Providers' News

Arkansas BlueCross BlueShield

To: All Providers

From: Provider Network Operations

Date: June 21, 2000

Please Note: This newsletter contains information pertaining to Arkansas Blue Cross Blue Shield, a mutual insurance company, it's wholly owned subsidiaries and affiliates (ABCBS). This newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501)378-2307 or (800)827-4814.

What's Inside?

ABCBS Fee Schedule Change

Reminder: Effective July 1, 2000 Arkansas Blue Cross Blue Shield is updating the fee schedule used to price professional claims. The update includes changes in the Relative Value Units used to calculate the maximum allowances as well as the implementation of Site-Of - Service (SOS) pricing.

Under SOS pricing, a given procedure may have different allowances when provided in a setting other than the office.

The Place Of Service reported in block 24b on the HCFA 1500 claim form indicates which allowance should be applied. An "11" in this field indicates that the service was delivered in the office setting. Any value other than "11" in block 24b will result in the application of the SOS pricing, if there is an applicable SOS allowance for that service.

The allowable amount for claims submitted to ABCBS will be determined based on the date that the claim is processed. The allowable amount for claims submitted to Health Advantage and USAble will be determined based on the date services were rendered.

Health Advantage Referral Reminder

Proper use of the referral process will save time and reduce the number of claims adjustments.

Primary Care Physicians (PCP's) Participating with Health Advantage: For referrals to participating in-network specialist providers, please complete the Health Advantage Specialty referral sheet. Retroactive referrals are discouraged and may not be eligible for benefits. Any request for a referral to a provider not participating with Health Advantage requires prior notification and review for benefits to be authorized.

Specialist providers Participating with Health Advantage: Please remember that in order for your services to be eligible for in-network benefits, you must place the referral number marked on the "scrip" referral sheet in field 23 of the HCFA-1500 form every time. If the referral number is not on each claim, then the service will either be denied or paid at the out-of-network benefit level if the patient has Point of Service (POS) benefits. Retroactive referrals are discouraged and may not be eligible for benefits.

Please note that this does NOT include referrals for Medi-Pak HMO or referrals for providers located in the Southeast or Southwest Regions.

If you have any questions, please contact the Regional Office nearest you.

Dental Fee Schedule
Effective May 1, 2000

The dental fee schedule (see codes beginning page 17) has been updated to include new allowances for numerous codes. The allowances for these dental procedures are based on data reflecting average amounts billed by Arkansas dentists. It should be noted that billed amounts for many codes vary significantly in different regions of Arkansas and additional averaging was needed to calculate a state-wide fee allowance. The new fee schedule utilizes the Dental HCPCS codes. Please bill using the new codes.

Electronic Filing Reminder

All Arkansas' FirstSource claims may be filed electronically, including those for members covered under access-only groups.

CPT Code 99070

CPT code 99070 will no longer be developed for description of services. Charges will be denied. Please use appropriate CPT4 or HCPCS code for services rendered.

Claims Imaging and Eligibility

As part of the new imaging project recently installed for Private Business paper claims, a new Enterprise eligibility verification process is now being used. In order to help ensure that claims are processed as accurately and quickly as possible, it is critical that your paper claims are submitted with the following correct information.

1. Patient's Contract Number-This number should match the number on the ID card exactly, including any three digit alpha prefixes.
2. Patient's Last and First Name-Names should appear on claims exactly as on the patient's ID card. Avoid the use of nicknames. Also, do not include titles such as Mr., Mrs, Jr., Sr., etc.
3. Patient's Date of Birth-This information may not be available on the ID card, but it is important to make sure that correct eligibility for claims is established prior to payment.

If you receive a letter of rejection for eligibility information, be sure to **correct any of these items above and submit a NEW claim form**. Be sure to use the red form for new HCFA-1500 or UB-92 claims. Please correct any invalid eligibility information on your patient records so that any future claims will be filed correctly and processed as quickly as possible.

Anesthesia Base Units

Some anesthesia base units allowed by Arkansas Blue Cross Blue Shield differ from those recommended by the American Society of Anesthesiologists. Providers that file paper claims are reminded to bill anesthesia time by indicating the number of minutes in the units field (box 24G) on the HCFA 1500 claim form. Changes have been made in the anesthesia base units of the following CPT codes to match the year 2000 Relative Value Guide of the American Society of Anesthesiologists.

Code/Units	Code/Units	Code/Units
00560 15	00700 4	00794 8
00800 4	00810 5	00850 7
00857 7	00865 7	00873 5
01150 10	01214 8	01440 8
01770 6	01921 8	

Coronary Artery Interventions

CPT codes 92980 and 92981 (coronary artery stenting), and 92982 and 92984 (coronary PTCA), may occasionally be billed on the same date of service if the services are done in different vessels. Currently, the claim must be developed to make that determination.

The AMA's *CPT Assistant* (Vol 6, Issue 8, August 1996) defined four coronary vessels:

LMCA	Left Main Coronary Artery
RCA	Right Coronary Artery
LAD	Left Anterior Descending Coronary Artery
LCX	Left Circumflex Coronary Artery

Only one intervention can be coded for each major artery per session, no matter how many blockages are treated in that artery or its branches.

Effective January 1, 1997, HCFA added new modifiers to help code interventions to a major coronary artery or one of its branches. ABCBS will now require use of the following modifiers for coronary artery intervention billing. Use of the following modifiers will help facilitate claims processing and avoid payment delays:

-LD (left anterior descending artery)
-LC (left circumflex coronary artery)
-RC (right coronary artery)
-LMCA (left main coronary artery)

These modifiers should be used with CPT codes 92980-92984 and 92995-92996.

Claims for interventional services in coronary arteries filed without the above modifiers will be returned to the submitter as incomplete.

Type of Service Corrections

Please note the following corrections to the Type of Service cross reference list in the March Providers' News issue:

CPT Codes 88300-88499 Type of Service should be 02 (Surgery)
CPT Codes 88170-88179 Type of Service should be 02 (Surgery)
CPT Codes 88240-88291 Type of Service should be 02 (Surgery)
CPT Codes 99241-99275 Type of Service should be 03 (Consultation)
CPT Codes 77261-77799 Type of Service should be 06 (Radiation Therapy)

Claims submitted with incorrect or invalid National Standard Format (NSF) Type of Service codes may be returned to providers for corrected billing. See page 15 for a listing of valid TOS codes.

Claims Payment Issues

While one of our ongoing goals is to minimize the number of claims paid incorrectly, errors will occasionally be made. Some of these error conditions can affect 1099 earnings and/or patients' claim history, deductibles, and benefit limits. These situations can result in incorrect information being reported to the IRS and/or incorrect patient benefit determination.

Please note:

- amounts of issued provider payee checks are recorded as increases to the 1099 earnings;
- amounts of voided provider payee checks are recorded as decreases to the 1099 earnings;
- amounts received from providers (claims refunds) are recorded as decreases to the 1099 earnings.

