents
2012039	Preventive Services for Non-grandfathered (PPACA) Plans: Tuberculosis Screening In Infants, Children And Adolescents
2012042	Preventive Services for Non-grandfathered (PPACA) Plans: Media Use By Children & Adolescents, Screening & Counseling
2012044	Preventive Services for Non-grandfathered (PPACA) Plans: Bicycle Helmet Use for Children & Adolescents, Counseling
2012045	Preventive Services for Non-grandfathered (PPACA) Plans: Autism Screening
2012046	Preventive Services for Non-grandfathered (PPACA) Plans: Well-Child Visits, Newborn, Infant, Children, Adolescents & Ages 18-21
2012047	Preventive Services for Non-grandfathered (PPACA) Plans: Cardiometabolic Risks Of Obesity In Children And Adolescents, Counseling
2012055	Preventive Services for Non-grandfathered (PPACA) Plans: Prevention Of Falls In Community-Dwelling Older Adults
2013006	Prostate, Saturation Biopsy
2013018	Genetic Test: Lactase Insufficiency (-13910 C>T)
2013019	Laser Treatment of Onychomycosis
2013020	Genetic Test: Statin-Induced Myopathy (SLCO1B1)
2013021	Myocardial Sympathetic Innervation Imaging in Patients with Heart Failure
2013022	Genetic Test: Inherited Peripheral Neuropathies (Charcot Marie Tooth, HNPP)
2013023	Preventive Services for Non-grandfathered (PPACA) Plans: Hepatitis C Virus Screening
2013024	Phototherapy for Vitiligo

Fee Schedule

Fee schedule additions and 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
29870	$0.00	$0.00	$0.00	$650.27	$0.00	$0.00
81200	$232.67	$16.29	$216.38	$0.00	$16.29	$0.00
81202	$475.00	$33.25	$441.75	$0.00	$33.25	$0.00
81205	$217.65	$15.24	$202.41	$0.00	$15.24	$0.00
81209	$83.75	$5.86	$77.89	$0.00	$5.86	$0.00
81221	$123.97	$8.68	$115.29	$0.00	$8.68	$0.00
81222	$145.61	$10.19	$135.42	$0.00	$10.19	$0.00
81224	$98.77	$6.91	$91.86	$0.00	$6.91	$0.00
81225	$267.80	$18.75	$249.05	$0.00	$18.75	$0.00
81226	$505.55	$35.39	$470.16	$0.00	$35.39	$0.00
81229	$840.73	$58.85	$781.88	$0.00	$58.85	$0.00
81235	$399.92	$27.99	$371.93	$0.00	$27.99	$0.00
81243	$86.90	$6.08	$80.82	$0.00	$6.08	$0.00
81244	$58.80	$4.12	$54.68	$0.00	$4.12	$0.00
81250	$159.10	$11.14	$147.96	$0.00	$11.14	$0.00
81251	$291.22	$20.39	$270.83	$0.00	$20.39	$0.00
81252	$420.00	$29.40	$390.60	$0.00	$29.40	$0.00
81253	$169.03	$11.83	$157.20	$0.00	$11.83	$0.00
81254	$60.33	$4.22	$56.11	$0.00	$4.22	$0.00
81255	$172.59	$12.08	$160.51	$0.00	$12.08	$0.00
81256	$103.87	$7.27	$96.60	$0.00	$7.27	$0.00
81257	$247.68	$17.34	$230.34	$0.00	$17.34	$0.00
81260	$118.72	$8.31	$110.41	$0.00	$8.31	$0.00
81270	$86.90	$6.08	$80.82	$0.00	$6.08	$0.00
81275	$314.63	$22.02	$292.61	$0.00	$22.02	$0.00
81280	$238.03	$16.66	$221.37	$0.00	$16.66	$0.00
81291	$112.26	$7.86	$104.40	$0.00	$7.86	$0.00
81301	$395.17	$27.66	$367.51	$0.00	$27.66	$0.00
81302	$604.08	$42.29	$561.79	$0.00	$42.29	$0.00
81304	$100.80	$7.06	$93.74	$0.00	$7.06	$0.00
81324	$1,539.10	$107.74	$1,431.36	$0.00	$107.74	$0.00
81330	$197.53	$13.83	$183.70	$0.00	$13.83	$0.00