- 1099 earnings are accumulated under the Tax Identification Number (TIN) of the payee, as recorded in our files at the time of the transaction. You must notify us promptly if your TIN or your name changes in order to ensure accurate reporting to the IRS. If the IRS sends us a B-Notice indicating that the Taxpayer Name and TIN we filed does not match their records, we will be required to withhold, and remit to the IRS, 31% of future amounts payable to you if corrected data is not received within the mandated time frame. Once withheld amounts are remitted to the IRS, they cannot be refunded to you, but will be reported on your 1099 as Federal Income Tax Withheld.

Notes to physicians:
For Paper Claims: As the provider of service, you should always enter your individual provider number in box # 24K of the HCFA1500 claim form. If you want a clinic to be the payee, you must enter the clinic's provider number in box # 33.
For Electronic Claims: As the provider of service, you should always enter your individual provider number beginning in position 93 of field 23 on the FA0 record. For non-Medicare claims, you must enter the "pay to" provider number beginning in position 105 of field 14 on the BA0 record. For Medicare claims, the "pay to" provider number must be entered beginning in position 48 of field 9 on the BA0 record.

- Deductibles, benefit limits, out-of-pocket maximums, and lifetime maximums are accumulated by individual member. If erroneous claims are not adjusted appropriately and promptly, subsequent claims may be incorrectly adjudicated.

Listed below are examples of some situations that can occur along with procedures recommended to facilitate correction of the data.

- Please verify that the payee is correct on all checks that you receive prior to negotiating them.

- If you receive payment for a claim for services that you did not provide:
  Please refund the amount paid in error. Even if you know to whom the payment should have been made, do not forward the amount to that party. Your 1099 can only be corrected if the money is returned so that the claim can be re-processed to the appropriate party.

- If the patient was paid and payment should have been made directly to you:
  Please advise the patient to return the check, or refund the amount paid, along with a request to re-process the payment to the provider. If you accept payment from the patient, we could subsequently discover the error and send a request for refund to him/her since our records will reflect that he/she received the payment.

- If you were paid and payment should have been made to the patient:
  Please refund the payment to us (rather than to the patient) along with a request to re-process the payment to the patient. Your 1099 can only be corrected if the money is returned, so that the claim can be re-processed to the appropriate party.

- If a check is made payable to an individual physician but should have been made payable to the clinic:
  Please return the check to us (rather than depositing it in the clinic's account) with a request to re-process the payment to the appropriate provider. Your 1099 can only be corrected if the money is returned, so that the claim can be re-processed to the appropriate party.
  NOTE: If the check is made payable to an individual physician, the 1099 will be generated in the physician's name, even if he/she is an employee of the clinic.

- We recommend that you endorse and deposit all checks as soon as possible after confirming that the payee is correct. Most of our checks have a pre-printed staledate message indicating that the check will be void if not cashed within a specific time frame (usually six months). After that time, the check must be re-issued or, in some cases, the claim must be re-processed.

- As a deterrent to fraud and to enhance the quality of copies of cleared checks that might be requested in the future, we also recommend that endorsements be made in black ink and include the bank account number into which the deposit is being made.

- To minimize the time required to process a claim refund and to ensure that your 1099 earnings are adjusted accurately:

- When sending us a *requested* refund:
  Please return the remittance copy of the refund request letter along with your check.

- When sending us an *unrequested* refund:
  It is not necessary to return the original check and the entire remittance advice/ explanation of payment if just one or two patient claims are paid incorrectly. Please enclose copies of the remittance advice/ explanation of payment pages with the claims paid in error highlighted and a notation of the reason for the refund
  or enclose the following information for each claim paid in error:
  (1) reason for the refund,
  (2) patient name,
  (3) patient ID number,
  (4) date of service,
  (5) amount
  (6) provider name (pay to)
  (7) provider number (pay to)
  (8) and TIN (pay to).
  A separate refund check for each claim is preferred, if you are not returning the original check.

- **Your 1099 earnings can only be corrected if we have your specific provider name, number, and TIN. If you use the services of a third party for these financial transactions, please instruct them to provide this information on each refund**.

- Please do not combine refunds for Arkansas Blue Cross Blue Shield, Health Advantage, USAble Administrators, First Pyramid Life (FPL), and Medicare. The following are the correct addresses to use for claims refund:

  Arkansas Blue Cross Blue Shield
  P.O. Box 2099
  Little Rock, AR 72203

  Health Advantage
  P.O. Box 8069
  Little Rock, AR 72203

  USAble Administrators
  P.O. Box 1460
  Little Rock, AR 72203

  First Pyramid Life
  P.O. Box 1151
  Little Rock, AR 72203

Medicare *(part A or B)*
P.O. Box 8075
Little Rock, AR 72203

- Please do not issue refund checks to Arkansas First Source.

The Providers' News

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

Kimberly Hartsfield, Editor
Arkansas Blue Cross Blue Shield
PO Box 2181
Little Rock AR 72203
Email: kchartsfield@arkbluecross.com

A Guide to
The HCFA - 1500
Claim Form
(Paper Claims)

May 8, 2000
Arkansas Blue Cross and Blue Shield

ABCBS HCFA-1500-OCR Instructions

These guidelines will help you prepare your claims for Optical Character Recognition (OCR) scanning when filing claims for Arkansas Blue Cross and Blue Shield, Health Advantage, and USAble. If you follow these simple guidelines, we'll be able to process your claims accurately. A correctly completed claim form means quicker payment for your office and no-refiling for you!

Align the form-Please align your form carefully so that all data falls within the blocks on the claim form. You'll be able to keep your form aligned if you center an "X" in the boxes at the top right and left corners of the claim. Please be sure that all line-item information appears on the same horizontal line.

Keep it clean-Please don't print, write or stamp extra data on the claim form. When you correct errors, please use white correction tape only, not correction fluid.

Ribbons and fonts-Use only black ribbons in your typewriter or printer. Change your ribbons frequently. Although we can accept claims using a 12-pitch setting, we prefer that you use a 10-pitch setting. If software supports fonts, please use Courier 12 monospace font.

Use UPPERCASE-Use only UPPERCASE letters for alphabetical entries. Don't mix fonts or use italics, script, percent signs, question marks or parentheses.

Names-For all blocks requiring names, please omit any titles, such as Mr. or Mrs. **Enter the last name first, followed by a comma and then the first name (Last Name, First Name – for example, DOE, JAMES)**

Dates-Use an eight-digit format for all dates. For example, enter July 1, 1999 as 07011999. All dates must be valid dates. Some fields require an entry such as DOS, others are optional.

Time-Use a four-digit format for time, referred to on the form as "units" (see Block 24G). For example, enter one hour and 15 minutes as 0075.

Print quality-You can help ensure that your paper claims are accurately processed by checking the quality of the print carefully. Faint printing can cause scanning problems. Please replace your printer ribbon regularly, and be sure to use the highest quality print setting available.

Dollars and cents-Please don't use dollar signs in any block. Separate dollars and cents with a blank space. For example, enter $1,322.00 as 1332 00.

Forms-Please don't fold, staple or tape your claim. Please separate your forms carefully. If you use bursting equipment, adjust the splitters to precisely remove the pinfeed edges. Claims must be submitted on the 12/90 version of the HCFA 1500 form printed with red “drop out” ink. You may obtain copies of the HCFA 1500 through various vendors, the American Medical Association, or the U.S. Government Printing Office.

Lines of Service (block 24)-Please limit yourself to six lines on each claim you file.

If you follow these guidelines, we'll be able to process your claims expeditiously.

ABCBS HCFA-1500-Step-by-Step Instructions

The following information is designed to help you complete the HCFA 1500. Please only submit paper claims if electronic claim submission isn't possible. Please remember that you only need to fill out the blocks for which we've provided instructions.

Block I a-Insured's I.D. number
Enter the subscriber's current identification number exactly as it appears on their health insurance identification card, including any alpha or numeric prefix or suffix, if present. For example, when submitting claims for BlueCard® (Out-of-Area) Program patients, please be sure to use the three-letter prefix that appears on the identification card. An entry in this block is required. Please don't list any extra data, such as the name of the plan. Transposed or incomplete contract numbers will cause a delay in processing or denial of the claim.

Block 2-Patient's name
Enter the patient's last name followed by a comma and the first name in all capital letters. An entry in this block is required. Do not include any titles (such as Mr. or Mrs.), suffixes (like Jr. or Sr.), apostrophes, hyphens, or any other marks of punctuation besides the comma. For example, enter the name Mary O'Hara as "OHARA, MARY." Do not use nicknames.

Block 3-Patient's birth date and sex
Enter the patient's birth date and sex. Date of Birth is required.

Block 4-Insured's name
Enter the last name of the policyholder or subscriber, followed by a comma and the first name. Please enter this name exactly as it appears on their card**.** Do not include any titles (such as Mr. or Mrs.), suffixes (like Jr. or Sr.), apostrophes, hyphens, or any other marks of punctuation besides the comma. Do not use nicknames. For example, enter the name Mary always as "OHARA, MARY."

Please don't use the terms "same" or "self" if the insured's name is the same as the patient's name.

Block 5-Patient's address
Fill out this block only if the patient's address is different from the insured's address, in Block 7, and please enter no more than 24 characters in this field. Do not use a Post Office Box address unless absolutely necessary.

Block 6-Patient relationship to insured
Check the appropriate box for patient's relationship to the insured when block 4 is completed. Enter an "X" in one of the following boxes:

• Self - the patient is the subscriber or insured

• Spouse - the husband or wife of the insured

• Child - children covered under a family contract, who are unmarried and under age 19.

• Other - stepchildren, student dependents, handicapped children, and domestic partners. Please write in appropriate category above the box marked "other." Handicapped children who are incapable of self support may be retained on the family contract beyond age 19 if a written application is approved.

Block 7-Insured's address
It's very important to enter the insured's complete address for identification. The zip code is required.

Block 9(a-d)-Other insured's name & other information
If the patient is covered under another health benefit plan and Health Advantage, USAble, or Arkansas Blue Cross and Blue Shield is the secondary payer, please enter the full name of the policyholder and include the following information in Blocks 9 (a) - (d).

(a) Other Insured's Policy or Group Number
(b) Other Insured's Date of Birth and Sex
(c) Employer's Name or School Name
(d) Insurance Plan or Program Name

Block 10(a-c)-Is patient's condition related to?
For each category (Employment, Auto Accident, Other), insert an "X" in either the YES or NO box. When applicable, attach an explanation of benefits (EOB) or letter from the auto carrier indicating personal injury protection benefits have been exhausted. If there are any "Yes" responses be sure to put a date in Block 14.

Block lld-Is there another health benefit plan?
Enter an "X" in the appropriate box.

Block 14-Date of current (illness. injury or pregnancy)
- Injury - Enter date the accident/injury occurred
- Illness - Enter for an acute medical emergency only and include onset date of Condition
- Pregnancy - Enter the date of the LMP
- Surgery - For post-operative visits, please enter the date of surgery

Block 17-Name of referring physician or other source
Complete this block when:

- Consultations are performed
- Co-attending care is provided
- A laboratory is rendering services at the physician's request
- Direct supervision is provided; enter the name and license number of the supervised assistant who actually rendered the service
- Patient is referred to a non-panel/network provider

Block 18-Hospitalization dates related to current services
Complete only for services related to inpatient hospitalization, enter the admission and discharge dates.

Block 19-Reserved for local use

Block 20-Outside lab?
If laboratory work was performed outside your office enter the laboratory's actual charge to you. If the laboratory bills us directly, enter an "X" in the NO box.

Block 21(1-4)-Diagnosis or nature of illness or injury
Enter the appropriate five-digit ICD.9.CM. diagnosis code for which the services have been performed. Services for treatment of a psychiatric disorder require DSM-111 or DSM-III(R) five-digit codes. You can use up to four codes in priority order. Do not include the narrative description of the code. When searching for codes, always be as specific and accurate as possible.

V codes are acceptable when billing for wellness benefits.

Block 23-Prior authorization number
Fill out this block for services requiring referrals.

Block 24A-Date(s) of service
It is very important that you fill out this block correctly. Enter the month, day, year for each procedure or service. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column "G".

Block 24B-Place of Service (POS)
For Arkansas Blue Cross and Blue Shield claims use the current National Standard Format (NSF) POS codes. The following are POS codes you should use when filling out this block.

11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	**Emergency Room - Hospital**
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance Land
42	Ambulance Air or Water
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Unlisted Facility

Block 24C-Type Of Service (TOS)
For Arkansas Blue Cross and Blue Shield claims use the current National Standard Format (NSF) codes. The following table outlines TOS codes you should use when filling out this block. This field must be entered using two digits.

01 – Medical Care
02 – Surgery
03 – Consultation
04 – Diagnostic X-Ray
05 – Diagnostic Lab
06 – Radiation Therapy
07 – Anesthesia
08 – Surgical Assistance
09 – Other Medical
10 – Blood Charges
11 – Used DME
12 – DME Purchase
13 – ASC Facility
14 – Renal Supplies in the Home
15 – Alternate Method Dialysis
16 – CRD Equipment
17 – Pre-Admission Testing
18 – DME Rental
19 – Pneumonia vaccine
20 – Second Surgical Opinion
21 – Third Surgical Opinion
99 – Other (e.g., used for prescription drugs)

Block 24D-Procedures, services or supplies
Complete this field with the current and valid CPT/HCPCS procedure codes and any applicable modifiers to further explain the services rendered.

Block 24E- Diagnosis "Pointer" code
Do not show the actual diagnosis code in this block. Enter the line-item diagnosis code as it relates to the services reported in Block 24D. Do not range, list primary diagnosis for service line first. (1,2,3 not 1-3). This requires you to enter the diagnosis code reference number "Pointer" (1, 2, 3, or 4) that corresponds with the diagnosis as entered in Block 21. Use the reference number for the primary diagnosis for why the service was performed. Each service or procedure must have a reference to one of the ICD-9 codes in Block 21.

Block 24F-Charges
Enter the charges for each line with a blank space separating the dollars and cents.
(e.g., enter 60.00 as 60 00)

Block 24G-Days or units
Enter the appropriate units of service for the procedure. Anesthesia services require the number of minutes to be

billed in this field. Other procedure codes that require time units should be billed as appropriate for the code.