CPT / HCPCS Code	Total / Purchase	Professional / Rental	Technical / Used	Total SOS / Purchase	Prof SOS / Rental	Tech SOS / Used
81331	$72.17	$5.05	$67.12	$0.00	$5.05	$0.00
81332	$103.87	$7.27	$96.60	$0.00	$7.27	$0.00
81350	$161.65	$11.32	$150.33	$0.00	$11.32	$0.00
81400	$68.73	$4.81	$63.92	$0.00	$4.81	$0.00
81401	$127.53	$8.93	$118.60	$0.00	$8.93	$0.00
81402	$221.28	$15.49	$205.79	$0.00	$15.49	$0.00
81403	$169.03	$11.83	$157.20	$0.00	$11.83	$0.00
81404	$473.49	$33.14	$440.35	$0.00	$33.14	$0.00
81405	$646.08	$45.23	$600.85	$0.00	$45.23	$0.00
81406	$1,266.38	$88.65	$1,177.73	$0.00	$88.65	$0.00
81407	$2,148.02	$150.36	$1,997.66	$0.00	$150.36	$0.00
81408	$1,290.65	$90.35	$1,200.30	$0.00	$90.35	$0.00
88141	$47.84	$47.84	$0.00	$47.84	$47.84	$0.00
90672	$17.15	$0.00	$0.00	$650.27	$0.00	$0.00
90686	$17.15	$0.00	$0.00	$0.00	$0.00	$0.00
90686	$15.15	$0.00	$0.00	$0.00	$0.00	$0.00
0001M	BR	$0.00	$0.00	BR	$0.00	$0.00
0002M	BR	$0.00	$0.00	BR	$0.00	$0.00
0003M	BR	$0.00	$0.00	BR	$0.00	$0.00
0329T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0330T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0331T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0332T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0333T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
0334T	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9131	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
C9726	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
E0485	$500.00	$0.00	$0.00	$0.00	$0.00	$0.00
E0486	$858.50	$0.00	$0.00	$0.00	$0.00	$0.00
E0603	$119.88	$0.00	$89.91	$0.00	$0.00	$0.00
J0800	$3,012.00	$0.00	$0.00	$0.00	$0.00	$0.00
J0878	$0.59	$0.00	$0.00	$0.00	$0.00	$0.00
J2353	$199.81	$0.00	$0.00	$0.00	$0.00	$0.00
J7330	$30,420.00	$0.00	$0.00	$0.00	$0.00	$0.00
L8680	$418.53	$0.00	$0.00	$0.00	$0.00	$0.00
Q0090	BR	$0.00	$0.00	$0.00	$0.00	$0.00
Q0090	$650.32	$0.00	$0.00	$0.00	$0.00	$0.00
Q2033	BR	$0.00	$0.00	$0.00	$0.00	$0.00
V5014	$30.00	$0.00	$0.00	$0.00	$0.00	$0.00

Fee Schedule

Injection Code Updates

The following injection codes were updated on Arkansas Blue Cross and Blue Shield fee schedule.

CPT Code	Allowed
90371	$105.04
90375	$224.28
90376	$221.55
90385	$25.94
90585	$124.07
90586	$124.07
90632	$52.41
90670	$150.91
90675	$211.57
90691	$63.69
90703	$39.48
90714	$19.70
A9576	$1.95
A9577	$3.13
A9578	$2.35
A9579	$2.25
A9581	$13.83
A9583	$12.19
A9585	$0.43
J0129	$23.75
J0130	$654.57
J0132	$3.21
J0135	$547.45
J0150	$5.51
J0152	$113.50
J0171	$0.07
J0180	$151.54
J0207	$307.79
J0220	$214.33
J0221	$159.76
J0256	$4.15
J0257	$4.19
J0278	$1.23
J0280	$0.84

CPT Code	Allowed
J0285	$14.63
J0287	$11.86
J0290	$1.67
J0295	$2.13
J0348	$0.68
J0360	$3.87
J0364	$34.13
J0400	$0.54
J0456	$2.19
J0470	$31.49
J0475	$180.93
J0476	$78.20
J0480	$2,528.87
J0490	$39.76
J0500	$40.15
J0515	$24.46
J0558	$4.14
J0561	$5.31
J0583	$3.34
J0586	$7.24
J0588	$4.66
J0592	$1.03
J0594	$25.80
J0595	$1.91
J0598	$50.62
J0610	$1.07
J0630	$71.28
J0636	$0.38
J0638	$89.20
J0640	$4.95
J0641	$1.86
J0670	$2.66
J0690	$0.79
J0692	$2.95