Block 24K-Reserved for local use
It is essential that you provide the accurate servicing provider's number. Please follow the example listed below when you enter the servicing provider's identification number and the control letters in Block 24K.

Example:
Provider Number – 1J2345

Enter on your form as: 1J2345

Block 25-Federal Tax ID number
If available, please enter this identification number. If this number changes, notify ABCBS Provider Network Operations, Provider File section at Post Office Box 2181, Little Rock, AR 72203.

Block 28-Total charge
Enter the sum of all line charges.

Block 29-Amount paid
Report payments you've already received from another insurer. Attach a copy of the other insurer's explanation of benefits (EOB) and complete Block 9. Please note: if we're the secondary payer, you should not submit a claim until you've received the primary payer's payment.

Block 30-Balance due
Once you have received payment from another insurer, enter the balance due from us.

Block 31-Signature of physician or supplier
Have the physician or supplier sign here unless a signature waiver application has been completed already.

Block 33-Physician/supplier's billing name, address and phone
It's essential that you provide us with the correct billing provider's number. Please follow the example listed below when you enter the provider identification number. If a clinic - enter the Group # in the Group field. If a solo practitioner - enter the individual provider # in the PIN field.

Example:

Provider Number - 12345
Enter on your form as: 12345

The BlueCard Program
Provider Manual

What is the BlueCard Program?

The BlueCard Program links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for professional, outpatient and inpatient claims processing and reimbursement. The program allows participating Blue Cross and Blue Shield providers in every state to submit claims for indemnity and PPO patients who are enrolled through another Blue Plan to their local Blue Cross and Blue Shield Plan.

Through the BlueCard Program, you can submit claims for Blue Cross and Blue Shield members (including Blue Cross only and Blue Shield only) visiting you from other areas directly to ***Arkansas Blue Cross and Blue Shield***. ***Arkansas Blue Cross and Blue Shield*** **is** your sole contact for all Blue Cross and Blue Shield claims submissions, payments, adjustments, services and inquiries.

What services and products are covered under the BlueCard® Program?

The BlueCard Program applies to all inpatient, outpatient and professional services. The BlueCard Program does not yet apply to the following:

- stand-alone dental and prescription drugs
- vision and hearing
- Medicare supplemental

How do I identify BlueCard members?

When members from other Blue Cross and Blue Shield Plans arrive at your office or facility be sure to ask them for their current membership identification card. The two main identifiers for BlueCard members are the alpha prefix and, for eligible PPO members, the "PPO in a suitcase" logo.

Alpha Prefix
The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the Plan or national account to which the member belongs.

There are two types of alpha prefixes: Plan-specific and account-specific.

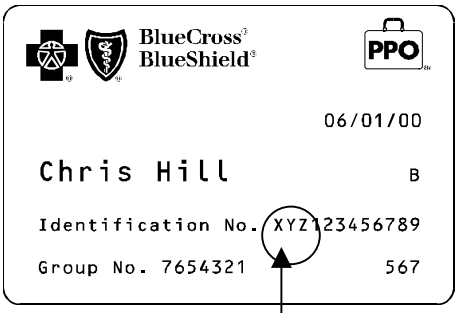
- **Plan-specific alpha prefixes** are assigned to every Plan and start with X, Y, Z or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
  - First character X, Y, Z or Q
  - Second character A-Z
  - Third character A-Z

- **Account-specific prefixes** are assigned to centrally processed national accounts. National accounts are employer groups that have offices or branches in more than one area, but offer uniform coverage benefits to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z or Q. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

TheBlueCard®
Now, Home Is Where The Card Is®

- **International alpha prefixes:** Occasionally, you may see identification cards from foreign Blue Cross and Blue Shield members. These ID cards will also contain three-character alpha prefixes. For example, "JIS" indicates Blue Cross and Blue Shield of Israel members. The BlueCard claims process for international members is the same as that for domestic Blue Cross and Blue Shield members.

"PPO in a suitcase" Logo
You'll immediately recognize BlueCard PPO members by the special "PPO in a suitcase" logo on their membership card. BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program. *It is important to remember that not all PPO members are BlueCard PPO members, only those whose membership cards carry this logo.* Members traveling or living outside of their Blue Plan's area receive the PPO level of benefits when they obtain services from designated PPO providers.



The "PPO in a suitcase" logo may appear anywhere on the front of the card.

The easy-to-find alpha prefix identifies the member's Blue Cross and Blue Shield Plan.

Identification Cards with no Alpha Prefix
Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member's ID card for how to file these claims.

It is very important to capture all ID card data at the time of service. This is critical for verifying membership and coverage. We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. **Do not make up alpha prefixes.**

If you are not sure about your participation status (PPO or non-PPO), call ***Arkansas Blue Cross and Blue Shield***.

How do I find out about the member's eligibility?

1.800.676.BLUE (2583)
With the member's most current ID card in hand, you can verify membership and coverage by calling BlueCard *Eligibility*® at 1-800-676-BLUE (2583). An operator will ask you for the alpha prefix on the member's ID card and will connect you to the appropriate membership and coverage unit at the member's Blue Cross and Blue Shield Plan.

If you are unable to locate an alpha prefix on the member's ID card, check for a phone number on the back of the ID card.

What about utilization review (precertification/preauthorization)?
You should remind patients from other Blue Plans that they are responsible for obtaining precertification/preauthorization for their services from their Blue Cross and Blue Shield Plan. You may also choose to contact the member's Plan on behalf of the member. If you choose to do so, refer to the precertification/preauthorization phone number on the back of the member's ID card.

Where and how do I submit BlueCard® Program claims?
You should always submit BlueCard claims to ***Arkansas Blue Cross and Blue Shield, Post Office Box 2181, Little Rock, Arkansas 72203-2181***. The only exception to this is if you contract with the member's Plan (for example, in contiguous county or overlapping service area situations), in which case you should file the claim directly to the member's Plan.

Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. **Do not make up alpha prefixes**. Incorrect or missing alpha prefixes and member identification numbers delay claims processing.

Once ***Arkansas Blue Cross and Blue Shield*** receives a claim, it will electronically route the claim to the member's Blue Cross and Blue Shield Plan. The member's Plan then processes the claim and approves payment, and ***Arkansas Blue Cross and Blue Shield will*** pay you.

If you are a non-PPO (traditional) provider and are presented with an identification card with the "PPO in a suitcase" logo on it, you should still accept the card and file with your local Blue Cross and Blue Shield Plan. You will still be given the appropriate traditional pricing.

The claim submission process for international Blue Cross and Blue Shield members is the same as for domestic Blue Cross and Blue Shield members.

Indirect, Support or Remote Providers
IF YOU ARE A HEALTH CARE PROVIDER THAT OFFERS PRODUCTS, MATERIALS, INFORMATIONAL REPORTS AND REMOTE ANALYSES OR SERVICES, AND ARE NOT PRESENT IN THE SAME PHYSICAL LOCATION AS A PATIENT, YOU ARE CONSIDERED AN INDIRECT, SUPPORT OR REMOTE PROVIDER. EXAMPLES INCLUDE, BUT ARE NOT LIMITED TO, PROSTHESIS MANUFACTURERS, DURABLE MEDICAL EQUIPMENT SUPPLIERS, INDEPENDENT OR CHAIN LABORATORIES, OR TELEMEDICINE PROVIDERS.

IF YOU ARE AN INDIRECT PROVIDER FOR MEMBERS FROM MULTIPLE BLUE PLANS, FOLLOW THESE CLAIM FILING RULES:

- IF YOU HAVE A CONTRACT WITH THE MEMBER'S PLAN, FILE WITH THAT PLAN.
- IF YOU NORMALLY SEND CLAIMS TO THE DIRECT PROVIDER OF CARE, FOLLOW NORMAL PROCEDURES.

- IF YOU DO NOT NORMALLY SEND CLAIMS TO THE DIRECT PROVIDER OF CARE AND YOU DO NOT HAVE A CONTRACT WITH THE MEMBER'S PLAN, FILE WITH YOUR LOCAL BLUE CROSS AND BLUE SHIELD PLAN.

When and how will I be paid for BlueCard® claims?

In some cases, a member's Blue Cross and Blue Shield Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, ***Arkansas Blue Cross and Blue Shield*** may either ask you for the information or give the member's Plan permission to contact you directly.

Who do I call about claims status, adjusting BlueCard® claims and resolving other issues?

Arkansas Blue Cross and Blue Shield – BlueCard Customer Service – 501-378-2127 or 1-800-880-0918.

How do I handle calls from members and others regarding claims status or payment?

If a member contacts you, tell the member to contact their Blue Cross and Blue Shield Plan. Refer them to the front or back of their ID card for a customer service number.

The member's Plan should not be contacting you directly. However, if the member's Plan does contact you to send them another copy of the member's claim, refer them to ***Arkansas Blue Cross and Blue Shield, 501-378-2127 or 1-800-880-0918*.**

How can I find out more information about the BlueCard® Program?

For more information about the BlueCard Program, call ***Arkansas Blue Cross and Blue Shield at* 501-378-2127 or 1-800-880-0918** or visit the BlueCard Program Web site at www.bluecares.com/bluecard

Type of Service Codes 2000

Beginning	Ending	NSF TYPE
A0021	A0999	01
A4000	A4640	12
A4641	A4647	04
A4648	A8999	12
A9150	A9150	09
A9500	A9500	04
A9503	A9503	04
A9505	A9505	04
A9507	A9507	04
A9605	A9605	04
A9900	A9901	12
B4000	B9999	12
B4000	B9999	18
E0100	E0784	12
E0100	E0784	18
E0785	E0785	12
E0786	E9999	12
E0786	E9999	18
G0001	G0001	05
G0002	G0002	02
G0003	G0007	05
G0008	G0010	01
G0015	G0027	05
G0030	G0050	04
G0101	G0103	05
G0104	G0106	02
G0107	G0107	05
G0108	G0109	01
G0110	G0116	01
G0120	G0121	02
G0122	G0122	04
G0123	G0126	05
G0127	G0127	02
G0128	G0129	01
G0130	G0132	05
G0141	G0141	05
G0143	G0148	05
G0151	G0156	01
G0159	G0160	02
G0161	G0165	04
G0166	G0167	01
G0168	G0171	02
G0168	G0171	08
G0172	G0172	01
H5300	H5300	01
J0000	J9999	09
J0000	J9999	01

Beginning	Ending	NSF TYPE
K0000	K0048	12
K0049	K0049	12
K0050	K0104	12
K0050	K0104	18
K0105	K0105	12
K0106	K0118	12
K0106	K0118	18
K0119	K0123	09
K0124	K0136	12
K0124	K0136	18
K0137	K0412	12
K0415	K0418	09
K0419	K0461	12
K0462	K0462	12
K0462	K0462	18
K0463	K0501	12
K0503	K0528	09
K0529	K0530	12
K0531	K0534	12
K0531	K0534	18
L0100	L0119	12
L0100	L0119	18
L0120	L1120	12
L1200	L1290	12
L1300	L1300	12
L1300	L1300	18
L1310	L1499	12
L1500	L2999	12
L1500	L2999	18
L3000	L3100	12
L3140	L8039	12
L3140	L8039	18
L8100	L8239	12
L8300	L8330	12
L8400	L8699	12
L8400	L8699	18
L9084	L9084	12
L9900	L9900	12
L9900	L9900	18
M0005	M0064	01
M0075	M0100	01
M0101	M0101	02
M0102	M0300	01
M0301	M0302	05
P0000	P9999	05
Q0035	Q0035	05
Q0068	Q0068	05

Type of Service Codes 2000

Beginning	Ending	NSF TYPE
Q0081	Q0086	01
Q0091	Q0091	05
Q0092	Q0092	04
Q0103	Q0104	01
Q0111	Q0115	05
Q0132	Q0132	12
Q0136	Q0157	09
Q0163	Q0185	09
Q0186	Q0186	01
Q0187	Q0187	09
Q1001	Q1005	12
Q1001	Q1005	18
Q9920	Q9940	9
R0070	R0076	04
V0000	V2799	01
V5000	V5299	05
W0009	W0009	01
W7230	W7230	02
W7240	W7240	02
W9122	W9122	01
W9123	W9124	01
W9220	W9220	02
W9450	W9450	12
X9150	X9915	12
Y9120	Y9120	12
Y9121	Y9122	01
Y9123	Y9124	12
Y9125	Y9130	01
10000	69999	02
10000	69999	08
70010	77260	04
77261	77799	06
78000	79999	04
80048	85094	05
85095	85095	02
85096	88169	05
88170	88179	02
88180	88239	05
88240	88291	02
88299	88299	05
88300	88499	02
89005	89399	05
90281	90911	01
91000	91299	05
92012	92015	01
92018	92019	02
92020	92499	01
92500	92599	01

Beginning	Ending	NSF TYPE
92950	92971	01
92975	92998	02
93000	93499	05
93500	93660	02
93700	93726	05
93727	93727	04
93728	93740	05
93741	93744	04
93745	93999	04
94010	94799	05
95004	95199	01
95805	95999	05
96100	96105	01
96110	96110	01
96111	96549	01
96552	96552	12
96570	96571	02
97001	99142	01
99167	99169	12
99170	99170	02
99171	99171	12
99173	99173	01
99175	99192	01
99193	99194	12
99195	99199	01
99201	99240	01
99241	99275	03
99276	99499	01
00100	01999	07

ARKANSAS BLUE CROSS AND BLUE SHIELD

PREFERRED PAYMENT PLAN (PPP) DENTAL FEE SCHEDULE

"THE BLUE BOOK"