CPT Code	Allowed
J0694	$5.56
J0697	$2.97
J0698	$1.92
J0702	$5.89
J0706	$0.45
J0713	$2.16
J0718	$5.21
J0720	$29.47
J0725	$14.99
J0735	$23.49
J0740	$713.56
J0744	$1.15
J0770	$12.89
J0775	$40.23
J0780	$4.42
J0795	$7.38
J0800	$3,134.08
J0834	$68.96
J0840	$2,305.47
J0850	$1,054.44
J0881	$3.60
J0882	$3.60
J0885	$11.41
J0886	$11.41
J0890	$8.52
J0894	$35.92
J0897	$14.73
J1000	$8.41
J1020	$3.25
J1030	$3.01
J1040	$5.77
J1050	$0.22
J1070	$4.18
J1080	$5.60

CPT Code	Allowed
J1100	$0.13
J1110	$42.38
J1120	$27.62
J1160	$1.73
J1162	$1,134.59
J1165	$0.62
J1170	$1.86
J1200	$0.71
J1205	$184.32
J1212	$85.30
J1230	$7.49
J1240	$5.44
J1245	$0.85
J1250	$7.20
J1260	$5.78
J1265	$0.44
J1267	$0.56
J1270	$1.92
J1290	$329.21
J1325	$15.03
J1327	$27.16
J1335	$33.18
J1364	$21.82
J1380	$9.15
J1410	$154.83
J1438	$263.62
J1440	$296.81
J1441	$470.35
J1450	$3.74
J1451	$6.71
J1458	$371.61
J1459	$38.07
J1460	$24.76
J1557	$38.42
J1560	$247.60
J1561	$40.53
J1566	$31.89
J1568	$32.84
J1569	$40.73
J1570	$75.56
J1571	$53.80

CPT Code	Allowed
J1572	$37.38
J1573	$53.80
J1580	$1.19
J1600	$31.36
J1610	$127.16
J1626	$0.71
J1630	$1.20
J1631	$20.50
J1640	$16.28
J1644	$0.20
J1645	$12.57
J1650	$1.94
J1652	$4.31
J1670	$378.43
J1720	$5.11
J1740	$160.85
J1742	$138.91
J1743	$487.73
J1750	$12.61
J1756	$0.35
J1786	$43.62
J1790	$3.39
J1800	$3.31
J1815	$0.62
J1817	$6.13
J1930	$37.91
J1931	$29.40
J1940	$3.64
J1950	$774.52
J1953	$0.18
J1955	$8.28
J1980	$17.74
J2010	$8.07
J2020	$42.57
J2060	$0.75
J2150	$2.28
J2175	$2.51
J2210	$4.11
J2250	$0.14
J2270	$4.97
J2271	$0.76

CPT Code	Allowed
J2275	$3.40
J2280	$3.34
J2300	$1.05
J2310	$17.25
J2315	$2.95
J2323	$13.60
J2325	$62.11
J2353	$140.03
J2354	$1.35
J2355	$288.82
J2357	$25.44
J2360	$7.05
J2370	$3.84
J2400	$21.91
J2410	$2.45
J2426	$7.72
J2430	$10.69
J2469	$19.69
J2501	$1.62
J2503	$1,068.39
J2504	$286.92
J2505	$3,134.42
J2507	$439.98
J2510	$15.37
J2515	$33.56
J2540	$0.60
J2543	$1.57
J2545	$83.96
J2560	$14.60
J2562	$308.53
J2590	$0.53
J2597	$5.86
J2675	$1.88
J2680	$20.55
J2690	$19.97
J2700	$2.24
J2720	$0.89
J2724	$14.89
J2730	$93.77

(Continued on page 26)

Injection code updates (Continued from page 25)

CPT Code	Allowed
J2760	$124.39
J2765	$0.81
J2770	$208.42
J2778	$413.41
J2780	$1.21
J2783	$219.40
J2785	$55.62
J2788	$27.64
J2790	$95.68
J2791	$4.95
J2792	$19.05
J2794	$6.00
J2795	$0.12
J2796	$52.97
J2800	$35.69
J2805	$86.96
J2810	$0.33
J2820	$29.75
J2916	$3.21
J2920	$1.92
J2930	$2.74
J2997	$58.60
J3000	$11.45
J3070	$32.36
J3095	$2.75
J3101	$77.97
J3105	$1.91
J3120	$4.42
J3130	$9.79
J3230	$17.90
J3240	$1,095.39
J3243	$1.83
J3246	$8.36
J3250	$10.99
J3260	$2.32
J3262	$3.85
J3300	$4.06
J3301	$1.84
J3303	$1.60
J3315	$200.13

CPT Code	Allowed
J3355	$66.99
J3357	$143.82
J3360	$3.55
J3370	$2.13
J3385	$362.58
J3396	$10.85
J3410	$0.48
J3411	$3.80
J3415	$8.29
J3420	$1.90
J3430	$0.72
J3465	$4.84
J3473	$0.32
J3475	$0.21
J3486	$9.91
J7030	$1.19
J7040	$0.59
J7042	$0.51
J7050	$0.30
J7060	$1.08
J7070	$2.14
J7100	$22.99
J7120	$1.03
J7183	$0.94
J7185	$1.15
J7189	$1.72
J7190	$0.96
J7193	$1.00
J7195	$1.39
J7197	$3.18
J7308	$180.95
J7309	$87.03
J7312	$203.72
J7321	$88.54
J7323	$159.00
J7324	$179.08
J7325	$13.07
J7326	$644.91
J7500	$0.62
J7501	$193.74

CPT Code	Allowed
J7502	$3.64
J7504	$754.00
J7506	$0.03
J7507	$1.63
J7509	$0.69
J7510	$0.04
J7511	$602.08
J7515	$0.99
J7516	$34.76
J7518	$3.96
J7520	$13.74
J7525	$143.07
J7527	$6.72
J7605	$5.56
J7606	$6.15
J7608	$6.90
J7612	$0.30
J7613	$0.06
J7620	$0.19
J7626	$5.30
J7639	$33.91
J7644	$0.24
J7669	$0.45
J7674	$0.51
J7682	$123.33
J7686	$478.86
J8501	$6.95
J8510	$11.44
J8520	$9.97
J8521	$33.18
J8530	$1.01
J8540	$0.28
J8560	$57.33
J8600	$9.06
J8610	$0.54
J8700	$11.67
J8705	$90.11
J9000	$3.81
J9017	$49.30
J9019	$356.45

CPT Code	Allowed
J9020	$67.15
J9025	$6.00
J9027	$134.37
J9031	$124.07
J9033	$21.65
J9035	$67.23
J9040	$21.30
J9041	$47.14
J9042	$106.85
J9043	$145.32
J9045	$3.09
J9050	$182.31
J9055	$54.58
J9060	$1.91
J9065	$27.02
J9070	$41.99
J9098	$566.00
J9100	$0.98
J9120	$643.54
J9130	$4.22
J9150	$29.88
J9155	$3.17
J9171	$4.95
J9178	$1.39
J9179	$101.84
J9181	$0.78
J9185	$92.07
J9190	$2.20
J9200	$66.70
J9201	$5.89
J9202	$197.12
J9206	$2.34
J9207	$70.37
J9208	$31.48
J9209	$2.95
J9211	$45.51
J9214	$19.55
J9217	$214.25
J9218	$10.92
J9226	$15,894.00
J9228	$132.13

CPT Code	Allowed
J9230	$163.92
J9245	$1,324.03
J9250	$0.28
J9260	$2.87
J9261	$132.37
J9263	$0.91
J9265	$4.27
J9266	$2,891.50
J9268	$1,455.26
J9280	$24.95
J9293	$38.66
J9302	$48.36
J9303	$94.74
J9305	$61.86
J9307	$189.88
J9310	$706.02
J9315	$263.61
J9320	$287.09
J9328	$5.03
J9330	$58.19
J9340	$275.60
J9351	$2.22
J9355	$81.84
J9357	$1,096.66
J9360	$1.69
J9370	$4.60
J9390	$10.64
J9395	$93.20
Q0138	$0.69
Q0139	$0.69
Q0162	$0.04
Q0165	$0.06
Q0166	$2.63
Q0167	$3.66
Q0168	$7.42
Q0169	$0.05
Q0170	$0.03
Q0180	$69.95
Q2009	$1.14
Q2017	$333.89
Q2050	$567.26

CPT Code	Allowed
Q2051	$204.27
Q3025	$323.76
Q4074	$79.86
Q4081	$1.14
Q4101	$42.66
Q4102	$8.49
Q4103	$8.49
Q4104	$23.70
Q4105	$14.44
Q4106	$46.26
Q4107	$105.02
Q4108	$29.70
Q4110	$41.12
Q4111	$7.23
Q4112	$364.60
Q4113	$364.60
Q4114	$1,304.05
Q4115	$9.34
Q4116	$33.49
Q4121	$24.29
Q4123	$16.39
Q9956	$38.34
Q9957	$57.52
Q9958	$0.13
Q9960	$0.17
Q9961	$0.19
Q9963	$0.42
Q9965	$1.03
Q9966	$0.41
Q9967	$0.23

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providers' news staff

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