Effective - May 1, 2000

PROC CODE		DESCRIPTION	ALLOWANCE
D0120		Periodic Oral Examination	$20.00
D0140		Limited Oral Evaluation - Problem Focused (Formerly Code 00130)	$25.00
D0150		Comprehensive Oral Examination (Formerly Code 00110)	$30.00
D0210		Intraoral - Complete Series (Including Bitewings)	$55.00
D0220		Intraoral- Periapical-First Film	$15.00
D0230		Intraoral-Periapical-Each Additional Film	$13.00
D0240		Intraoral-Occlusal Film	$18.00
D0250		Extraoral-First Film	$20.00
D0260		Extraoral-Each Additional Film	$15.00
D0270		Bitewing-Single Film	$13.00
D0272		Bitewings - Two Films	$22.00
D0274		Bitewings - Four Films	$32.00
D0290		Posterior - Anterior Or Lateral Skull And Facial Bone Survey Film	$45.00
D0330		Panoramic Film	$50.00
D0340		Cephalometric Film	$45.00
D0460		Pulp Vitality Tests	$20.00
D0470		Diagnostic Casts	$25.00
D1110		Prophylaxis - Adults	$40.00
D1120		Prophylaxis - Child	$26.00
D1201		Topical Application Of Fluoride (Including Prophy)-Child	$34.00
D1351		Sealant - Per Tooth	$23.00
D1510		Space Maintainer - Fixed Unilateral	$120.00
D1515		Space Maintainer - Fixed - Bilateral Type	$172.00
D1520		Space Maintainer - Removable - Unilateral	$120.00
D1525		Space Maintainer - Removable - Bilateral	$172.00
D1550		Recementation Of Space Maintainer	$26.00
D2110		Amalgam - One Surface, Primary	$46.00
D2120		Amalgam - Two Surfaces, Primary	$62.00
D2130		Amalgam - Three Surfaces, Primary	$73.00
D2131		Amalgam - Four Or More Surfaces, Primary	$81.00
D2140		Amalgam - One Surface Permanent	$50.00
D2150		Amalgam - Two Surfaces Permanent	$63.00
D2160		Amalgam - Three Surfaces Permanent	$80.00
D2161		Amalgam - Four Or More Surfaces Perm	$95.00
D2330		Resin - One Surface, Anterior	$65.00
D2331		Resin - Two Surfaces, Anterior	$77.00
D2332		Resin - Three Surfaces, Anterior	$98.00
D2335		Resin - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	$125.00
D2336		Composite Resin Crown - Anterior - Primary	$105.00
D2337		Resin-Based Composite Crown, Anterior Permanent	$105.00
D2380		Resin - One Surface, Posterior - Primary	$60.00
D2381		Resin - Two Surfaces Posterior - Primary	$70.00
D2382		Resin - Three Or More Surfaces - Posterior - Primary	$88.00
D2385		Resin - One Surface Posterior - Permanent	$70.00
D2386		Resin - Two Surfaces Posterior - Permanent	$88.00
D2387		Resin - Three Or More Surfaces, Posterior - Permanent	$110.00
D2388		Resin-Based Composite -Four Or More Surfaces, Posterior Permanent	$120.00
D2510		Inlay - Metallic - One Surface	$275.00
D2520		Inlay - Metallic - Two Surfaces	$370.00

ARKANSAS BLUE CROSS AND BLUE SHIELD
PREFERRED PAYMENT PLAN (PPP) DENTAL FEE SCHEDULE
"THE BLUE BOOK"
Effective - May 1, 2000

PROC CODE		DESCRIPTION	ALLOWANCE
D2530		Inlay - Metallic - Three Surfaces	$415.00
D2542	*	Onlay - Metallic - Two Surfaces	$410.00
D2543	*	Onlay-Metallic - Three Surfaces	$430.00
D2544	*	Onlay-Metallic - Four Or More Surfaces	$450.00
D2610		Inlay - Porcelain/Ceramic - One Surface	$320.00
D2620		Inlay - Porcelain/Ceramic - Two Surfaces	$405.00
D2630		Inlay - Porcelain/Ceramic - Three Surfaces	$435.00
D2642	*	Onlay- Porcelain/Ceramic - Two Surfaces	$450.00
D2643	*	Onlay-Porcelain/Ceramic - Three Surfaces	$470.00
D2644	*	Onlay-Porcelain/Ceramic - Four Or More Surfaces	$490.00
D2650		Inlay - Composite/Resin - One Surface	$275.00
D2651		Inlay - Composite/Resin - Two Surface	$405.00
D2652		Inlay - Composite/Resin - Three Or More Surfaces	$435.00
D2662	*	Onlay - Composite/Resin - Two Surfaces	$420.00
D2663	*	Onlay - Composite/Resin - Three Surfaces	$450.00
D2664	*	Onlay - Composite/Resin - Four Or More Surfaces	$470.00
D2740	*	Crown - Porcelain/Ceramic Substrate	$550.00
D2750	*	Crown - Porcelain Fused To High Noble Metal	$550.00
D2751	*	Crown - Porcelain Fused To Predominantly Base Metal	$475.00
D2752	*	Crown - Porcelain Fused To Noble Metal	$485.00
D2780	*	Crown - 3/4 Cast High Noble Metal	$485.00
D2781	*	Crown - 3/4 Cast Predominately Base Metal	$465.00
D2782	*	Crown - 3/4 Cast Noble Metal	$475.00
D2783	*	Crown - 3/4 Porcelain/Ceramic (Not Veneers)	$500.00
D2790	*	Crown - Full Cast High Noble Metal	$500.00
D2791	*	Crown - Full Cast Predominantly Base Metal	$425.00
D2792	*	Crown - Full Cast Noble Metal	$435.00
D2910		Recement Inlay	$35.00
D2920		Recement Crown	$35.00
D2930		Prefabricated Stainless Steel Crown - Primary Tooth	$105.00
D2931		Prefabricated Stainless Steel Crown - Permanent Tooth	$105.00
D2932		Prefabricated Resin Crown	$105.00
D2933		Prefabricated Stainless Steel Crown With Resin Window	$105.00
D2940		Sedative Filling	$33.00
D2950	*	Core Buildup, Including Any Pins	$115.00
D2951		Pin Retention - Per Tooth, In Addition To Restoration	$25.00
D2952	*	Cast Post & Core In Addition To Crown	$190.00
D2954	*	Prefabricated Post & Core In Addition To Crown	$130.00
D2962	*	Labial Veneer (Porcelain Laminate) - Lab	$480.00
D2980		Crown Repair - By Report	$55.00
D3110		Pulp Cap - Direct (Excluding Final Restoration)	$22.00
D3220		Therapeutic Pulpotomy (Excluding Final Restoration)	$60.00
D3310		Root Canal Therapy - Anterior (Excluding Final Restoration)	$330.00
D3320		Root Canal Therapy - Bicuspid (Excluding Final Restoration)	$400.00
D3330		Root Canal Therapy - Molar (Excluding Final Restoration)	$510.00
D3346		Retreatment - Anterior	$330.00
D3347		Retreatment - Bicuspid	$400.00
D3348		Retreatment - Molar	$510.00
D3351		Apexification/Recalcification - Initial Visit	$180.00
D3352		Apexification/Recalcification - Interim Medication Replacement	$65.00

ARKANSAS BLUE CROSS AND BLUE SHIELD
PREFERRED PAYMENT PLAN (PPP) DENTAL FEE SCHEDULE
"THE BLUE BOOK"
Effective - May 1, 2000

PROC CODE		DESCRIPTION	ALLOWANCE
D3353		Apexification/Recalcification - Final Visit	$65.00
D3410		Apicoectomy/Periradicular Surgery - Anterior	$213.00
D3421		Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$213.00
D3425		Apicoectomy/Periradicular Surgery - Molar (First Root)	$213.00
D3426		Apicoectomy/Periadicular Surgery Each Addt'l Root	$113.00
D3430		Retrograde Filling - Per Root	$104.00
D3450		Root Amputation - Per Root	$138.00
D3920		Hemisection (Including Any Root Removal)	$144.00
D3950		Canal Preparation & Fitting Of Preformed Dowel Or Post	$100.00
D4210	*	Gingivectomy/Gingivoplasty - Per Quadrant	$296.00
D4211	*	Gingivectomy/Gingivoplasty-Per Tooth	$74.00
D4220		Gingival Curettage, Surgical, Per Quadrant - By Report	$150.00
D4240		Gingival Flap, Including Root Planing - Per Quadrant	$300.00
D4249		Crown Lengthening - Hard/Soft Tissue, By Report	$270.00
D4250		Mucogingival Surgery - Per Quadrant	$431.00
D4260	*	Osseous Surgery (Including Flap Entry & Closure - Per Quadrant	$518.00
D4263	*	Bone Replacement Graft - Single Site	$350.00
D4264	*	Bone Replacement Graft - Each Additional Site In Quadrant	$200.00
D4266		Guided Tissue Regeneration - Resorbable Barrier Per Site Per Tooth	$200.00
D4267		Guided Tissue Regeneration - Nonresorbable Barrier Per Site Per Tooth	$210.00
D4270		Pedicle Soft Tissue Graft Procedure	$331.00
D4271		Free Soft Tissue Graft Procedure (Including Donor Site)	$403.00
D4273		Subepithelial Connective Tissue Graft Procedure	$435.00
D4341		Periodontal Scaling And Root Planing - Per Quadrant	$132.00
D4355		Full Mouth Debridement	$49.00
D4910		Periodontal Maintenance Procedures (Following Active Therapy)	$69.00
D5110		Complete Denture - Upper	$650.00
D5120		Complete Denture - Lower	$650.00
D5130		Immediate Denture - Upper	$675.00
D5140		Immediate Denture - Lower	$675.00
D5211		Upper Partial - Resin Base (With Conventional Clasps,Rests & Teeth	$400.00
D5212		Lower Partial - Resin Base (With Conventional Clasps,Rests & Teeth	$400.00
D5213		Upper Partial - Cast Metal Base With Resin Saddles	$780.00
D5214		Lower Partial - Cast Metal Base With Resin Saddles	$780.00
D5281		Removable Unilateral Partial Denture -1 Piece Cast Metal	$350.00
D5410		Adjust Complete Denture - Upper	$32.00
D5411		Adjust Complete Denture - Lower	$32.00
D5421		Adjust Partial Denture - Upper	$32.00
D5422		Adjust Partial Denture - Lower	$32.00
D5510		Repair Broken Complete Denture Base	$100.00
D5520		Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	$65.00
D5610		Repair Resin Saddle Or Base	$60.00
D5620		Repair Cast Framework	$100.00
D5630		Repair Or Replace Broken Clasp	$90.00
D5640		Replace Broken Teeth - Per Tooth	$65.00
D5650		Add Tooth To Existing Partial Denture	$100.00
D5660		Add Clasp To Existing Partial Denture	$113.00
D5710		Rebase Complete Upper Denture	$250.00
D5711		Rebase Complete Lower Denture	$250.00
D5720		Rebase Upper Partial Denture	$200.00

ARKANSAS BLUE CROSS AND BLUE SHIELD
PREFERRED PAYMENT PLAN (PPP) DENTAL FEE SCHEDULE
"THE BLUE BOOK"
Effective - May 1, 2000

PROC CODE		DESCRIPTION	ALLOWANCE
D5721		Rebase Lower Partial Denture	$200.00
D5730		Reline Complete Upper Denture (Chairside)	$115.00
D5731		Reline Complete Lower Denture (Chairside)	$115.00
D5740		Reline Upper Partial Denture (Chairside)	$75.00
D5741		Reline Lower Partial Denture (Chairside)	$75.00
D5750		Reline Complete Upper Denture (Lab)	$180.00
D5751		Reline Complete Lower Denture (Lab)	$180.00
D5760		Reline Upper Partial Denture (Lab)	$180.00
D5761		Reline Lower Partial Denture (Lab)	$180.00
D6210	*	Pontic - Cast High Noble Metal	$480.00
D6211	*	Pontic - Cast Predominantly Base Metal	$405.00
D6212	*	Pontic - Cast Noble Metal	$415.00
D6240	*	Pontic - Porcelain Fused To High Noble Metal	$530.00
D6241	*	Pontic - Porcelain Fused To Predominantly Base Metal	$455.00
D6242	*	Pontic - Porcelain Fused To Noble Metal	$465.00
D6245		Pontic - Procelain / Ceramic	$530.00
D6519	*	Inlay / Onlay - Porcelain / Ceramic	$320.00
D6545	*	Retainer - Cast Metal For Acid Etched Fixed Prosthesis	$125.00
D6548	*	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	$150.00
D6740	*	Crown - Porcelain / Ceramic	$550.00
D6750	*	Crown - Porcelain Fused To High Noble Metal	$550.00
D6751	*	Crown - Porcelain Fused To Predominantly Base Metal	$475.00
D6752	*	Crown - Porcelain Fused To Noble Metal	$485.00
D6780	*	Crown - 3/4 Cast High Noble	$485.00
D6781	*	Crown 3/4 Cast Predominately Based Metal	$445.00
D6782	*	Crown 3/4 Noble Metal	$455.00
D6783	*	Crown 3/4 Porcelain / Ceramic	$480.00
D6790	*	Crown - Full Cast High Noble Metal	$500.00
D6791	*	Crown - Full Cast Predominantly Base Metal	$425.00
D6792	*	Crown - Full Cast Noble Metal	$435.00
D6930		Recement Bridge	$45.00
D6970	*	Cast Post & Core In Addition To Bridge Retainer	$190.00
D6971	*	Cast Post As Part Of Bridge Retainer	$150.00
D6972	*	Prefabricated Post And Core In Addition To Bridge Retainer	$130.00
D6973		Core Build-Up Or Retainer, Including Any Pins	$115.00
D6980		Bridge Repair - By Report	$120.00
D7110		Oral Surgery Extraction - Single Tooth	$60.00
D7120		Oral Surgery Extraction - Each Addt'l Tooth	$60.00
D7130		Oral Surgery Root Removal - Exposed Roots	$60.00
D7210		Surgical Removal Of Erupted Tooth	$120.00
D7220		Removal Of Impacted Tooth - Soft Tissue	$160.00
D7230		Removal Of Impacted Tooth - Partially Bony	$200.00
D7240		Removal Of Impacted Tooth - Completely Bony	$225.00
D7241	*	Removal Of Impacted Tooth - Completely Bony With Complications	$290.00
D7250		Surgical Removal Of Residual Tooth Roots - Cutting Procedures	$120.00
D7260		Oral Antral Fistula Closure	$276.00
D7270		Tooth Reimplant. And/Or Stabilization Of Accidentally Evulsed Tooth	$200.00
D7280		Surgical Exposure Of Impacted Or Unerupted Tooth - Ortho	$200.00
D7281		Surgical Exposure Of Impacted Or Unerupted Tooth To Aid Eruption	$161.00
D7285		Biopsy Of Oral Tissue - Hard	$80.00

ARKANSAS BLUE CROSS AND BLUE SHIELD
PREFERRED PAYMENT PLAN (PPP) DENTAL FEE SCHEDULE
"THE BLUE BOOK"
Effective - May 1, 2000

PROC CODE		DESCRIPTION	ALLOWANCE
D7286		Biopsy Of Oral Tissue - Soft	$75.00
D7310		Alveoplasty In Conjunction With Extractions - Per Quadrant	$120.00
D7320		Alveoplasty Not In Conjunction With Extractions - Per Quadrant	$140.00
D7340		Vestibuloplasty - Ridge Extension (Secondary Epithelialization)	$230.00
D7350	*	Vestibuloplasty - Ridge Extension (Including Soft Tissue Grafts, Etc.)	$450.00
D7410		Radical Excision - Lesion Diameter Up To 1.25 Cm	$90.00
D7420		Radical Excision - Lesion Diameter Greater Than 1.25 Cm	$130.00
D7430		Excision Of Benign Tumor - Lesion Diameter Up To 1.25 Cm	$138.00
D7431		Excision Of Benign Tumor - Lesion Diameter Greater Than 1.25 Cm	$230.00
D7440		Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm	$170.00
D7441		Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm	$275.00
D7450		Removal Of Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	$161.00
D7451		Removal Of Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	$253.00
D7460		Removal Of Nonodontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	$253.00
D7461		Removal Of Nonodontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	$299.00
D7465		Destruction Of Lesion(S) By Physical Or Chemical Method, By Report	$100.00
D7471		Removal Of Exostosis - Maxilla Or Mandible	$260.00
D7510		Incision And Drainage Of Abscess - Intraoral Soft Tissue	$65.00
D7520		Incision And Drainage Of Abscess - Extraoral Soft Tissue	$95.00
D7530		Removal Of Foreign Body, Skin, Or Subcutaneous Areolar Tissue	$130.00
D7540		Removal Of Reaction - Producing Foreign Bodies - Musculo System	$140.00
D7550		Sequestrectomy For Osteomyelitis	$138.00
D7560		Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body	$250.00
D7610		Maxilla - Open Reduction (Teeth Immobilized If Present)	$902.00
D7620		Maxilla - Closed Reduction (Teeth Immobilized If Present)	$646.00
D7630		Mandible - Open Reduction (Teeth Immobilized If Present)	$902.00
D7640		Mandible - Closed Reduction (Teeth Immobilized If Present)	$646.00
D7650		Malar And/Or Zygomatic Arch-Open Reduction	$902.00
D7660		Malar And/Or Zygomatic Arch-Closed Reduction	$646.00
D7670		Alveolus-Stabilization Of Teeth, Open Reduction Splinting	$646.00
D7680		Facial Bones - Complicated Reduction With Fixation And Multiple Surgical Approaches	$200.00
D7710		Maxilla - Open Reduction	$1,270.00
D7720		Maxilla - Closed Reduction	$953.00
D7730		Mandible - Open Reduction	$1,270.00
D7740		Mandible - Closed Reduction	$953.00
D7750		Malar And/Or Zygomatic Arch - Open Reduction	$1,270.00
D7760		Malar And/Or Zygomatic Arch - Closed Reduction	$902.00
D7770		Alveolus - Stabilization Of Teeth, Open Reduction Splinting	$953.00
D7780		Facial Bones - Complicated Reduction With Fixation And Multiple Surg Approaches	$1,400.00
D7910		Suture Of Recent Small Wounds Up To 5 Cm	$50.00
D7911		Complicated Suture - Up To 5 Cm	$78.00
D7912		Complicated Suture - Greater Than 5 Cm	$185.00
D7920		Skin Grafts (Identify Defect Covered, Location And Type Of Graft)	$80.00
D7940		Osteoplasty - For Orthognathic Deformities	$1,785.00
D7941		Osteotomy - Ramus, Closed	$902.00
D7942		Osteotomy - Ramus, Opened	$902.00
D7943		Osteotomy - Ramus, Open With Bone Graft	$1,025.00
D7944		Osteotomy - Segmented Or Subapical - Per Sextant Or Quadrant	$600.00
D7945		Osteotomy - Body Of Mandible	$902.00
D7950		Osseous, Osteoperiosteal, Periosteal, Or Cartilage Graft Of The Mandible	$1,200.00

ARKANSAS BLUE CROSS AND BLUE SHIELD
PREFERRED PAYMENT PLAN (PPP) DENTAL FEE SCHEDULE
"THE BLUE BOOK"
Effective - May 1, 2000

PROC CODE		DESCRIPTION	ALLOWANCE
D7955		Repair Of Maxillofacial Soft And Hard Tissue Defects	$1,200.00
D7960		Frenulectomy - Separate Procedure	$150.00
D7970		Excision Of Hyperplastic Tissue-Per Arch	$167.00
D7971		Excision Of Pericoronal Gingiva	$57.00
D7980		Sialolithotomy	$270.00
D7981		Excision Of Salivary Gland	$180.00
D7982		Sialodochoplasty	$410.00
D7983		Closure Of Salivary Fistula	$240.00
D8010		Limited Orthodontic Treatment Of Primary Dentition	$1,000.00
D8020		Limited Orthodontic Treatment Of Transitional Dentition	$1,000.00
D8030		Limited Orthodontic Treatment Of Adolescent Dentition	$1,000.00
D8040		Limited Orthodontic Treatment Of Adult Dentition	$1,200.00
D8050		Interceptive Orthodontic Treatment Of The Primary Dentition	$1,500.00
D8060		Interceptive Orthodontic Treatment Of The Transitional Dentition	$1,500.00
D8070		Comprehensive Ortho Treatment Of The Transitional Dentition	$3,400.00
D8080		Comprehensive Ortho Treatment Of The Adolescent Dentition	$4,100.00
D8090		Comprehensive Ortho Treatment Of The Adult Dentition	$4,800.00
D8210		Removable Appliance Therapy	$1,000.00
D8220		Fixed Appliance Therapy	$1,200.00
D8650		Treatment For The Atypical Or Extended Skeletal Case	$5,000.00
D8680		Orthodontic Retention	$300.00
D9110		Palliative (Emergency) Treatment Of Dental Pain - Minor Procedures	$38.00
D9220		General Anesthesia	$200.00
D9420		Hospital Call	$65.00
D9940		Occlusal Guards By Report	$150.00

NOTES:

"BR" = BY REPORT

*** = PROCEDURE REQUIRES AN X-RAY**

When separate fees are reported for an examination on the same day as a root canal or surgical procedure, the examination will be denied as a related procedure to the surgery. No payment will be made for the examination.